HEALTH COMMITTEE

Tuesday 2 September 2003
(*Afternoon*)

Session 2

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HEALTH COMMITTEE
4th Meeting 2003, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Jenny Bennison (Royal College of General Practitioners)
Dr Mary Church (British Medical Association Scotland)
Dr David Love (British Medical Association Scotland)
Dr Bill Reith (Royal College of General Practitioners)
Carrie Young, Scottish GP Committee (British Medical Association Scotland)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Elliot

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 2 September 2003

(*Afternoon*)

[THE CONVENER *opened the meeting at 13:59*]

The Convener (Christine Grahame): Welcome to the meeting. No apologies have been tendered.

With us as an observer today is Mr Andrew Walube, who is head of Hansard in the Ugandan Parliament. Andrew is a fine Scottish name and I am glad to welcome him to this meeting.

Item in Private

The Convener: Item 4 on our agenda concerns consideration of the appointment of an adviser to assist us with our work relating to the budget process. Do members agree to deal with the matter in private on the basis that it would not be appropriate to bandy people's names about while we consider their CVs?

Members *indicated agreement.*

Subordinate Legislation

The Convener: Our next item concerns negative instruments. I will have something to say later with regard to the subordinate legislation papers because I think that we were drowning in them previously.

Tobacco Advertising and Promotion (Sponsorship Transitional Provisions) (Scotland) Amendment Regulations 2003 (SSI 2003/265)

Adults with Incapacity (Management of Residents' Finances) (No 2) (Scotland) Regulations 2003 (SSI 2003/266)

The Convener: No comments have been received from members on the instruments. The Subordinate Legislation Committee had no comments to make and no motions to annul have been lodged. Do members agree to make no recommendations in relation to the instruments?

Members *indicated agreement*.

National Health Service Superannuation Scheme (Scotland) Amendment (No 2) Regulations 2003 (SSI 2003/270)

The Convener: No comments have been received from members on the instrument. The Subordinate Legislation Committee has raised a number of points with the Executive; copies of those comments have been e-mailed to members. The comments relate to the use of the word "may", as I recall. Over such things lives have been lost in the past, of course, but no motion to annul has been lodged because the Executive's explanation was accepted by the Subordinate Legislation Committee. Do we agree to make no recommendation in relation to the instrument?

Members *indicated agreement.*

Sweeteners in Food Amendment (Scotland) Regulations 2003 (SSI 2003/274)

The Convener: No comments have been received from members on the instrument. Again, the Subordinate Legislation Committee has raised a number of points with the Executive and copies of those comments have been e-mailed to members. The Subordinate Legislation Committee seems to be quite happy with the Executive's response. Do we agree to make no recommendation in relation to the instrument?

Members *indicated agreement.*

Feeding Stuffs (Miscellaneous Amendments) (Scotland) Regulations 2003 (SSI 2003/277)

The Convener: No comments from members have been received on this instrument. The Subordinate Legislation Committee had no comments to make and no motion to annul has been lodged. Do members agree to make no recommendations in relation to this instrument?

Members *indicated agreement.*

Primary Medical Services (Scotland) Bill: Stage 1

14:03

The Convener: I welcome Dr David Love—whom we have met before—and Dr Mary Church of the British Medical Association Scotland, and Carrie Young, who sits on the BMA's Scottish General Practitioners Committee. I refer members to our witnesses' written submission, committee paper HC/S2/03/04/1, which we have had an opportunity to peruse.

I invite Dr Jean Turner to begin the question and answer session.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Do you have any evidence on the number of practices that might opt out of provision of what are referred to as enhanced services, such as out-of-hours services?

Dr David Love (British Medical Association Scotland): There has been no formal data collection. However, we get the impression from informal feedback that, although a significant number of GPs have stated their intention to continue to provide out-of-hours care, the vast majority of practices will opt out of responsibility for that. For example, I gather that about 50 per cent of GPs in Glasgow have indicated that they will continue to carry out some out-of-hours work under the new arrangements, but the vast majority will give up the responsibility for such provision.

Dr Turner: Would there be any restriction on the number of hours that those particular doctors could work out of hours?

Dr Love: As GPs are self-employed and will be independent contractors, the junior doctors' new deal and the European working time directive will not apply to them.

Dr Turner: That is how I understand the situation.

Mr David Davidson (North East Scotland) (Con): Will health boards in areas in which no GP co-operatives provide out-of-hours services be in a position to implement quickly an out-of-hours service in order to ensure that patients do not suffer? We have already heard the GPs' opinion of their own role, but are health boards ready to provide such a service?

