HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 4 September 2002
(*Morning*)

Session 1

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

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HEALTH AND COMMUNITY CARE COMMITTEE

†20th Meeting 2002, Session 1

CONVENER

Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Bill Butler (Glasgow Anniesland) (Lab)
*Dorothy-Grace Elder (Glasgow) (Ind)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Nicola Sturgeon (Glasgow) (SNP)

COMMITTEE SUBSTITUTES

Brian Adam (North-East Scotland) (SNP)
Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD)
Ben Wallace (North-East Scotland) (Con)

*attended

WITNESSES

Malcolm Chisholm (Minister for Health and Community Care)
Dr David Love (Scottish General Practitioners Committee)
Mr Simon Mackintosh (Turcan Connell WS)
Dr Graham McIntosh (Scottish Medical Practices Committee)
Mr David Ritchie (Scottish Hospital Trust)
Mrs Heather Sheerin (Highland Primary Care NHS Trust)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

LOCATION

Committee Room 1

†19th Meeting 2002, Session 1—held in private.

Scottish Parliament

Health and Community Care Committee

Wednesday 4 September 2002

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting at 09:34*]

Items in Private

The Deputy Convener (Margaret Jamieson): I welcome members back and hope that they had a productive recess. Agenda item 1 is consideration of whether to discuss in private items 6 and 7. Item 6 concerns the draft report on the Local Government in Scotland Bill and item 7 is consideration of the committee's forward work plan. Do members agree to discuss those items in private?

Members *indicated agreement*.

Subordinate Legislation

The Deputy Convener: The committee has a number of items of subordinate legislation with which to deal.

Community Care (Disregard of Resources) (Scotland) Order 2002 (SSI 2002/264)

Community Care (Additional Payments) (Scotland) Regulations 2002 (SSI 2002/265)

Community Care (Deferred Payment of Accommodation Costs) (Scotland) Regulations 2002 (SSI 2002/266)

Contaminants in Food (Scotland) Regulations 2002 (SSI 2002/267)

National Health Service (General Dental Services) (Scotland) Amendment (No 2) Regulations 2002 (SSI 2002/268)

The Deputy Convener: No members' comments have been received on the instruments and the Subordinate Legislation Committee had no comments to make. No motions to annul have been lodged. The recommendation is, that the committee does not wish to make any recommendations in relation to the instruments. Is that agreed?

Members *indicated agreement*.

Animal By-Products (Identification) Amendment (Scotland) Regulations 2002 (SSI 2002/283)

The Deputy Convener: No members' comments have been received; however, the Subordinate Legislation Committee made the following comment:

"The committee … draws the attention of the lead committee and the Parliament to regulation 4(a) on the ground that it is defectively drafted";

The Subordinate Legislation Committee also said:

"The committee … draws the attention of the lead committee and the Parliament to"

the drafting of regulation 4(a)

"on the ground that its meaning could be clearer, acknowledged by the Agency".

The Subordinate Legislation Committee also drew

"the attention of the lead committee and the Parliament to the Agency's response and to the Regulations on the ground that they are in need of consolidation."

No motion to annul has been lodged. The recommendation is, that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Food (Control of Irradiation) Amendment (Scotland) Regulations 2002 (SSI 2002/284)

Feeding Stuffs Amendment (Scotland) Regulations 2002 (SSI 2002/285)

The Deputy Convener: No members' comments have been received on the above and the Subordinate Legislation Committee had no comments to make. No motions to annul have been lodged. The recommendation is, that the committee does not wish to make any recommendations in relation to the instruments. Is that agreed?

Members *indicated agreement*.

Public Appointments and Public Bodies etc in Scotland Bill: Stage 1

The Deputy Convener: We are ahead of our scheduled timing. I welcome Dr Graham McIntosh of the Scottish Medical Practices Committee and Dr David Love of the Scottish General Practitioners Committee to the committee. They will give evidence in relation to the Public Appointments and Public Bodies etc in Scotland Bill. Do the witnesses wish to make an introductory statement before we proceed to questions?

Dr Graham McIntosh (Scottish Medical Practices Committee): I am quite happy to proceed to questions. I submitted a short paper to the committee and there seems to be no point in repeating what was said in it.

Dr David Love (Scottish General Practitioners Committee): That applies to me, too.

The Deputy Convener: Okay. We will start our questions. Do you believe that you have been consulted adequately on the bill? I will take Dr McIntosh's response first.

Dr McIntosh: Yes. Some people thought that the time frame was quite short, but I am quite satisfied with it.

Dr Love: We are quite happy with the process of consultation and we are grateful for the opportunity to appear before the committee today.

The Deputy Convener: Do you agree with the general principles of the bill?

Dr Love: No one would argue with the general principles of the bill, given that it reduces the number of unnecessary quangos. We have no objection to the general principles of the bill. However, we have reservations about whether it is a sensible idea to abolish the Scottish Medical Practices Committee. We also have reservations about how efficient or effective the proposed new arrangements will turn out to be.

Dr McIntosh: Despite the fact that we are appearing together as witnesses, we do not work together, although I agree with everything that Dr Love said. Like Dr Love, I agree that we should reduce bureaucracy and I support the reduction in the number of quangos. However, in the case of the SMPC, the suggestions about a replacement seem to be even more bureaucratic and expensive. They also seem to be less functional and could lead to a bit of instability in the general practice work force in Scotland.

Mary Scanlon (Highlands and Islands) (Con): In your submission, Dr McIntosh, you make clear that you have serious reservations about the abolition of the SMPC. I note that you set out in section 5 of your submission that the abolition will

"destabilise the workforce, increase the divide between secondary and primary care and lead to an exodus of young doctors to south of the Border … a worsening of recruitment and … potential for GPs to resign from hospital posts to concentrate on GMS."

The picture that you paint is not very rosy, particularly when you also set out that your

"concern is supported by communications we have been copied into from individuals and Trusts."

Dr McIntosh: Yes. The concerns that are expressed relate to the suggestion that finance for primary care is no longer to be ring fenced, but is to be contained in health boards' lump sums. There is a poor history of money being transferred to primary care and of primary care getting its share of resources.

The one saving factor at the moment is that because the non-cash-limited money is coming from the centre, there is a ring-fenced pot of money that preserves the general practice work force in a health board area. If that ring fencing disappears, primary care will have to compete against all the other problems in the health service. A health board might decide that it cannot afford to replace a general practitioner. That happens in secondary care where reappointment of consultants is deferred to save money. If the same thing happened in primary care, it would be totally destabilised. We do not really have waiting lists, but the scenario is that if GPs cannot be replaced, there will also be waiting lists in primary care.

09:45

General practice is a UK work force, not a ring-fenced Scottish work force. We are already net exporters of general practitioners and medical graduates to the UK. The income of general practitioners in Scotland is much less than the income of GPs in England. If we add to that the fact that the work load will increase if GPs cannot be replaced, more young GPs will travel to England. We already see that happening; I have an example from one of my neighbouring practices—an extremely desirable practice in which to work. That practice has had difficulty recruiting. They thought that they had recruited someone but, at the last minute, she wrote to them and said that she was not coming because she had been offered a better package in England. We are really concerned about that.

Mary Scanlon: If the money for GPs was ring fenced and GPs did not have to compete against the uplift in the drugs budget and secondary care, would the new system, which you describe as "cumbersome" and having "three tiers", work?

Dr McIntosh: It would be improved. At the moment, if a general practitioner retires, we get notification of retiral and we consider the various factors in the practice. We decide almost immediately whether there is justification for replacement. Practices need that instant reapproval. A three-tier local, regional and national committee will not function very rapidly. We are not sure who will be on that committee. Our current committee consists of members of the public and medical representatives.

Mary Scanlon: There is a serious crisis with the GPs in Caithness and Sutherland, which is part of the Highlands and Islands region that I represent. Do you believe that you have done everything possible under the current arrangements to consider recruitment and retention? Is there any chance that recruitment and retention could be done better? What difference will the new system make for the Helmsdale GP? What can I say to local people who are being told that the new system might bring them a doctor?

Dr Love: The SMPC is not in the business of recruiting doctors. The SMPC's role is to permit practices to appoint either a replacement doctor or an additional doctor; having done that, its role ends. We are then in the market to recruit GPs to the areas where recruitment, as Mary Scanlon rightly says, is extremely difficult. Nothing that the SMPC currently does inhibits recruitment and retention. I do not envisage the new arrangements making any substantial difference to that given that, similarly, the new arrangements will cease once approval has been given or withheld for the appointment of another GP.

Dorothy-Grace Elder (Glasgow) (Ind): You stated that Scotland is a net exporter of general practitioners and medical graduates to the UK. You also said that the income of GPs in Scotland is much less than it is in England. Could either or both of you expand on that? How much less does a GP earn in Scotland?

Dr Love: The best estimates are that a GP in Scotland earns about £10,000 to £12,000 less per annum.

Nicola Sturgeon (Glasgow) (SNP): I will play devil's advocate. One of the points that I picked up from Dr McIntosh's written submission was that the national set-up at the moment protects against local enthusiasm for the employment of additional doctors that might not be objectively justified. Could the opposite be the case with local arrangements, whereby local organisations are more able to understand and be sensitive to local needs, in a way that the SMPC is not?

Dr McIntosh: The SMPC is a useful arbiter. There have been recent examples of the involvement of local community representatives and MSPs in high-pressure groups that have tried to push for an extra practitioner in an area. We took a lot of soundings from the health board and from other areas—I think that Margaret Jamieson was involved in that—and at the end of the day, we had to take a view on the actual need for a general practitioner in that area, rather than the desire for a general practitioner. We had to weigh that against what would be expected in, and the needs of, other parts of the country. In some ways, we took the flak, but we had to stick with the medical need of the area, which did not justify another general practitioner.

The Deputy Convener: Dr McIntosh should understand that I got some flak as well.

Nicola Sturgeon: I can see the strength of such an independent system operating in that way. Finally, do you think that the way in which you make those decisions—which, I am sure, is objective and robust—takes account of local variations, such as rurality and deprivation?

Dr McIntosh: Yes. As a committee, we introduced measures to take account of all those things. The Medical Practices Committee in England does not, as we have done over the years, take into account other factors that we think cause an increase in work load—deprivation is one of them. That was one of the early things we did. Our guidelines illustrate that. We work on what are called notional lists. A practice has an actual number of patients, but we add a factor for deprivation. Rurality is another factor.

If we just worked to strict guidelines, many areas would not have general practitioners; they certainly would not have extra partners. Even though those factors are in our guidelines, we do not apply them rigidly. If a practice says that other factors influence the situation, we ask the practice and the health board to expand on those factors and to give us details. Other factors that we have recently added take into account asylum seekers, large numbers of drug addicts, and homelessness. We take all such factors into account. As I said, the committee is not rigid: if someone feels that they have a problem, we want them to explain it in order to allow us to make a decision. Even if we refuse them, we still tell them that they should come back to us again if they think that circumstances have changed.

Janis Hughes (Glasgow Rutherglen) (Lab): Your written submission says that abolishing the SMPC would involve replicating part of its work across all health boards. How will such a role be played out in each health board area?

Dr McIntosh: The SMPC and general practitioners are concerned that, with the new unitary board system, primary care will not have a very large seat at the table and that it will be fighting its corner all the time. We need a strong organisation that will push for primary care. Over the years, many of the good administrative staff in primary care have disappeared. As a result, there is now among the current administration a lack of knowledge about primary care. We feel that many of the boards will not be able to cope with the situation and will therefore need more administrators to carry out the SMPC's functions. At the moment, the SMPC is very small and functional and has very few staff. We just feel that each of the 15 health board areas will need a few people, and spreading them so thinly over the area will greatly diminish the level of expertise.

Janis Hughes: But you believe that the problem is more about administrative staff than professional input.

Dr Love: It is a combination of both. The problem is that such situations arise relatively infrequently in some of the smaller board areas, which means that they have no experience to go on. On the other hand, the SMPC deals with every situation throughout Scotland and is building up expertise simply as a result of its volume of work. Small boards do not have that expertise; they do not have the volume of work to build up expertise, nor do they have the robust and transparent methodology with which the SMPC reaches decisions. It should be said that GPs often do not like the SMPC's decisions and come to the SGPC as their union to take up cudgels on their behalf against the SMPC. Although we have occasionally done so over the years, we are quite satisfied that the SMPC reaches transparent and objective decisions and that the professional generally accepts those decisions graciously.

Janis Hughes: Do you think that that will not happen if the role is devolved to health trusts?

Dr Love: It is quite difficult to make a judgment on a matter about which there is very little information—we are really going into the dark. I have identified no robust proposals about how such functions will be taken on at local level.

Janis Hughes: You also mentioned cost implications. Might such implications arise partly from a perceived administrative deficit?

Dr McIntosh: Yes.

Dr Love: Each board will need to set up its own GP work force facility that might do nothing for long periods of time. There will need to be another regional work force organisation that will focus on planning GP numbers. Moreover, there will need to be a national organisation to oversee everything and to give central direction. I am sceptical about how those three tiers will gel and how rapidly they will reach decisions.

The Deputy Convener: Surely there is some expertise at health board level just now. For example, a request to fill or create a GP post is either supported or not by the area health board.

Dr Love: Generally, the request for an additional or replacement partner is passed to the GP sub-committee of the area medical committee that advises the board. The GP sub-committee will generally support such an application; it is relatively unusual for it not to do so. I do not think that any judgment is made at board level and the boards tend to accept the recommendation of—

The Deputy Convener: Surely there is a financial implication if health board A receives a recommendation that it requires one or more extra GPs. My understanding is that there are few circumstances in which the board does not support an application for additional GPs.

10:00

Dr Love: Your point about the financial implication for the board is quite right; the financial implication is borne centrally, because the money for GPs' pay comes from the non-cash-limited fund, which is held centrally. That payment is guaranteed on the appointment of the doctor. Our concern is that the decision to appoint be made on the ground of the needs of the population. Our fear is that in future the decision to appoint will be made not on those grounds, but on the basis of the amount of money that is available to boards at any given time.

Shona Robison (North-East Scotland) (SNP): My question has been answered to some degree. The arguments about decentralising authority to the health boards, responding to local needs and abolishing the SMPC have been made. In your answer to Nicola Sturgeon you said that you already take account of local needs, deprivation factors and rurality.

Dr McIntosh: Absolutely.

Mary Scanlon: In paragraph 4 of your submission you talk about promoting manpower in areas of deprivation and rurality. What have you done to promote recruitment and retention in such areas? Do you think that GP provision in such areas would suffer if the SMPC were abolished?

Dr McIntosh: I have always found such questions difficult to answer. With the non-cash-limited fund, GPs can apply to take on extra partners without much difficulty. There are health board areas that have high levels of deprivation and that have long waiting lists that would have no difficulty in getting extra general practitioners, but they do not do so.

Every year I get a report from each health board area. When a GP retires, we get a profile of their practice and a submission asking for a replacement GP. We often say yes and ask whether the practice would like to replace the GP with two GPs, because the practice warrants more GPs because it is in a deprived area. Such offers have been ignored. I cannot see how the new system will improve that situation. Many boards are aware that they could have more GPs, but they do not seem to do much about it.

Mary Scanlon: Are you saying that there have been circumstances in which you have recommended that a practice in a deprived area should have more GPs, but the trust has refused to implement that recommendation?

Dr McIntosh: The situation is difficult. The trusts accept that they could have more GPs, but we do not know what they do to encourage practices to increase the number of GPs. All we can do is keep making the recommendation.

Dr Love: The real problem is the current GP contract, which dates back to 1990. Prior to that, practices could appoint additional partners at marginal cost to the existing one. With the change to the contract that took place in 1990, the balance of payments that supported the presence of a GP in a practice was reduced significantly. Practices that would be permitted by the SMPC to appoint an additional partner may not do as that would cause the existing partners to suffer a substantial loss of income, which is a disincentive. For several years we have been trying to change the current contract and payments system to solve that problem, which deters practices from taking on additional partners.

The Deputy Convener: Would the same conditions apply to practices that wanted to take on associates?

Dr Love: Associates in rural areas who work with inducement practitioners are fully funded by the board and have no financial implications for practices.

Mary Scanlon: I do not want discuss the GP contract, as I know that a consultation is under way on that issue and that a vote has yet to take place. However, I am worried by the fact that we are considering only part of the issue, rather than all of it. The SMPC is being abolished, but there seems to be very little trust in, or support for, what is being put in its place. The main issue in Caithness, Sutherland and the Highlands is that the health service and the GP structure are being fragmented. I am concerned not only that you have no faith in the structure that will replace the SMPC, but that your recommendations are falling on deaf ears.

Dr McIntosh: I think of primary care services as not restricted to GPs. Although every year I receive a report from health boards about the

adequacy of general medical services in their area, I try to encourage them also to report on the adequacy of primary care services. Primary care is now delivered in many different ways—through GPs, district nurses, partners in general practice, locums and assistants.

There has been considerable resistance to making such reports. One or two boards have responded very well. We have sent out a report from one board that we regard as the gold standard, and have asked other boards to send us the same information. We have told them that such a report would provide them with a great picture of how primary care services are delivered in their area. Some boards have just thumbed their nose at us, but we have persevered.

Reports of the kind that we suggest provide an excellent picture of primary care services and of what GPs do. They indicate what work GPs do in hospitals and what outside commitments they have. GPs have many outside commitments. They do not merely sit in their surgery with patients. They work in local hospitals, teach students and teach GP registrars.

We have tried to get a picture of primary care services, but some boards have resisted our suggestions. That is why I am worried about transferring the primary care function to the boards. If they are not interested now, when primary care trusts still exist, how will they perform when those trusts have been disbanded and there is no strong focus on primary care in the unitary boards?

Mary Scanlon: Do you believe that the abolition of the SMPC will dilute the central role of the GP within the structure of the NHS?

Dr Love: There is a danger that that will happen. A theme runs through much of the work force planning that takes place. As Dr McIntosh said, we deliver care in teams. The danger is that the GP's central role in the team will not be recognised and there could be attempts to reduce the provision of general practitioner service and substitute by other members of the team. We regard all the other members of the primary care team as important in their own areas of expertise. We do not regard them as cheap, substitute GPs.

Janis Hughes: I want to pick up on what Dr McIntosh said about primary care trusts being disbanded.

Dr McIntosh: Yes, I believe that they are being disbanded. There are now unitary boards so primary care trusts are disappearing.

Janis Hughes: Yes, but primary care trusts will still be an entity in the unitary board.

Dr McIntosh: I am sorry, but I have always been led to believe that legislation will be introduced to disband trusts and that there will be only unitary boards. In my board area, that is what we are being told.

Nicola Sturgeon: To clear up the confusion, there has been no announcement about that yet, but my understanding of the direction of travel accords with that of Dr McIntosh. Perhaps the news is not yet formal.

The Deputy Convener: The trusts are still a legal entity. Nicola Sturgeon is correct in saying that there is nothing to suggest otherwise.

Nicola Sturgeon: We expect a statement from the minister about the outcome of the management review of the health service in September or October. It was announced in Parliament before the recess.

The Deputy Convener: Whether trusts remain is another issue to which we will return to take evidence.

Dr McIntosh: In my board, we are working on the assumption that the trusts are disappearing.

Nicola Sturgeon: Which is your health board?

Dr McIntosh: Grampian NHS Board.

Nicola Sturgeon: We must remember that some health boards, such as Borders NHS Board, are already merging. Some boards are ahead of the game and Grampian might be one of them. Dumfries and Galloway NHS Board is another one.