Dr Love: The straight answer is that the health boards are not ready today; however, they have until December 2004 to get their arrangements in place. After all, they have known about this eventuality for at least a year, or maybe two years.

A national implementation group has met twice to allow health boards and other national health

service stakeholders to consider provision of alternative services. Furthermore, a specific out-of-hours implementation group has been set up in which boards and representatives of the ambulance service, NHS 24 and other health service workers meet regularly to discuss how alternative arrangements will be put in place and made ready for December 2004.

Mr Davidson: Is your committee concerned about where the bodies will come from to provide the service?

Dr Love: That depends on what kind of bodies you mean. The vision is that the out-of-hours service in future might not look as it does at the moment, with GPs delivering the majority of care directly. Instead, there might be a much greater reliance on other members of the primary health care team, such as paramedics, nurses and pharmacists and NHS 24. I think that there will be a complete redesign of services and that they might not look exactly as they do now.

The Convener: Dr Love, if you feel that either of your colleagues has any additional comments to make, you should simply indicate that to me instead of formally approaching me each time. I am not quite sure whether the witnesses have agreed that Dr Love should be the main speaker.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): In Dr Love's response to Dr Turner's question, he said that there would be no limit on the working time of those who would be required to provide an out-of-hours service. Are there any guidelines in place? How do we ensure that we do not, as a result of the contract, have doctors who are overworked and overtired, who then do not treat patients correctly and who fall down on the big question of increased quality for patients?

Dr Mary Church (British Medical Association Scotland): The new contract will introduce far more flexibility and will allow new types of GP to emerge. For example, some GPs who continue to work during the day will do some out-of-hours work; however, there will be more salaried GPs, some of whom will carry out only out-of-hours work for perhaps two or three years before they change career. The flexibility within the proposed contract will make such a change much easier. At the moment, we all just become GPs. GPs will have the flexibility to have a salaried post during the day without having the same obligation to work as hard as they do now. In turn, we will have happier and less tired GPs and will therefore improve quality for the patient.

Mr McNeil: I must press you on whether any guidelines are in place for those who will provide out-of-hours services. In effect, because of pressures such as financial pressures, there would be no limits on the hours that the person providing that service would work. He or she could be called out to see a patient in the middle of the night and might misdiagnose as a result of tiredness.

Dr Love: That is the current situation, especially in rural areas, and it is completely unacceptable. Over-tired GPs—indeed, GPs who are probably not even fit to drive, never mind treat patients—have to go out and treat patients, because there is no alternative. The new contract will offer much greater scope for GPs to limit their working hours, so that they do not turn up at a surgery at 9 o'clock in the morning exhausted and sleep-deprived. As you say, that is a danger to patients.

Mr McNeil: I accept that point for the GPs who pass on responsibility for out-of-hours cover. However, that responsibility will pass on to someone else and I take it that there are no guidelines or advice in place to encourage the people who will provide the out-of-hours service to limit their number of hours and to ensure that they provide quality care.

Dr Church: That issue has been acknowledged in recent years. It is good practice to examine one's working hours; the need not to work long hours has been promoted more. There are good practice guidelines, but they are not set in tablets of stone. Independent contractors can still do what they like, but I presume that someone who is employed would be covered by the working time directive.

Mr McNeil: Are there guidelines?

Dr Church: You are talking about guidelines that are there in black and white for people to see.

Mr McNeil: Yes. If there are not, are there any plans to give such advice?

Dr Church: I cannot answer that. We might be able to consider the matter.

Mr McNeil: Do you believe that it would be advisable to provide such advice?

Dr Church: The issue has been discussed and is being discussed with increasing frequency. There might be something written down, but I cannot at the moment think what it might be. The profession recognises that it is good practice not to work too many hours. We might be able to provide the committee with something at a later stage, if we can find anything.

The Convener: Could working hours be dealt with in the regulations that will follow the bill, or am I flying the wrong kite?

Dr Love: I do not think that it is intended to lay regulations to limit the working week of general practitioners who are independent contractors, but we would very much like that to be the case. We have highlighted the issue of doctors who have to work excessive hours and who are unable to get

relief from their out-of-hours commitment. At the moment, there are no guidelines, rules or regulations that limit the working week of a GP.

The Convener: That could be dealt with in draft regulations. Your statement is on the record for the Executive to see.

Dr Love: There is no intent in the negotiations that any such regulations might be laid, but anything is possible.

The Convener: That is right.

Mr Davidson: Dr Church talked about sending some information to the committee. It would be helpful if we could get a view from the BMA on the number of new medically qualified people that its figures suggest might be required to fill the service gap that could be approaching. I know that the BMA has consulted its members very closely. Could you arrange for that? We would be able to study that information as part of our consideration of the bill.

Carrie Young (British Medical Association Scotland): We could have a look at that and try to report back to you.

Mr Davidson: Thank you.

I want to deal with rural practice. I am sure that all members of the committee have been approached by practitioners in rural areas who are expressing concern—which we must take into account—about whether the new contract will have an equivalent to inducement payments and whether any practices in remote areas will be disadvantaged to the extent that they will no longer be viable. Will you expand on that?

Dr Love: Yes. The UK General Practitioners Committee and the SGPC have spent a great deal of time seeking to ensure that the new contract addresses the problems that remote and rural practitioners face. The Scottish allocation formula, which allocates resources to practices, is weighted to deliver additional resources to remote and rural practices.

The minimum practice income guarantee also protects existing rural practice payments—mileage and what are known as chapter 10.5 payments. The new contract provides the opportunity for rural practices to be funded for the enhanced services whose delivery is unavoidable when the practices are huge distances from the nearest district general hospital.

We have paid particular attention to the inducement practitioners situation and we are in the midst of negotiations with the Executive to deliver an alternative scheme to the inducement scheme. The remote and rural practitioners sub-committee of the BMA, which met representatives of inducement practitioners last week, has discussed outline proposals for that replacement scheme. The sub-committee was positive about the proposals, but a fair amount of detail remains to be thrashed out. However, I cannot imagine that any practice would become unviable under the proposals, because the minimum practice income guarantee locks in existing rural practice payments.

14:15

Mr Davidson: You are saying to the committee that the SGPC believes that no one will suffer any financial detriment when the contract is adopted in remote areas; however, it was suggested informally to the committee by practitioners in Argyll, who come from areas with small populations, that the current payment that allows them to deliver a service will be reduced unless the contract is modified.

Dr Love: That would have been true had the allocation formula been fully effected without the protection of the minimum practice income guarantee. The MPIG guarantees that historical subsidies for rural practices will continue and we trust that they will continue in perpetuity, because those subsidies are vital for those practices' continuing viability.

Mr Davidson: Is that your committee's hope or belief?

Dr Love: It is the belief of the BMA and the SGPC negotiators. Some of the statements by the financial memorandum's authors were not as unequivocal and we will pursue that point.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I will pursue the matter, which is essential. I have an e-mail from one practitioner whom we met informally in Argyll last week. I will not mention his name, but I will read out a little of the e-mail, which says:

"On the first of April 2004 the Inducement scheme"—

to which you just referred—

"is to be abolished. This was decided 1 year ago yet none of us know whether our practices will survive after this date. Assurances have been given by the Exec and our negotiators, but they do not yet appear to have grasped the seriousness of the situation for remote practices and as yet haven't worked anything out."

I received that e-mail from one of the island GPs, who are, as that e-mail shows, extremely concerned.

You talked about the proposals for replacing the inducement scheme. I will link one of my concerns about the bill to your submission. You say that the bill is unique and that all we have to do is implement the arrangements that have been made by the negotiators—the national health service and GPs—but our role is not just to do that; our

role in the committee and in Parliament is to make good law. We must ensure that everything is covered.

The bill's intention is to make powers

"to ensure that practices and Health Boards maintain a base level of quality and organisation wherever in Scotland they happen to be."

I am unhappy with what I have read and what people have told me about how the new contract would apply to single-handed practices in the islands, for instance, and to the 70 inducement practitioners. Will you comment on my worries?

Dr Love: It is fair to say that some practitioners do not understand what is available in the new contract. We have been involved with representatives of inducement practitioners in the past 18 months or so and have constantly sought their views and concerns. We have ensured that they were fully involved as the contract was negotiated.

It was envisaged at the outset of the negotiations that the only realistic option for inducement practitioners under the new contract would be a salaried post. At the moment, inducement practitioners are employed on a complicated salaried basis into which are built perverse incentives. Over the past few years, inducement practitioners have complained vociferously about the scheme and have asked us to do something about it.

The conversion to a salaried scheme was undertaken as part of the new contract. Inducement practitioners will be able to use a model salaried contract, which has been priced by the review body. Any inducement practitioner who wishes to take up a salaried post as an employee of a health board in order to continue practising where they are can do so.

Mike Rumbles: Surely that is the point, but you are saying that the solution is to have salaried practitioners.