Shona Robison: The second paragraph of Dr Love's evidence talks about the need for safeguards to maintain the effectiveness of the SMPC's functions when—or if—they are transferred to primary care trusts and health boards. What sort of safeguards do you have in mind?

Dr Love: The safeguards would protect the funding stream, largely. We highlighted the fact that we are not confident that the present funding stream, which goes to resource GP services throughout Scotland, will be secure if the functions are devolved to individual boards. I have a reservation about the equity of provision throughout Scotland if all the decision making is left at board level. At the moment, the SMPC takes a national overview of the distribution of GPs. For instance, it could be by some fortuitous accident of funding that an area found itself particularly well off—although that is hard to imagine, it might happen. That area might decide to invest heavily in appointing additional GPs, which might be a good idea for that particular area. However, that would use up the scarce resource of GPs and distort the current equitable distribution of GP posts in Scotland.

Shona Robison: I take your point, which was well made. Do you mean that, with the caveat of the safeguards being in place, the functions of the SMPC could be performed safely by trusts and boards?

Dr Love: Yes—given that big caveat, if boards were able to make those decisions, those functions could be divorced from financial pressure. I find it hard to imagine that scenario.

Shona Robison: Yes, indeed.

Dorothy-Grace Elder: How many staff does the SMPC employ? The proposal for your organisation seems to relate to the desire of some to get rid of quangos. As a quango, how large, medium or small are you?

Dr McIntosh: We are very small. There are two part-time staff. The committee comprises four general practitioners and two lay members. That is the sum total.

10:15

Dorothy-Grace Elder: That is for the whole of Scotland. The number is small in the context of quangos.

You talked about the danger of basing decisions about GPs on short-term, local financial imperatives, instead of ensuring equitable provision for patients. How real is that danger?

Dr McIntosh: We have experience of trusts and of financial pressures in acute trusts. As I said, trusts delay staff appointments or do not reappoint staff to save money in the short term. We in general practice cannot work like that. We could not work without replacements.

However, replacement is not an automatic function. We consider each case. In areas where the population may have fallen, such as city centres, we have said to some practices, "Sorry, but although you had three full-timers before, only two and a half full-timers are justified now." General practice needs some stability in the work force in order to plan. Competing with secondary care for resources without that ring-fenced element would be destabilising and make it difficult to recruit GPs.

There is another slant to the matter. GPs undertake extra tasks. In my practice, one of my partners has an appointment in paediatrics at Aberdeen royal infirmary, and one partner is the medical director of a local hospital. I have a function on the SMPC. If GPs could not recruit partners, they would have to return to providing only general medical services. That would place a burden on secondary care. All over the country, GPs provide a valuable service in out-patient clinics and casualty services, for example.

Dorothy-Grace Elder: Your submission mentions the possible knock-on effect on secondary care.

Correct me if I am wrong, but you appear to be saying that too much power would be put in the hands of the health boards and that fragmentation would occur. The body that is being replaced involves only two part-time staff and four GPs. Do you fear that replacement of the SMPC will lead to more bureaucracy in every health board?

Dr McIntosh: I am sure that replacement will lead to that.

Dorothy-Grace Elder: Do you regard yourselves as a brake on what health boards might do in relation to GPs, particularly in areas of deprivation?

Dr McIntosh: Yes, if the funding stream is unprotected.

Mr John McAllion (Dundee East) (Lab): My question is for Dr Love. Your submission refers to the appeal mechanism and expresses concern that an appeal by a GP against a local appointment decision will be heard at the regional level of the structure, which is also responsible for establishing the level of general medical services in its region. You described that as a conflict of interest. Will you give an example of that?

Dr Love: It is difficult to give an example, as the situation has not arisen yet. It is more a concept of general principle about any appeal—the body that is hearing the appeal should be independent of the bodies that have made the decision against which the appeal is being made. Presumably, when the three tiers of work force planning are set up they will work in happy harmony and will attempt to implement a commonly agreed policy. It is hard to imagine that an appeal by a practice, against a decision that has been taken by the local arm of that structure, could be heard independently by the next step up in line management. That can hardly be described as independent.

Mr McAllion: Can you clarify that? For example, in my area in Dundee, what would be the regional level of the structure? Would it be Tayside?

Dr Love: My understanding is that the board is the local level. The regional level will be, I think, the proposed three functional regions for Scotland.

Mr McAllion: You have both expressed concern that the local health board level, for financial reasons, may turn down an application for a replacement GP because it does not have the money. Is not that a classic example whereby somebody could appeal to the regional level that there is a real need for the position, despite the local board refusing the application for financial reasons, and the regional people could overrule the local health board?

Dr Love: That is possible, but it may be that the regional level has agreed the board's policy.

Mr McAllion: If somebody is unhappy with a decision of the SMPC, to whom do they appeal?

Dr McIntosh: To the minister.

Mr McAllion: To the civil servants who appoint the SMPC.

Dr McIntosh: Well, the minister makes the—

Mr McAllion: Is not there a conflict of interest there as well? Should not there be a completely independent appeals body that is nothing to do with the minister—although it would have to be appointed through the minister—and the establishment in which it operates and which can, without having financial pressures and local concerns, genuinely take to heart the interests of the people?

Dr Love: Yes.

Mr McAllion: I have a final question that arises from earlier evidence. Throughout the acute services strategy reviews, which have caused enormous heartache across Scotland, the argument for centralising all the services in big super-hospitals was that enough cases and patients were needed to build up expertise. That is why local facilities were being shut down and facilities were being concentrated. The opposite argument is being used in this case, is it not? Local groups are being set up that have a small work load and therefore will have only a little expertise and knowledge. The argument in the acute services reviews was for having national knowledge, but that is being completely reversed in this situation. Is that the case?

Dr McIntosh: Yes, but I think that the numbers are much smaller in this case.

Mr McAllion: In Tayside, for example, how many times in a year will a decision have to be taken about a new GP?

Dr McIntosh: I do not have the figure with me, but it needs only one decision—in inner Dundee, for example—to destabilise the situation. If there were a shortage of money, it would take only one decision not to replace a GP, in one of the highly deprived parts of Dundee, to cause a lot of problems.

Mr McAllion: I can see that, but how often would such decisions be taken locally?

Dr McIntosh: Many times a year.

Mr McAllion: A hundred.

Dr McIntosh: No, probably not in Tayside.

Mr McAllion: I am trying to get an idea of the number of times such decisions are taken.

Dr McIntosh: I am sorry, but I do not have the figures with me.

Mr McAllion: How many cases do you deal with in a year?

Dr McIntosh: How many cases? Again, I do not have the figures with me.

The Deputy Convener: You can provide the committee with those details later.

Dr McIntosh: I forgot to bring our annual report with me today, which has everything in it.

Bill Butler (Glasgow Anniesland) (Lab): Dr Love, do you have a view, or do you know whether the British Medical Association has a view, for or against the abolition of the Scottish Hospital Trust?

Dr Love: I am sorry, but that is outwith my remit. I am chairman of the SGPC and that is not a matter that we have considered or discussed.

Bill Butler: Do you have a personal view?

Dr Love: I do not have a personal view, because I do not understand the issues. I have not thought about it.

Bill Butler: That is very honest. Thank you. That deals with that question comprehensively.

Janis Hughes: You stated in your written submission, and you also said in answer to an earlier question, that you recognise the Executive's intent to reduce the number of quangos. At the risk of upsetting some of your colleagues, can you give us your opinion of what other quangos could usefully be abolished with a view to reducing, as you stated, bureaucracy within the NHS?

Dr McIntosh: Do you mean all the quangos in Scotland?

Janis Hughes: You will obviously be aware of a number of quangos that operate within the NHS framework. Do you have a view on any other quangos that could usefully be abolished?

Dr McIntosh: I have to be honest and say no. Like most people in Scotland, who have no idea what my committee does, I am not really in a position to make justifiable comment on what other committees do, but I was surprised by the huge number of quangos listed in the bill. I also saw a paper detailing the costs of the quangos, some of which were enormous; my little quango hardly featured. The cost benefit of quangos is the key issue. To get rid of things just because they exist is not necessarily a good thing. We must consider the function and outcomes of quangos and study their decisions.

Janis Hughes: That is the problem, though. People agree in principle with the idea of

streamlining, but they want to preserve their own little quango.

The Deputy Convener: I thank both witnesses for providing answers to the varied questions that members of the committee have put. The clerks will speak to you about the issues on which we require further information.

Dr McIntosh: Thank you for inviting us. May we stay and listen to the rest of the meeting?

The Deputy Convener: Certainly.

The next witnesses are Mr David Ritchie, chairman of the Scottish Hospital Trust and Mr Simon Mackintosh of solicitors Turcan Connell. Good morning, gentlemen, and thank you for agreeing to come before the committee. Do you wish to make a short presentation before we start questions?

Mr David Ritchie (Scottish Hospital Trust): Having listened to the previous debate, I should say that the role of the Scottish Hospital Trust is very narrow in comparison with that of the organisations represented by other witnesses. In a nutshell, the Scottish Hospital Trust was set up to collect in one central fund the endowments that existed before 1948. Our role is simply to invest and to distribute the income from investments to the various health authorities.

As far as abolition is concerned, I do not think that it is appropriate for members of the trust to have a direct view. We take the stance that, under its present remit, the trust is effective and costs practically nothing to run. The more important issue is whether it is necessary to maintain it as a separate entity. If the trust were to be abolished, the natural course would be to distribute the funds to the various health boards and trusts. I should point out to the committee that, at present, there is a restriction that only the income from the investments may be used. If that restriction is maintained, the abolition of the Scottish Hospital Trust would not achieve a great deal, because the income received at local level would still be very much as it was before. If the whole thing were to be split up, the likelihood is that the aggregate costs would be greater. The cost argument for abolition would be less strong if the restriction were to be maintained.