Dr Love: That is one option; there are three other—

Mike Rumbles: Okay. I would like to pursue that, but let us put that option to one side. What happens if the general practitioner does not want to go down the route of being a salaried practitioner?

Dr Love: The second option is that GPs will receive the equivalent of a minimum practice income guarantee. We are currently discussing with the Executive what that equivalent should be. Moreover, GPs will be able to have additional earnings through seniority payments, through the provision of enhanced services and through the achievement of higher quality. Inducement practitioners cannot do that at the moment. If inducement practitioners do any extra work and earn any more money, that money is simply subtracted from their inducement payment. There is therefore no incentive for them to do anything extra. The new option will provide the incentive for inducement practitioners to earn above the basic level.

The main disincentive for young doctors going to remote areas is the out-of-hours commitment. As part of the new contract they will, in most areas, have the ability to opt out of the responsibility for out-of-hours care. That will be a huge boost to recruitment in remote and rural areas. I emphasise that those proposals were discussed with the representatives of the inducement practitioners last week and they were very positive about them.

Mike Rumbles: You say that discussions on the proposals are continuing. However, we are scrutinising legislation and we have to be satisfied with the outcomes. I had thought that the proposals had been topped and tailed and that we were considering their implementation. Are discussions continuing?

Dr Love: Yes.

Mike Rumbles: What happens if a doctor in a one-person practice on an island opts out? The legislation that we are being asked to accept says that responsibility will lie with the health board. How will the health board offer health cover on the island if the GP does not like what you have negotiated and opts out?

Dr Love: We accept that, in some situations, it might be impossible for the GP to opt out of out-of-hours responsibility. For example, in the situation that you describe, with a single GP on an island, there might be no practical alternative. However, we have negotiated that GPs should, in such circumstances, be appropriately supported and should receive help from the board with the provision of locums and with periodic relief from out-of-hours work. Their remuneration should be enhanced because of their unavoidable out-of-hours responsibility. There will be situations in which it is simply not feasible for the GP to opt out of out-of-hours responsibility.

Mike Rumbles: I do not want to hog the questions, but this is a serious point on the only area in the bill with which I am not happy. You say that negotiations continue, yet the impression that has been created is that we have a done deal. I fear that, if we pass this legislation with these questions still unanswered, we will be heading for problems in the really remote areas of Scotland. This committee has to ensure that everybody in Scotland has proper medical cover.

Dr Church: Under the current system, doctors are either not going to remote areas or are leaving

them. That is a problem that the new contract tries to address. The concept behind the MPIG is that no one loses current income; whatever happens, their earnings will be at least equal to their earnings now. Moreover, there are all the extras. We cannot keep the status quo, because rural doctors are leaving.

Mike Rumbles: So why are the proposals still under discussion? Why have they not been agreed?

Dr Church: The discussions are on the fine details of exactly how things will be worked out, but the principle is that no practice will lose income. That has been agreed and will go ahead. The kind of detail that is being discussed is whether the figure will be £69,000 or £68,500 or whatever, but the principle has been agreed.

The Convener: I want to ask a couple of questions on remote practices, as distinct from rural practices. You referred to the subsidies for inducement practices, which will remain. Will those subsidies be upgraded over the years in line with inflation or some other factor?

Dr Love: The global sum allocation and the minimum practice income guarantee will be reviewed as the years go by and will be upgraded. My guess is that that will happen consistently throughout the country.

The Convener: My second question is on enhanced payments, which you said would probably benefit practitioners in remote areas. There is no definition of the enhanced services in the primary legislation; again, the definition is in the regulations. Is it therefore important that the committee see draft regulations that define those services before we deal with primary legislation? If people's livelihoods will be affected by the definition, should not we see that definition?

Dr Love: Absolutely. The bill enables things to go ahead, but an awful lot of things will be determined by regulations. The previous question was on whether it was surprising that negotiations were continuing. They are continuing—and they affect every GP in the country, not only the rural ones. Much technical detail has to be sorted out before the implementation of the contract on 1 April next year.

The bill itself will not determine the income or the viability of rural practices, but it will enable arrangements to be made whereby their viability is ensured. That is our objective. The BMA has no interest in threatening the viability and security of remote and rural practices. Indeed, we have made representations over many years on the problems that those practices face, with their out-of-hours commitments in particular. Those problems have been unacceptable. For the majority of remote and rural practices, they should be addressed.

Mr Davidson: I want to move away from questions of viability and of payments to doctors that would allow them to subcontract; I want to consider the practicalities of delivering quality health care. You spoke earlier about doctors' being too tired to be able to practise to the best of their ability. What should be done to ensure that remote practitioners do not end up reasonably paid but exhausted and therefore unable to satisfy the needs of the community?

The BMA's figures show that only 55 per cent of doctors in practice appear to support the contract. Do the figures give a clear statement of concerns among remote and rural practitioners that things have not been sorted out?

Dr Love: The 55 per cent figure was the number of GPs who were entitled to vote; of those who voted, 79 per cent voted in favour of the contract. However, there was no breakdown to show the votes of GPs in different parts of the UK, so we do not know how rural doctors or inner city deprived-area doctors voted.

Mr Davidson: The main point was about the quality of care that patients receive.

14:30

Dr Love: There are a couple of things to bear in mind about out-of-hours cover. Being on call overnight for out-of-hours co-operatives in Glasgow is a quite different proposition from being on call overnight on Eigg. On Eigg, doctors are liable to be undisturbed and not called out of their beds for weeks on end, whereas they work solidly all night in Glasgow out-of-hours co-operatives. There is a balance to be struck. Of course it is unacceptable that doctors are treating patients if they are sleep-deprived, but in remote and rural areas with small numbers of patients, doctors are able to get their sleep most nights. The problem is the psychological one of the unrelenting pressure of doctors' having to be available and not getting a break, rather than the intensity of work.

Mr Davidson: Can you comment on whether the contract has been signed and sealed?

Dr Church: Negotiations are continuing. Everyone wants the people on the islands to benefit from being able to opt out, which will be addressed in future. There is not a closed mind on island GPs' being able to opt out and we will pursue that.

The Convener: We have come to appreciate that the contract has not been topped and tailed or signed and sealed.

Mike Rumbles: I am not happy with this. In the conclusion to your written evidence, you state:

"A clear majority of GPs support the new GMS contract."

That is self-evident. However, you go on to say:

"The unique purpose of this legislation is to enable the implementation of the elements of the contract."

My question is simple. I am trying to find out what the elements of the contract are. It strikes me that we are being asked to consider something that will come along later in regulations. I want to flag up the fact that I am somewhat wary of this process.

The Convener: We have dealt to some extent with the regulations on enhanced services. We should write to the Minister for Health and Community Care to ask whether draft regulations can come before the committee before we go much further down the line. Does the committee agree on that as a way forward? It seems to me that regulations are crucial to the bill.

Members *indicated agreement*.

Janis Hughes (Glasgow Rutherglen) (Lab): This follows on from what we have discussed. You say that the bill is unique and that you welcome it and the overall discussion on new contracts. You comment on many of the proposals in the bill. In the light of the information that you have given us today about issues that are not yet cut and dried, can you think of amendments that would enhance the bill?

Dr Love: The bill as drafted is perfectly acceptable and does not need major amendment. We share the committee's view that the anxieties and concerns that we have raised will be addressed through regulations. We are equally anxious to see the regulations and have an input. It is important to point out that the bill is not going through in a vacuum; there are two blue books describing the agreements negotiated under the new contract. There are implementation issues. The bill is there to back up the principles, but the implementation process and the regulations will address the anxieties that we and the committee have.

Janis Hughes: So you are quite happy with the time scales for the bill, which has started on its road through the Parliament. Are you quite happy that through the discussions between you and the powers that be, and the agreements that are reached by next April, enough progress will have been made and that sound legislation will be in place?

Dr Love: The timetable is challenging, but unless we have a target—

Janis Hughes: So you still have concerns that the timetable is not achievable.

Dr Love: I think that the timetable for the bill is perfectly reasonable. However, we have yet to see what the regulations will look like. It will take time to consider those to see whether they are acceptable to both sides. Therefore, there is quite a bit of work to be done. There is also a lot of work to be done by the service to get the arrangements in place for next April.

Helen Eadie (Dunfermline East) (Lab): Continuing on amendments and on what provisions you would like the committee or the Scottish Parliament to address as the bill makes progress, I have a question concerning the persons who may enter into GMS contracts. Paragraph 3 on page 2 of the BMA's written submission states:

"We would question the use of the word 'reasonable'",

as that word is used in proposed new section 2C(1), which deals with the obligation of health boards to provide services. Will you comment a little more on that? In light of what the BMA has said, should the committee or the Parliament have a role in amending the bill?