Bill Butler: Do you agree with the general principles of the bill and do you feel that you have been adequately consulted?

Mr Ritchie: We have been perfectly well consulted. We proposed a number of options, including abolition, during the consultative process.

Bill Butler: Why did you propose the abolition of the trust, given that you said in your opening remarks that you do not have a view? Did you mean that abolition could be one way in which to proceed? You seemed to say in your opening remarks that abolition would make little difference unless the role of capital was changed.

Mr Ritchie: The fund has ring-fenced endowments that existed before 1948. When that ring fencing was done, there is no doubt that it affected by far the greater part of the endowments. Time has moved on and the health boards and trusts have other, post-1948, endowment funds that they run themselves. There is a management decision to be made about whether that distinction is necessary. If it is not considered necessary, strictly speaking, the Scottish Hospital Trust would not be necessary.

10:30

Nicola Sturgeon: In your written and oral evidence, you summarised the role of the Scottish Hospital Trust. What are the trust's total assets? How much money does it distribute annually to health boards?

Mr Ritchie: On the last accounts date, which was in March, the trust's assets were about £50 million, although the stock markets have done some damage since then. We distributed about £1.7 million to £1.8 million in the past year.

Nicola Sturgeon: I have a layperson's question, and I apologise if it sounds a bit daft.

I understand perfectly that the capital from the pre-1948 endowments cannot be touched and that only the interest is disbursed. If responsibility for investment is passed to health boards, the costs of administering the operation will increase, but will income reduce as well? If you invest a sum of money globally, you maximise income. However, will breaking up that pot of money into smaller amounts for health boards to invest individually result in less income, because the economies of scale will be lost?

Mr Ritchie: Economies of scale come from costs, not from gross income. The larger health boards in particular might be able to treat extra funds as simply an incremental amount on top of existing assets. Perhaps in those cases, the costs would not be significantly different. The smaller the pot, the more the cost of administering it becomes an issue.

Dorothy-Grace Elder: Would you be kind enough to expand on point 8 of your written submission, in which you suggest that there may be a reason to keep the SHT in its present form? Would you also clarify your comment about money? You said that you have assets of £50 million, which are held on a Scottish-wide basis, and that annually you distribute £1.8 million—at least, you said that you distributed £1.8 million last year. I presume that that money was made up

entirely of interest, and that you did not touch any of the capital funds. Do you handle other post-1948 assets?

Mr Ritchie: No. The trust's pot of assets, if I may use that term, has been fixed since 1971. The assets have changed only because stock market values have changed.

Could you clarify your question about point 8 of our submission?

Dorothy-Grace Elder: In point 8, you suggest that there may be a reason to keep the SHT in its present form.

Mr Ritchie: As I just said, one reason for splitting up a central body that disburses funds is that of giving the local level greater decision-making powers. All that I am suggesting is that, if we retain the constraint that only income may be spent, income at the local level will not be materially different from income that is distributed centrally. Let me put it another way. If the Scottish Hospital Trust is to be broken up, and if a proper job is to be done, we should also consider whether the constraint of using income alone remains appropriate.

Dorothy-Grace Elder: I have a final question. Those funds or moneys are probably made up from many old trusts and benefactions under people's individual names. Is there not a permanent legal constraint to use the interest money rather than the capital?

Mr Ritchie: I am afraid that I have no idea whether that is so, unless Simon Mackintosh can help. My only evidence is that that system was in place during the 1960s and it was clearly kept in place when the Scottish Hospital Trust was formed. Prior to that, and indeed at the moment, health authorities can borrow against the assets of the trust, but they must get ministerial approval and they must make provision for repaying the borrowing.

Dorothy-Grace Elder: I assume that some of those benefactions are many generations old. They could go back to Victorian times when there was no concept of a state service.

Mr Ritchie: All that I can say is that my understanding is that, for the most part, the endowments that have been granted post 1948 and held by the health boards may be spent. The capital may be spent.

Dorothy-Grace Elder: The capital may be spent.

Mr Ritchie: We understand that, with some limited exceptions, endowments generally are not made in perpetuity, but are made with a view to being spent. I have no idea, and I do not know how we would find out, what the position was for endowments that were granted before 1948.

Dorothy-Grace Elder: It would be interesting to find out. I am surprised that the fund is only £50 million. Are you excluding individual benefactions to particular hospitals that have been made over the years?

Mr Simon Mackintosh (Turcan Connell WS): No. Everything that the trust has was put into one pot in 1971. Nothing has been added to it since, apart from occasional cases of long-running trusts where the income was left to someone and the capital went to one of the predecessor bodies and, when the income beneficiary died, the capital fell back into the SHT. Apart from that, there has been no addition to the trust fund at all over the years.

The Deputy Convener: In 1948, £50 million would have been a significant sum.

How many employees does the Scottish Hospital Trust have, and what are the yearly costs for running the trust?

Mr Ritchie: We have no employees as such. We currently have five members, none of whom gets paid, and we employ investment managers to run the funds for us. We employ Turcan Connell WS to act as secretaries.

Mr Mackintosh: The total cost last year was £95,000 on professional and advisory fees; and approximately £15,000 on irrecoverable VAT. That makes a total for administrative costs of £110,000.

The Deputy Convener: Thank you.

Mr Ritchie: The greater part of that would be the cost of running the investments, which would fall in the event of the fund's being broken up.

Janis Hughes: We know that boards are managing the post-1948 endowments. Notwithstanding the comments you made in answer to an earlier question about the administrative costs of a smaller pot being greater, do you have any evidence that the Scottish Hospital Trust is better than the health boards at managing the endowments, perhaps from the point of view of expertise or because the pooling of resources leads to better investment?

Mr Ritchie: It is difficult to answer that question directly. I simply say that the remit given to the Scottish Hospital Trust right at the beginning was not to invest to achieve the largest possible immediate income. Particularly in the 1970s, all that would have achieved would have been an erosion of capital through inflation. The remit was to achieve a level of income that would be expected to rise with the cost of living over time.

Generally speaking, that was achieved, certainly until the early to mid 1990s. Income has stagnated somewhat since the mid-1990s, but that is primarily because of the changing corporate tax regimes and what has happened to dividends in

particular. We are going through a phase of losing advance corporation tax recovery. That will probably keep our income flat for the next two years. I hope that we can then start to move forward again.

We have been given a specific remit—to invest in such a way as to ensure that income can rise. Two of our members are investment professionals who can advise on how the funds need to be run in order to achieve that. If we were running funds with a view to spending the capital, we would invest in a very different way.

Janis Hughes: So that would be the downside to health boards taking over the SHT's function completely.

Mr Ritchie: One cannot approach the issue in such narrow terms. If boards were given the opportunity to use some of the capital, different factors would influence what they decided to do with their investments. If they were to continue to run the funds as the Scottish Hospital Trust is running them—using only the income—that might create complications, given that the bulk of their funds are run on a different basis.

Janis Hughes: Do you have different criteria for the allocation of funds?

Mr Ritchie: Seventy per cent of our fund is invested in equity markets for future growth. The balance is invested to achieve income.

Mr McAllion: Will you comment on section 7 of the bill, which gives health boards powers of investment and borrowing similar to yours? I do not understand why they need to be given such powers if they are already managing their local endowments. Do they not have such powers already?

Mr Mackintosh: I am not sure what investment powers the health boards already have. I am concerned that the powers set out in the bill are simply a restatement of the powers of the SHT, as outlined in the Hospital Endowments (Scotland) Act 1971. Law on investment powers has moved on considerably in the past 30 years. If it is necessary to give the health boards powers, it seems unnecessarily restrictive simply to restate the powers that are set out in the 1971 act.

Mr McAllion: I understand the SHT's investment criteria and how it operates. It is trying to defend the assets, to ensure that they last for a long time and continue to generate income for the NHS. Are not the 15 health boards small versions of the SHT that do the same thing locally? I do not know whether that is the case.

Mr Ritchie: The large boards, such as Greater Glasgow NHS Board and Lothian NHS Board, collected all their endowments into one commingled pot. Each of those pots is larger than the Scottish Hospital Trust. We are not talking about small amounts of money.

How the large boards handle their investments is not an issue. I am less certain about the smaller boards.

Mr McAllion: If the SHT is abolished and ceases to have paid members, smaller boards such as Tayside NHS Board will have to create investment and borrowing trusts to look after the moneys that they will continue to generate.

Mr Ritchie: All the authorities, except perhaps the very small island health boards, have funds of a reasonable size, which are already run by professional managers. However, their remit for running those funds may be different from that of the Scottish Hospital Trust.

Mr McAllion: By abolishing the SHT, are we not abolishing the investment criteria that ensure that assets are protected for all time?

Mr Ritchie: In so far as we are expressing a view, we believe that, if a decision is made to get rid of the Scottish Hospital Trust as a central collecting body, it would make sense to examine the restriction on investment.

Mary Scanlon: I want to pursue the issue of protection of assets. If the Scottish Hospital Trust is abolished, are you confident that its assets will be divided equitably between the health boards?

Will you explain point 7 of your submission? In it you state:

> "If the decision is taken to abolish SHT ... but to maintain the requirement that Health Boards and trusts use only the income from the funds and not the capital, it is important for the Committee to be aware of the following difficulties".

Are you concerned that the £50 million capital asset, rather than just the income from it, will be spent? Is the abolition of the SHT a means of allowing trusts to get their hands on this £50 million asset?

Mr Ritchie: If the SHT were abolished, an existing formula would be used to split the funds between 38 health boards and NHS trusts. The concept is that the funds would be gathered at health-board level, but the boards would have the opportunity to spread them throughout the trusts in their area.

10:45

Mary Scanlon: Would that depend on how much each trust put into the funds in the first place?