Dr Love: We had a little concern about the way in which "reasonable" might be interpreted. The foundation for that concern is the new contract's patient services guarantee. We think it extremely important that that guarantee should be delivered. We would not like to see a situation in which health boards could decide not to continue to honour the principles of the patient services guarantee by exploiting the word "reasonable". However, I do not think that we have come to a firm view as to whether we should propose a formal amendment to that wording. We are just highlighting our concern about that.

Helen Eadie: Is there a possibility that you might revisit that at a later date?

Dr Love: It is possible.

The Convener: I noted that you said that you did not think that the bill required amendment and that you would not flag up any points. However, page 2 of your written submission has an interesting section on accessing patient records, which states:

"Patient confidentiality must be protected."

Of course, we would agree with that. The paper goes on to say that

"an agreement exists between the Scottish GP committee and the Scottish Executive Health Department that only medically qualified personnel will have access to full general practice patient records".

First—this may be a daft-lassie question; I do not mind—who are "medically qualified personnel"? How wide is that net? Secondly, the paper then says:

"we would seek clear definitions on who has the right to inspect patient records."

Does that mean that we do not have a clear definition of medically qualified personnel? I ask

because an issue was raised with me when I was out and about. I was told about the difficulty of accessing the data that would be helpful when people are doing all this partnership working, which involves nurses doing things that GPs might have done. That is all part of the big change that is going on. Will you tell me who those people are, and whether the situation will change with the bill? If it changes, will that be a change for better or worse? If the change is for worse, why do you not want the bill amended? Is that question clear?

Dr Love: The current practice is for the inspection of notes to be carried out by retired GPs. I think that the agreement states "medically qualified personnel" because the idea is that such personnel are bound by the General Medical Council rules on confidentiality.

The sharing of records with other health professionals is not a major issue. There is no great restriction under any code of ethics or GMC guidelines or data protection legislation that prevents other health professionals who are involved in the care of the patient from accessing the notes. I do not see that as a difficulty. However, the bill states that regulations will be laid as to who has the right to inspect patient records—

The Convener: So we are back to regulations.

Dr Love: Yes. We are back to regulations and the importance of seeing exactly what the regulations will say. We are extremely concerned that the regulations be compatible with the wishes of patients, as regards who has the right to trawl through their medical records, and with what we would wish, as regards our need to comply with our ethical duties under GMC guidelines.

The Convener: So your position might be that, if the regulations were not available in draft form in sufficient time before the bill reached the end of its amendment procedure, you might indeed want to amend the primary legislation. Otherwise, how will you be secure?

Dr Love: The primary legislation is perfectly okay in its intention to define who can access records, as long as the definition meets the wishes of patients and the BMA's ethical obligations.

The Convener: I am reminded by a colleague that, to the best of our knowledge, although we can comment on regulations in draft form, we cannot amend them. I understand that the professionals can also comment on the regulations. The more that we discuss the bill, the more it seems that we should also look at the regulations. Is that correct?

Dr Love: We expect to be consulted on the regulations. I do not know what the role of the committee is—

The Convener: We need to get the regulations in time so that we can see how they interlock.

Mr Davidson: I want to expand on a point that you made about other professionals accessing patient records at times of need. Does the BMA feel that it would be helpful for the bill to address all the issues that relate to access to patient records? I accept that that reference was made specifically about audit procedures, but there is a lot of discussion on the subject.

About two years ago, I made a proposal for a central system whereby paramedics and professionals in other areas—professionals who are on holiday or away from home—can get immediate access to patient records, for example to check a patient's drugs in use, contra-indications, idiosyncratic responses and so forth. Would that proposal offer a better platform for this debate? If we are to be dependent on regulations, perhaps we should see what the issue is all about up front.

Dr Love: Those issues are extremely important. My concern is that, in attempting to address them on the back of the bill, we could delay its progress. We hope to have the contract implemented by 1 April 2004. That said, the issues have to be addressed.

Mr Davidson: That is all right. I am not pushing you to say yes. I simply wanted to know what your opinion was.

Mike Rumbles: I will give an example of the parliamentary procedure that I am talking about. In the previous session of the Parliament, I was a member of the Rural Development Committee. The first piece of legislation that we passed was the National Parks (Scotland) Act 2000, which was an enabling act of Parliament. Everyone was supportive of it and it went through. Yesterday, the Cairngorms national park was launched amid a flurry of controversy. When the regulations came before the Rural Development Committee, we said "Hang on a minute. This is not right", but we could not do anything because we wanted the national parks and we could not amend the regulations.

I am worried that you might come back to us at a later stage in the negotiations and say that you do not like the regulations that are being introduced. Because we cannot amend the regulations, we would be faced with the choice of implementing the bill or rejecting it. Do you share that concern?

Dr Love: Clearly there is concern about regulations that no one has seen. The purpose of the regulations is to implement the agreements that have been negotiated in the blue books—members have a copy of them. The regulations will be closely monitored at a United Kingdom level. Given that we are talking about a UK contract, it is important that the contract is

delivered equitably throughout the UK in order to maintain manpower across the various countries of the UK. If we get an uneven playing field, we face a risk in Scotland, as we are already losing a number of our young doctors—

Mike Rumbles: Our concern is to ensure that there is fair play across Scotland. That brings me back to the question of the islands.

The Convener: We have noted the point. We will issue a letter to the minister alerting him to our concerns about the concurrency of the regulations. We will circulate the letter around committee members by e-mail.

Mr McNeil: In the opening paragraph of your submission, you talk about the new contract. You say that you hope that

"over time, this will improve recruitment and retention into general practice, improve services to patients".

Which elements of the contract will achieve those ends?

Dr Church: There are many elements in the contract that will achieve that. GPs are people who became doctors because they wanted to look after sick people. That deep vocation keeps them hanging on in there as the work load and all of the extra work that has nothing to with general practice lands on their doorstep. A lot of frustration has been caused by the extra, unresourced work that has moved out of hospitals, for example, or from new work that has appeared or extra bureaucracy. GPs feel unable to help their patients, and it is frustrating for them if they are unable to do the job that they want to do for those patients.

The contract has been designed in such a way as to start to bring control back to the practice, so that GPs can focus on patients. The contract has been divided into three elements. The enhanced service element allows practices to decide what services would be useful for their particular communities. Practices can choose to provide the services that fall under that element, as long as they are funded. They are not under any obligation to provide any of them, so a practice that is struggling can opt not to provide those services, which could be obtained elsewhere. However, the services that patients need in their community will more than likely be provided to them.

There has never been recognition of the quality of service that GPs provide. The quality framework will now allow that to be recognised, and will act as an incentive for GPs to keep on working at their service and to improve, which will benefit the patient. The ability to opt out of out-of-hours care will also help the GP and patients.

14:45

Mr McNeil: I return to my earlier point about quality being at the heart of the matter. Under the proposed arrangements, we could simply be swapping one sleep-deprived doctor for another, which I do not think would be a satisfactory solution. Who makes the decisions on behalf of the patient about additional and enhanced services? How are those decisions delivered?

Dr Love: Various categories of services will—I hate to say this—be defined in regulation. We have a rough idea of what they are, however. The essential services involve treating patients who are ill, who believe themselves to be ill or who are concerned. Additional services are carried out by most practices. They provide—

The Convener: Get your definition in now, Dr Love: you could pre-empt the Scottish Executive.

Dr Love: Additional services include contraceptive and maternity services, which most practices will provide. Enhanced services include more specialised minor surgery, specialised drug monitoring and so on. We know what the categories of service are. All patients will be guaranteed provision of essential and additional services from their practices. It is unusual for a practice not to provide additional services. They would only not provide them if they had lost one or two partners and were unable to cope with their work load—although I would hope that that would be an unusual situation.

Mr McNeil: If patients are to experience improved services and quality, it is crucial that such issues are decided on at an early stage. The patients are excluded from the negotiation.

Dr Church: Practices that are struggling are able to obtain support to opt out on a temporary basis, and the primary care organisation and health board will help them get back on their feet. The primary care organisation—PCO—will make arrangements for patients to obtain services elsewhere on a temporary basis. The deal is to try to keep services on the patient's doorstep and to help practices reach the necessary stage to provide them. We are not seeking to allow services to disappear. The PCO will work with practices, as is defined in the contract.

Mr McNeil: We are becoming more cynical about the process. Such issues as doctors' hours are driving the availability of and access to acute health services. Nobody would argue with the principle of reducing junior doctors' hours but, a few years later, we can see how that impacts on access to services. I accept that it is not the intention to go in the direction of denying people access to services but, in some cases, that could be a consequence. It could be a question of specialist services versus the needs of the community.

Dr Church: A lot of work has moved out of the hospital into general practice without additional resources, be those finance or the bodies to carry out the work.

Mr McNeil: I accept that.

Dr Church: The contract is an attempt to control that movement and to achieve the right level of resource. Endless services cannot be provided without resources. The contract has tried to categorise services so that it is clear what each service is and that it will be properly funded. If services are underfunded, they will not be of a high quality, which does the patient no good. If services are clearly defined, with a clear specification of what the patient needs and expects—

Mr McNeil: Who will define those needs?