Mr Ritchie: The levels were fixed by statute in the 1990s.

Mr Mackintosh: After the health service was set up, the existing endowments went to the boards of

management under the National Health Service (Scotland) Act 1947. In 1971 they were collected together so that the Scottish Hospital Trust could provide the central fund. A list was kept of all the assets that were put into the SHT and we still have those ledgers in our office, so that we can trace back exactly what came from each board. There are complications, because some hospitals have been moved from one authority to another or they have been demolished and replaced by other ones. However, we can trace back to the inception of the SHT where all the assets came from.

When the basis of distribution was changed in 1993 to pure distribution on the basis of the assets that were contributed originally, there was a lot of negotiation on the percentage share of the underlying endowments that were identified with each health board area and, subsidiary to that, each NHS trust. Broadly, one could be satisfied that there would be an equitable distribution of the funds based on where they came from originally, if one used the income formula that is used currently, or something similar to it. The bill, as drafted, talks about regulations being made in consultation with the SHT and health boards.

The Deputy Convener: Is it possible for us to have a copy of the details of where the funds originated?

Mr Mackintosh: I could give you details of the current formula for distribution. There are two large black ledgers, which are several inches thick, that I would be happy to deliver to the Parliament for you to look at if you wish.

Mary Scanlon: I would like Mr Ritchie to clarify a second point, because I am not sure what he meant. It sounds like the decision to abolish the SHT might mean that trusts could use the capital rather than just the income. Is that a means of diminishing the fund, rather than borrowing against it or spending the income from it?

Mr Ritchie: I was trying to make the point the other way round. As matters stand, it looks as though the bill is suggesting that investment restrictions will remain. The funds will be dispersed, but the recipient bodies will be limited to spending only the income. The point that we are trying to make, as members of the Scottish Hospital Trust, is that if you are going as far as abolishing the SHT and dispersing the funds, for goodness' sake, have a think about whether you should allow people to spend capital as well as income.

Mary Scanlon: So you would be in favour of boards spending the capital asset?

Mr Ritchie: I am trying to say that the arguments for abolishing and breaking up the Scottish Hospital Trust are not strong unless you are also prepared to think about giving the different bodies the power to spend the capital in whatever way, limited or otherwise, that might be appropriate.

Mr Mackintosh: There might not be permanent depletion of the resources that we are talking about. The boards might simply be given an ability to spend an element of the capital gain that is produced each year, which is an important part of the overall return on the funds and has to stay in the endowment fund. We cannot distribute that, and the question should be whether the recipient bodies should have the ability to spend it annually.

Mary Scanlon: In the grand scheme of things, £50 million from the NHS budget is not very much. Are you saying that you would be quite happy for the fund to be depleted, prioritised by the trust and spent? Is it something of an anachronism?

Mr Ritchie: I am conscious of the scale in saying what I have just said about thinking of spending capital.

Mr Mackintosh: If one looks back at the 1969 report that led to the setting up of the SHT, the members of that body were clear that the relative importance of the pre-1948 endowments would diminish as years went by because of the increasing extent of locally-held endowments and changes in the value of money. Even then, they were saying there was far more requirement than anyone could find money for.

The Deputy Convener: Fifty-four years on it is time for a new look at that situation.

Dorothy-Grace Elder: Before moving on, have you or others considered that there is a moral responsibility? In fact, there might still be a legal responsibility to the old endowments to which I referred earlier. People made those endowments to the public for the best possible purposes when there was no state hospital service. Is not this a way of selling off the family silver of the NHS? Could other individual funds be raided by boards in the future?

Mr Mackintosh: To some extent that question might have been answered in the National Health Service (Scotland) Act 1947. In section 7(2) it says that pre-1948 endowments held by voluntary hospitals—other than those given between 1946 and 1947 when the announcement was made about the establishment of the NHS—were transferred to boards of management. They were then given particular responsibilities to continue meeting certain obligations that came with those endowments. We have a note about that from the 1974 SHT regulations. There was a certain amount of respect for the purposes for which people had given money and it is still incumbent on the recipient bodies to meet those obligations.

Dorothy-Grace Elder: Have you any examples

of them meeting those obligations? Some of the families that donated the money are still around. Do you agree that there is a moral responsibility?

Mr Ritchie: The act lists a number of the specific obligations. The first one states that Grampian NHS Board had a gift of £400 from which it should apply each year the sum of £13.75 in the purchase of gifts to bear the name of the donor's daughter. A tombstone was also to be maintained. The obligations are of that nature.

Dorothy-Grace Elder: There are bigger ones than that.

Would it be cheaper to maintain your own body as opposed to transferring functions to individual boards or is the administrative cost not of primary importance?

Mr Ritchie: I do not have an answer, which is why I am turning the question around. In the case of the larger boards—Glasgow, Lothian and perhaps Tayside and Aberdeen—it might be possible for the incremental costs to be de minimis. By the nature of the smaller boards, the costs will be de minimis anyway, so perhaps it is not a strong issue.

Mr McAllion: In Mr Ritchie's submission, he suggests that if the trusts are to be abolished, the opportunity should be taken to modernise the current rules on managing the pre-1948 endowments. Do you mean that as part of that modernisation, the restrictions on capital should be lifted and that it should be allowed to be used?

Mr Ritchie: I think we do.

Mr McAllion: You think that that is the case.

The Deputy Convener: Would it also provide the opportunity to ensure that everything was conducted according to the recent Financial Services Authority guidelines?

Mr Mackintosh: We thought it was important that, instead of the health boards being told to invest in accordance with the advice of someone they reasonably thought to be qualified, it would be more appropriate to say "in accordance with the Financial Services and Markets Act 2000". In that way, they can be sure they are taking advice from people who are properly authorised under the relevant UK legislation.

The Deputy Convener: Thank you very much for attending the Health and Community Care Committee and providing us with yet more questions to consider.

I welcome the next witness, Heather Sheerin, chairman of the Highland Primary Care NHS Trust. Good morning, Mrs Sheerin, do you wish to make a statement to the committee before we move to questions?

Mrs Heather Sheerin (Highland Primary Care NHS Trust): Good morning. I am afraid that you will have to excuse me, convener, but I have lost my voice this morning.

We sent a reply to the discussion document back in February 2001, but certain things have moved on since then. As I said in our recent submission, the appointment of a commissioner will cover many of the points that I raised in the original submission. In particular it covers points relating to how people are appointed and the requirement for training and accountability. The committee has my submission and I am happy to answer questions.

Bill Butler: Do you agree with the general principles of the bill and do you feel that you have been adequately consulted on the bill?

Mrs Sheerin: Yes. As I said in the submission, we have been consulted. I did not understand the bill totally when I read through it and had it not been for the explanatory notes I would still be struggling with part of it. I thoroughly enjoyed reading the explanatory notes. Given the earlier consultation and our responses I would say that we have been adequately consulted.

Dorothy-Grace Elder: Do you, or your colleagues in Highland NHS Board as a whole, feel equipped to take over two extra duties—the specialised roles of the Scottish Medical Practices Committee and the Scottish Hospital Trust?

Mrs Sheerin: I will comment on the Scottish Hospital Trust first. I was interested to hear the evidence that was given earlier. In the Highlands, we already have endowment bodies set up in the primary care trust and the acute trust. Highland NHS Board has a small endowment fund and, perhaps for the reason that the witness from the Scottish Hospital Trust mentioned, the board has given that fund to the Highland Primary Care NHS Trust to manage. We have trustees who are non-executive directors who manage that. It is the same for the acute trust. Whether that money is spent or not, it is looked after by the trust. In the Highlands that would be an extra £1 million. That would just go into our portfolio. We would not require any additional staff to manage that.

Dorothy-Grace Elder: Are the trustees volunteers?

Mrs Sheerin: No, the trustees are the non-executive directors of the trust. One of my concerns with the dissolution of the Scottish Hospital Trust is that currently, when the hospital trust disburses its funds, the funds go direct to the primary care trust, but it is suggested in the bill that the funds would go direct to the board. The board could do with the funds what it wants and need not pass them down to the trust. In our case—I can speak only for the primary care

trust—we devolve all our funds down to local level. All local health care co-operatives, mental health teams, sexual health teams and children's teams get money portioned out to them. They spend the money for the good and comfort of the patients and staff. That money provides things that would not otherwise be paid for from NHS money. I would not want that to disappear. That is one of my main concerns if the money is kept at the level of the NHS board and is not disbursed down to the trusts.

Dorothy-Grace Elder: Do you think that even hospital beds, and other things that the NHS should be buying, could be bought with those funds?

11:00

Mrs Sheerin: Although we use them to buy some items, we do not buy many hospital beds with them. As members know, we are closing down more beds and moving more people into the community in rural and remote areas, because that is where they want to live. If a district nurse finds it difficult to move some of those patients, the endowment fund will pay for Pegasus beds, hoists and adaptations to make patients' lives more comfortable.

Someone said that £50 million was not a lot of money out of the overarching amount of money that is spent on the NHS. However, when it comes down to the money that goes to primary care and to district nurses, £50 million is a tremendous amount of money. Our primary care trust gets £25,000, with which we do a tremendous amount of work. It may not seem like a lot of money to MSPs, but to us it is an awful lot of money, and in the Highlands we can do a lot with it.

Dorothy-Grace Elder: Are you saying that you are absolutely committed to distributing such moneys, if they come your way, for things that the NHS would not normally pay for?

Mrs Sheerin: Yes.

Dorothy-Grace Elder: I served on a hospital fundraising body for which a constant worry was being asked to pay for essentials that the NHS should have paid for.

What about taking over the specialist role of the SMPC?

Mrs Sheerin: We support the abolition of the SMPC and welcome the transfer of its work to local health systems. However, we are concerned that it might be better to give that work to three regional centres, rather than to each health board, because there must be a semblance of order to what is to be done in a region. We are also uncertain about the impact that that change will have on service delivery and the remuneration of practices before the new GP contract comes out. That particularly applies in the Highlands, where we have a lot of GPs in inducement practices.

Nicola Sturgeon: A number of concerns have been raised this morning about the abolition of the SMPC and I have no doubt that we will put those concerns to the minister. One concern strikes me as being quite powerful. The motivation behind the bill is to reduce bureaucracy and the number of quangos, yet you speak of setting up three regional structures. If I have understood you correctly, that will mean replacing one quango with three.

Mrs Sheerin: I am not as au fait with the SMPC as my medical director is. If he were sitting here, he could make a far stronger argument about that than I can. I know that we were concerned about whether the number of practices in a list would be recognised. If that work goes to 15 NHS boards, we could finish up with 15 systems that all do things differently. I am not sure that Scotland wants to go down that route. I firmly believe in devolution, but there must be a semblance of order to how we appoint GPs in Scotland.

Janis Hughes: I would like you to qualify some of your answers to the questions you were asked about the Scottish Hospital Trust. Are you saying that, if the Scottish Hospital Trust were abolished, you would still prefer endowments to be administered at primary care trust level, rather than at board level? Boards could disburse the money to their trusts.

Mrs Sheerin: I have no problem with the board servicing the endowment funds. In the case of the Highlands, we have been given the funds to administer because they are very small, but the board might take back a large endowment. I believe that the Scottish Hospital Trust gives us about £1 million, and the board might well take that money back. I am concerned that the income from that £1 million might not be disbursed to the trusts. I do not think that the bill says anything about boards having to disburse that money to the trusts—the boards could spend it at a different level. All that I am saying is that we would miss the money that we get from the Scottish Hospital Trust. In light of what has happened to endowments and to the markets after 11 September, all our endowment funds are worth much less than they were last year and the previous year. I would not like that fund to be eroded any more.

Janis Hughes: So you are saying that the system should be left as it is.

Mrs Sheerin: Not necessarily. However, if the fund is divided among the health boards, such as Highland NHS Board, they should be directed or required to ensure that acute and primary care

trusts receive their share of the income from that investment.

Mary Scanlon: I note in your submission that you support the abolition of the SMPC. I acknowledge that £26,000 goes a long way in providing hoists and so on for your patients. Do you agree that the SMPC safeguards the consistency and adequacy of GP services across the country, and helps to ensure that decisions are not made for short-term financial reasons? This morning, we have heard from doctors—representatives of the BMA and the SMPC—that they are worried that, when health boards start to make decisions about GP placements, those decisions will be made on financial grounds, instead of being based on the health and medical needs of the area in question. Is that the case?

Mrs Sheerin: The answer that I will give is the one that members would expect me to give. I like to think that we will always ensure that patients' interests are at the heart of decision making and that decisions about placements will not be made on financial grounds. I cannot imagine that that will happen.

Mary Scanlon: This morning Dr Love acknowledged that this measure might be a way of reducing the role of the GP. We are all aware of the importance of the full health team. Instead of the accident and emergency service in Thurso including GPs, it is being changed by the trust to a nurse-led service. There are serious GP shortages in Lybster, Helmsdale, Wick and throughout the Highlands. No day passes without my receiving letters and e-mails about this issue. Are you not reducing the role of the GP in the NHS infrastructure of the Highlands? Can you recruit and retain GPs whom people want, particularly in Helmsdale, through the primary care trust any better than the SMPC can?

Mrs Sheerin: I understand that the SMPC permits us to recruit GPs in more remote areas. It asks how many GPs are working in an area. In the case of inducement practices, it is for us to ensure that a GP is recruited.

If a practice with five or six GPs has a vacancy, we are not involved in filling that. It is up to the practice to do so. We are involved in filling vacancies only in inducement practices. We do that on behalf of the community. If there are vacancies in places such as Wick, it is up to practices to fill those. Practices are independent contractors and would not welcome the trust interfering and telling them whom they should appoint. GPs regard their practices as businesses. In rural areas where there are individual practices we appoint GPs on behalf of the community. Once a GP has been recruited, he or she is an independent contractor.

Mary Scanlon: Do you think that the SMPC makes decisions on the basis of health and medical need?

Mrs Sheerin: Yes.

Mary Scanlon: Why do you want the SMPC to be abolished, given the financial constraints that you face in the trust? Who makes the decisions in Helmsdale? The community there is up in arms because it has lost its doctor and believes that the trust is not giving it support. In Thurso the trust is reducing the role of GPs. Who is responsible?

Mrs Sheerin: We are not reducing the role of GPs in Dunbar hospital. The GPs have withdrawn their services from the hospital. That has nothing to do with the abolition of the SMPC. I did not come here to answer questions about what is happening in Dunbar hospital. As far as I am concerned, it has nothing to do with the role of the SMPC.

The Deputy Convener: I think that Mary Scanlon's question has been answered.

Nicola Sturgeon: You are right to draw a distinction between issues of recruitment of GPs and the role of the SMPC in determining how many GPs there should be in a given area, on which I want to focus. You said a minute ago that if the SMPC were to go, you would still do everything in your power to ensure that you had an adequate number of GPs and I am sure that you would. However, if the non-cash-limited general medical services fund becomes integrated into the health budget, that would no longer be within your power. You would have to compete with all the other parts of the health service for the funding. The fear that others have expressed this morning is that primary care would be the loser, as has happened all too often in the past.

Mrs Sheerin: I understand that fear. However, given the setting up of the NHS boards and the involvement of whole systems, I do not believe that primary care will be the loser. That is only my belief and I have no evidence to say that that will not happen, but I do not think that it will happen, given the system that we have nowadays, where people sit round the table at NHS boards.

In a primary care-led health service, which is what we should be considering, more funding should go into primary care, rather than community or acute hospitals. The majority of people seldom go into acute hospitals. GPs are the front and back door of health and they are the most viable part of the health service in Scotland. We should maintain that fact and their role should not be diminished.

Nicola Sturgeon: Absolutely. There is an argument for saying that a pot of money should remain ring fenced for general practice. I

absolutely agree. In a climate in which more and more money is being ring fenced notionally, for cancer for example, is there an argument that money should remain ring fenced to deal with those concerns?

Mrs Sheerin: Yes.

Mr McAllion: I accept entirely the fact that your perspective is that of the chair of a trust. However, we are talking about a new system in which, as Nicola Sturgeon identified, the board will make decisions about whether there is a need for a GP post in a given area and the board will be responsible for funding that post. From my experience with local authorities, I know that social work departments will often assess a patient's needs in terms of what they can afford to provide. Is there not a danger that given the mechanism that was set up to replace the SMPC, health boards will start to make those judgments, because they are responsible for budgets? Is there not a danger that they will say, "We can't say that we need a GP there, because we can't afford to fund a GP there"?

Mrs Sheerin: There is always that danger once we start devolving power and allowing local systems to make decisions.

Mr McAllion: I experienced the acute services crisis in Tayside, in which the chair of the health board told us continually that there would be no effect on patient care when millions of pounds were cut from the budget. The reality was that there was an effect on patient care. People always say that they do not intend that to happen, but is it not the reality that if the money is not ring fenced, we are in real danger?

Mrs Sheerin: As I said to Ms Sturgeon, I understand that there could be a strong case for the money to be ring fenced.

Mr McAllion: In the part of your submission in which you talk about the potential abolition of the SMPC, you refer to your uncertainty about the impact of the new GP contract on service delivery and remuneration options for practices with small patient lists. Will you expand on that uncertainty? Do you mean that you fear that the impact will be negative, or that you hope that it will be positive?

Mrs Sheerin: I know that the negotiations are going on just now, but my understanding is that the GP contract makes no mention of what is going to happen in many of our rural areas in the Highlands. I know that I am being parochial again, but the contract does not deal with a lot of our inducement practice GPs. That is why I said that I was uncertain about what will happen in such areas.

Mr McAllion: The impact could be negative on areas such as the Highlands.

Mrs Sheerin: I fear that the new contract could have a negative impact.

Mr McAllion: Do you have suggestions about what could be built into the new contract that would protect your interests?

Mrs Sheerin: No, I do not. I am uncertain, because we have not seen the final draft of the GP contract. We have fragile services already within the Highlands.

The health teams include a district nurse, perhaps a community psychiatric nurse and a GP, all of whom play their part. If part of that contract is suddenly changed and a team member works only 9 to 5 when everyone else has to work 24-hour days, I do not know what impact it will have. Even if it is changed, it will not happen in rural areas. Our rural GPs would not work in that way because they are committed to the people they serve. Returning to Mrs Scanlon's point, I think that, if there is no other service, we will have difficulty recruiting GPs. We will need more GPs than we have at the moment to cover an area. I am uncertain about the impact of the GP contract.

Nicola Sturgeon: The motivation behind the bill is to reduce the number of quangos and the bureaucracy. Are there any other quangos in the NHS that could be usefully abolished, but which are not covered by the bill?

Mrs Sheerin: I have examined the quangos and I do not know what many of them do.

Nicola Sturgeon: Which is probably a good reason for getting rid of them.

Mrs Sheerin: In relation to the code of practice that the commissioner will develop, I stated in my submission that we feel strongly about the accountability of non-executive directors, about which there is always a query. It is not only the accountability of the organisation that should be considered, but the accountability of the non-executive director.

We would also like more public bodies to have their board meetings in public, as they do in the NHS. Perhaps it is not always comfortable to do that, but they are dealing with public sector money and if they meet in private, it should be the exception rather than the rule.

The Deputy Convener: Thank you for your evidence.

The Minister for Health and Community Care is here, but Margaret Smith is unable to attend the meeting. We will have a five-minute break.

11:16

Meeting suspended.

11:26

On resuming—

The Deputy Convener: I welcome the Minister for Health and Community Care to the committee to answer some questions. Do you want to make an opening statement, minister?

The Minister for Health and Community Care (Malcolm Chisholm): Not really. We propose to abolish two non-departmental public bodies although, in the case of the SMPC, the time scale for doing that can still be discussed. I want to discuss that with those who have concerns about it, including the SGPC. No date for that is set in the bill. We will talk more about that in a little while.

Now that we are developing comprehensive work force development planning, it is better to get beyond a focus on only one part of that. The SMPC has never undertaken work force planning, but has been a reactive body concerning individual GPs. I am not saying that that has not been an important function, but we are seeking to extend that function through our new work force development arrangements. The other big change is that we are focusing on the whole primary health care team rather than simply on GPs. That also should be taken into account in work force planning.

I suspect that there may be more issues to do with that than with the Scottish Hospital Trust. Trusts and boards already operate endowment funds, so it seems unnecessary to have a separate body to deal with certain other endowment bodies. The proposal is to distribute those funds to NHS boards where they can be used at a local level. I will be pleased to answer questions on that issue as well as on the SMPC.

The Deputy Convener: You mentioned national work force planning, and a national work force committee is referred to in the Scottish Executive document "Working for Health". What role will that committee have in overseeing the distribution of GPs? You mentioned the changing role of primary care and the fact that not everything that was previously done by general practitioners will continue to be done by them, as people in other areas raise their levels of competency. How will that impact on the distribution of general practitioners on the ground?

Malcolm Chisholm: Many changes are taking place simultaneously in primary care. There is the new GP contract, the Arbuthnott proposals for the distribution of primary care money, the new developments in work force development, and—not least—the general developments in primary care and across the primary and secondary care sectors. This is an exciting time of great change in the development of primary care services. My overwhelming feeling is that we cannot just extract GPs from that.

Obviously, we are introducing work force planning for GPs for the first time ever. It is a sad fact that such planning and development has been rather lacking throughout the history of the NHS and we are very engaged with the issue. The Temple report has fed into our considerations, which means that, for the first time, we are looking properly at the needs of the medical work force as far as recruitment and retention are concerned.

Although that general activity is continuing, it is right for local health systems to make concrete decisions about how many staff there should be and so on. However, in response to concerns, we will also introduce an appeal mechanism to the regional work force development groups that will be compliant with the European convention on human rights and independent of the people in the primary care trust who make decisions on the employment of GPs. As a result, we are setting up a more comprehensive system that will not only take account of the whole health care team and work force planning but will come with an appeal mechanism.

11:30

The Deputy Convener: Your answer touched on the ways in which we have moved forward, particularly with the Arbuthnott formula. However, I do not share your view that the formula is applied to the n^{th} degree once the Scottish Executive makes its allocations to individual health boards. In fact, when I discuss the matter with my health board, people keep telling me that they are moving towards that aim, but no one can give me a time scale for doing so. The committee took detailed evidence on the changes that were proposed by Arbuthnott and on the advantages that they would have for significant areas that had been previously overlooked because of rurality, deprivation and so on. Given that the Arbuthnott formula is not dealt with equitably in health boards, never mind anything else, what assurances can you give me that the people who say yea or nay will deal with requests for a GP vacancy or a further GP equitably throughout Scotland?

Malcolm Chisholm: The time scale for Arbuthnott and GMS is completely different from that for the rest of the Arbuthnott measures. That is not happening yet; issues still have to be resolved. Indeed, as the Finance Committee pointed out in its recent report on stage 1 of the budget process, it would be ridiculous to do so before the contract issue was sorted out. I accept the Finance Committee's recommendation in that respect.

That said, although we continue to review issues

around Arbuthnott, people would in principle believe that primary care resources ought to be distributed over time according to some equitable formula instead of the traditional basis on which they have been distributed. That has to be the right approach, even though people will have different views about the detail of how that should work.

Although I understand your concerns, we are talking about a period in which we will expand the medical work force and the work force more generally. There will also be more developments and more decision making within primary care. Within that overall context, concerns about one particular body with very limited powers—the SMPC—are entirely understandable, but they are not where the key issues lie. However, I am keen to meet the SGPC to discuss its concerns and, not least, am prepared to examine the timing of any change in that regard.

Bill Butler: In their evidence this morning, the SMPC and the Scottish GPs' committee of the BMA stated their concern that the SMPC's abolition will mean that decisions on GP provision will be based on short-term financial considerations. They also outlined the negative consequences that could flow from such an approach. What is your response to those points?

Malcolm Chisholm: At the risk of repeating myself, I say that I would like to meet the Scottish General Practitioners Committee. I am not aware that it has asked for a meeting with me, but I am taking the unusual step of offering a meeting before I am asked because I would like to listen to the concerns of its members. I will seek in every way to meet their concerns as, generally, we want more GPs to work in primary care and for more to be done in that area. I would be concerned if GPs had fears about that and I am convinced that their concerns can be addressed and are being addressed.

In the longer term, however, we have to examine the planning of the GP work force in the context of the broader health care work force; we cannot take GPs out of the context in which they work, particularly given the emphasis that we have put on the primary health care team, which GPs welcome. We are all aware of the way in which practice nurses, for example, are doing more in that regard. A lot of that will be dealt with through the new contract as well.

Bill Butler: Do you think that the proposed abolition will lead to the exodus of young doctors to south of the border and increase the divide between secondary and primary care, as the SMPC predicts in its submission?

Malcolm Chisholm: The point of our policy is to break down the divide between primary and secondary care. You have an advantage over me in that I have not seen the submission that you are talking about. As with the SGPC, I would be glad to engage with the SMPC and, when making decisions about timing, I would take its views on board.

The Deputy Convener: Minister, I should point out that the submissions are in the public domain.

Malcolm Chisholm: Well, I have learned something this morning.

The Deputy Convener: I thought that you would have remembered from when you used to be a member of the committee.

Malcolm Chisholm: Back then I used to get the papers sent to me. I never had to get them off the web.

Nicola Sturgeon: Now that you know that, can we expect you to be prepared for your next appearance, please?

Malcolm Chisholm: I think that I am prepared—

Nicola Sturgeon: That was a joke, Malcolm.

This morning, serious concerns were raised about not only the abolition of the SMPC but the fact that the integration of the non-cash-limited grant management system funding into the health budget might mean that decisions about GPs are inevitably made on financial grounds rather than on those of need and that posts might not be created or vacancies not filled, as sometimes happens in relation to consultants, because the health board is trying to save money. Do you recognise that concern? How would you respond to the argument that there should be a degree of ring fencing, as has happened with other pots of money that have been given to the NHS?

Malcolm Chisholm: Ring fencing is a possibility, because the first change that would take place is that the money would go into the unified budget for the boards. However, there is no reason why ring fencing could not apply for whatever period of time people want it to. If that dealt with some of the SGPC's concerns, I would be prepared to consider the idea.

On reform of the health service, we have to examine how funds get into primary care. We know that the pressures on the acute sector mean that it is difficult to get funds into primary care, but that is the objective of our policy. I am prepared to consider various measures that will ensure that those resources get into primary care.

The Deputy Convener: That is welcome information.

Janis Hughes: What appeals mechanism would there be for reviewing decisions by primary care trusts on GP provision?

Malcolm Chisholm: I have already referred to the regional work force arrangements, which were outlined in the document that came out over the summer. Some of the details of the system have still to be fleshed out, but the general point is that the regional work force development group would be the appeal body. As I said, we will ensure that that body is totally separate from the people who make the original decisions in the primary care trusts. That is required under the ECHR. We will ensure that the responsibility for appeals rests with an independent body, which is the right place for it. In making those decisions, we must consider the NHS work force as a whole in each area.

Janis Hughes: Will you, as the minister, have the ultimate authority to overrule decisions that are unpopular or that generate local concern?

Malcolm Chisholm: That is not the proposal at the moment. I am in a no-win situation. I am criticised if I have too much control and I am criticised if I do not have enough control. If members have views on the matter, they can express them, but ministerial authority to overrule is not part of the present proposal.

Janis Hughes: So the ultimate decision will rest with you.

Malcolm Chisholm: No. The ultimate appeal body will be the regional work force development group.

Janis Hughes: That group will make the final decision.

Malcolm Chisholm: Yes.

Nicola Sturgeon: As we know minister, you cannot be relied on to overrule unpopular decisions even when you have the power.

As we have discussed with other witnesses, the motivation for the bill is to cut bureaucracy and to reduce the number of quangos. I think that all members would sign up to that. However, the bill will abolish one organisation and replace it with decision-making structures in each of the 15 health board areas plus regional organisations to deal with appeals. Is there not a danger of taking away a simple structure and replacing it with one that is more complex, bureaucratic and cumbersome?

Malcolm Chisholm: The bill will not create new structures or bodies. The regional work force development groups will exist for far more general purposes, which has been broadly welcomed. The bill will give those groups another task, but the groups will not be set up only to deal with that task. Equally, primary care trusts already have a role in making proposals to the SMPC. I am not sure what new body or bureaucracy will be created.

Mary Scanlon: I understood that we were participating in a consultation exercise about the possible abolition of the SMPC. After hearing this morning's evidence, I have grave reservations about that. We have received submissions that set out the potential problems of abolishing the SMPC. I am shocked that page 17 of the document "Working for Health: the Workforce Development Action Plan for NHSScotland" contains the phrase

"following the abolition of the Scottish Medical Practices Committee".

Have you already made up your mind?

Malcolm Chisholm: Nicola Sturgeon accused me of not doing my homework, but I thought that we were considering a bill this morning. There has been a consultation on the abolition of the SMPC, but we are now considering a bill. It is open to Mary Scanlon or any other member to attempt to amend the bill. The decision to abolish the SMPC was made long before I became Minister for Health and Community Care and it has gone through different processes over many months. The decision is now coming into legislation.

Mary Scanlon: Nicola Sturgeon and others raised the issues of bureaucracy, cost and whether the decision is based on financial or health considerations, but you have already made up your mind, minister.

Malcolm Chisholm: Collectively speaking, yes. However, the decision was made before I became Minister for Health and Community Care. I say that to illustrate that the proposal has gone through the long process that rightly takes place in Scotland. After consultation, the proposal was incorporated into a bill. I do not need to tell you your business, but the correct thing to do if you do not like the proposal is to lodge an amendment to the bill.

Mary Scanlon: During that long process of consultation you did not meet the SGPC, although this morning you invited them to meet you.

Malcolm Chisholm: I receive a large number of invitations to meetings and I have never yet turned down an invitation to meet the SGPC. It has not asked to meet me on the issue. Given that the proposal is now before the Parliament, I am keen to meet the SGPC to discuss its concerns, although it has not asked me for a meeting on the issue.

Mary Scanlon: So are you saying that, if the SGPC had grave reservations about the abolition of the SMPC, you would look on that sympathetically?

Malcolm Chisholm: No. The decision has been taken, but I have already indicated that the timing has been left open-ended. That is one of the issues on which we want to consult the SGPC. If I

can do anything else to meet its concerns on general policy, particularly primary care policy, I would want to do so.

11:45

Mary Scanlon: My question—

The Deputy Convener: Mary, just wait, because you have used up your time.

Mr McAllion: We heard evidence this morning from the Scottish Hospital Trust about the proposal to abolish the trust. The witnesses called for the modernisation of the rules on managing the pre-1948 endowments for which the trust is responsible—for example, they suggested that health boards should be allowed to use capital as well as interest. Do you agree with that suggestion, and if so, what do you intend to do about it?

Malcolm Chisholm: We will involve the SHT in the next stage of the process in relation to the distribution of the funds. The documents that accompany the bill explicitly state that. Obviously, I want to involve the trust in the detailed decisions that are made on the matter. Clearly, it knows far more about the issue than do most people in Scotland, so I would be open to its suggestion.

Mr McAllion: That is interesting, as section 7 of the bill gives health boards powers of investment and borrowing that are similar to those of the Scottish Hospital Trust, which described those powers as out of date and in need of modernisation. Was the SHT consulted before section 7 was drafted?

Malcolm Chisholm: The detailed suggestions that are being made can be taken on board through any amendments that may be required to the bill. It is by no means clear to me from your reference—

Mr McAllion: Almost every set of witnesses this morning has been asked whether they were consulted and they all answered yes. It amazes me to discover that what they told you is not in the bill; we will have to meet them again to listen to their concerns. There seems to be a gap between the consultation that is carried out and the people who draft the bill, who do not seem to listen to what they are told.

Malcolm Chisholm: I had better be careful about what I say, although I trod on this ground yesterday when I talked about the proposed mental health bill. There are more opportunities in the Scottish Parliament to re-examine issues if omissions have been made. I have not examined in detail the issue to which John McAllion refers, but I undertake to look into it now.

Shona Robison: On the general point of NHS quangos—leaving aside the SHT and the SMPC—can the other NHS quangos all be justified, or is there likely to be a further review of the number of quangos?

Malcolm Chisholm: Through the review of management and decision making we are examining many issues, including the number of NHS bodies in Scotland. We will have conclusions from that review fairly soon, so it would not be right to prejudge the issue. However, as most committee members realise, current legislation allows health systems to develop in relation to the number of health bodies. Members will know that in the Borders and in Dumfries and Galloway it is proposed to dissolve trusts. The power to do that exists under current legislation, so we do not need any general statement of policy for it to happen in local areas if that is what people there want. I draw that to the committee's attention. It could be said that, if the proposals are accepted—I have been sympathetic to them up until now—there will be a diminution in the number of health bodies in those areas. Under current legislation it is possible to dissolve trusts. Indeed, many were dissolved in 1999, when the new trusts were set up. We will have to wait for the conclusion of the review of management and decision making for a more general statement about the future of trusts.

Dorothy-Grace Elder: The witnesses from the BMA and the SMPC expressed particular concern about the way in which health boards deal with requests for GPs for areas of deprivation. They said that they already experience difficulties in persuading boards that when, for example, a doctor in an area of deprivation retires, an additional doctor—in other words, two doctors—is required. The witnesses suggested that, although boards might replace the doctor who retired, they are largely unsympathetic to the real needs of such areas of deprivation. Are you not handing over even greater power to boards, which the two bodies in question have found to be resistant to providing additional GPs in areas where they are most needed?

Malcolm Chisholm: I will look carefully at the evidence that was given on that issue. I would be concerned if what was said were the case, because addressing health inequalities is a key objective for all boards. We have sometimes had recruitment difficulties. Personal medical services have often been developed in areas of deprivation and they represent a good alternative way of dealing with the issue. I am confident that we could take action to ensure that areas of deprivation are properly covered. The Arbuthnott formula will offer the advantage for GMS of adequately taking account of that issue. One of the problems with the basis for the funding of GPs is that deprivation is not appropriately taken account of. The Arbuthnott formula will give

greater prominence to deprivation. The extensive nature of the shifts in GMS that will result from Arbuthnott means that the process must be gone through gradually and carefully. In general, the Arbuthnott formula will help in tackling deprivation.

The Deputy Convener: The SMPC indicated that although, when reviewing a request for a replacement GP, it had discovered on occasion that there were two vacancies, the GPs had a veto on whether to meet that extra requirement. How will that situation be managed in future?

Malcolm Chisholm: I am slightly confused by your point—in a way, it represents a critique of the present system. The situation to which you refer will not be caused by the proposed abolitions.

Dorothy-Grace Elder: The health boards will have greater control and they are already resistant to requests of the kind that I have described.

The Deputy Convener: You are misconstruing what the SMPC said. It said that when it received a request to consider whether a vacancy should be filled, it took the opportunity to examine the whole list and to take into account factors such as deprivation and rurality. On occasion, the SMPC has recommended that the requirement was not just to replace the single GP concerned, but to employ two GPs. It was the GPs, as independent contractors, who said, "Thanks, but no thanks." How would your proposals overcome that situation, minister?

Malcolm Chisholm: That is an entirely different issue, which is separate from today's main subject of discussion. I will reflect on the details of that situation and consider the motivation of the GPs in question. That seems to be a slightly odd situation. I will examine the matter further, but I do not think that it is relevant to the proposed change.

Mary Scanlon: Are you satisfied that the SMPC has helped to safeguard the adequate provision of GPs in rural and deprived areas?

Malcolm Chisholm: Many of the issues that we have discussed in relation to deprived and rural areas relate to recruitment and retention. They are not SMPC issues. You asked the chair of Highland Primary Care NHS Trust about Helmsdale. The issue in Helmsdale was a recruitment issue rather than an SMPC issue. We ought to be clear about the cause of the problem. In that sense, I do not think that the issue that you raise is relevant to our discussion today.

Mary Scanlon: Will the new arrangements help to safeguard adequate provision of GPs in rural and deprived areas?

Malcolm Chisholm: The key issue is not the arrangements, as there are many issues around the recruitment and retention of rural GPs. I visited several rural NHS boards over the summer, including Highland, Argyll and Clyde, Orkney and Shetland. During those visits, I saw many of the problems that exist in rural areas, including the particular difficulties with recruiting GPs. Most people understand the problems, but I do not think that the solutions hinge on the existence of the SMPC. We need to take initiatives in remuneration and training. I was interested in the proposal in Argyll to redesign care—in a sense—and the roles of certain members of the work force. There are a lot of innovative ideas but, as I said, most of them do not hinge on the existence of the SMPC.

Mary Scanlon: In reply to a question that Dorothy-Grace Elder asked earlier, we were told that, on average, GPs in England receive £11,000 to £12,000 more than GPs in Scotland. You mentioned remuneration. Are you considering giving GPs more money?

Malcolm Chisholm: The reason for that difference is that the present system of remuneration is based, to a large extent, on capitation and lists in England are longer. We are in the middle of introducing a new GP contract in which capitation will not be such a dominant element and in which there will be a greater focus on quality. I am sure that we all agree that that is a good step forward. Therefore, the new GP contract will change the position, to an extent. However, people should understand that the simple reason for the difference is the fact that GP lists are considerably longer—perhaps I should say larger—in England than in Scotland.

The Deputy Convener: I thank the minister for his evidence.

Subordinate Legislation

Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002 (SSI 2002/275)

The Deputy Convener: We move on to deal with other agenda items in which I believe the minister is involved.

Malcolm Chisholm: Do you want to ask me about the regulations?

The Deputy Convener: We must go through the formal process. You do not need to remain, but—

Malcolm Chisholm: I will stay if you want me to.

The Deputy Convener: You are welcome to stay, as always.

Adam Ingram lodged and subsequently withdrew a motion to annul the Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002 (SSI 2002/275). The report of the Subordinate Legislation Committee was circulated to members previously and is also included in the papers for today's meeting. The Executive has agreed to amend the regulations by removing the reference to neurosurgery for mental disorders from the instrument; the amending regulation is our next agenda item. A letter from the minister has also been circulated to members.

The Subordinate Legislation Committee draws the regulations to the attention of the lead committee and the Parliament because it is concerned about whether the regulations, even as amended, are compatible with the European convention on human rights. It also draws our attention to the Executive's explanation in that regard. We have received no comments from members and no further motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation on the instrument. Do members agree to that?

Members *indicated agreement*.

Adults with Incapacity (Specified Medical Treatments) (Scotland) Amendment Regulations 2002 (SSI 2002/302)

The Deputy Convener: We have received no comments on the regulations from members, the Subordinate Legislation Committee has no comments to make and no motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation on the instrument. Do members agree to that?

Members *indicated agreement*.

The Deputy Convener: That concludes the public part of the meeting.

11:59

Meeting continued in private until 12:14.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178