Dr Church: They will be defined in the contract.

Mr McNeil: What influence will patients have?

Dr Church: The quality framework will engage patients in what happens in practices. There will be questionnaires on what patients think about practices and patients will be able to meet people in practices and propose improvements. There are incentives in the quality framework for practices to design services around what patients say they need. Patients will tell us what is good and what is bad. The quality framework has a whole section on that matter.

Helen Eadie: What flexibility would there be with a development director centrally and strategically sitting in a health board wanting to take more services from hospitals and put even more services into local GP practices? Given how technology and medicine are developing, there must be almost endless possibilities in respect of what could come from hospitals. Is enough flexibility built into the contract? Planning authorities want to take more into primary care services in the community, but we and the patient must be reassured that that is realistically possible. Is that achievable within the framework of the new contract?

Dr Love: It is certainly achievable within the framework of the contract. The current problem—and much of the explanation for the low morale—is that work has been transferred without resources. Practices have become busier and busier and have less time for patients—they cannot deliver quality service. Of course, practices can provide many extra services for patients if they have enough staff, accommodation and equipment. In the past, work has simply been dumped on general practices without enough resources being made available. The new contract makes it explicit that practices will not have to accept the transference of additional work from hospitals unless they are given additional resources to cope with that work. In a sense, it will be up to the health boards to decide whether they wish to commission and fund services from practices in their area.

The Convener: Does Jean Turner have a question about that matter? There are concerns about it.

Dr Turner: I am naturally worried about patients and the family doctor service, as I worked hard in that area not long ago. We worked hard, but more and more would come out of the hospital and into general practice.

We often hear the little phrase that is contained in BMA Scotland's submission:

"if it can be done in primary care it should be done in primary care".

Do you have any worries about that phrase? Are there limits to what should be done in primary care? I recall that it is much cheaper to do things in general practice and wonder whether general practitioners are being a little conned into accepting larger payments.

Where will all the people come from? It is difficult to get nurses for hospitals and to get nurses and doctors for general practice. It has been said that morale is at the lowest level that it can possibly be. It appears that the only way to get extra nurses for NHS 24, for example, is to pay them large sums of money and bingo, a high quality nurse will perhaps move from a coronary care situation into an NHS 24 situation in which they will tick boxes. I am anxious that the quality of care should be continued for patients and doctors. I have not spoken to any doctor who is terribly enthusiastic about the new contracts—I must have been unfortunate in speaking to the small percentage that is not enthusiastic.

Do you have any reservations about what should be done in general practice? Should endoscopies be carried out in general practice? What sort of services would really benefit the patient? Maybe the principle should be, "If it can be done safely in primary care, it should be done in primary care." We are always talking about being confident, but are we competent? Many people want to fill the spaces. When GPs employ people, they must be sure that they are competent. Can you reassure me on that?

Dr Church: We all agree with the principle, but there are caveats. There must be sufficient resources and appropriate premises and quality of service. Part of the process of improving quality is the introduction of the appraisal and revalidation processes, both of which will address GPs competencies. The specification for providing a service will include certain competency levels that

GPs will have to reach, which will relate to the ability to provide the service, the premises and so on. Not all GPs can carry out endoscopies because they have not all been trained to do them and do not all have the correct type of premises or the resources. Only practices that meet those criteria will be allowed to do endoscopies. GPs will not be able to do them just because they fancy it; they will have to show that they can do them. The appraisal and revalidation process will contribute to that.

To provide enhanced services, GPs must show that everything is in place. As we said in answer to the previous two questions, at present, such services are moved out with no thought or planning. We do not know which doctors can carry out enhanced services or whether they have the appropriate premises or staff. The new contract provides for that. If GPs do not meet the criteria, they will not be able to provide enhanced services for the patient.

Dr Turner: That means that income will not go into some practices.

Dr Church: That is right, and GPs know that. If they want to provide a service and get paid for it—

Dr Turner: It might be difficult for some practices to provide such services because of their premises. Some doctors will have to move out of premises, even in Glasgow.

Dr Church: Many of the enhanced services that are provided at present are not paid for at all, but the enhanced services that will be provided in future will be paid for from new money. That money will be on top of the global sum and quality payments that GPs receive. At present, if GPs are not lucky enough to negotiate something with their health board, they provide such services for nothing.

Dr Turner: That is the way it was. GPs provided services such as diabetic and asthma clinics because it was their job to do so and because such work was part of a family doctor service. Sometimes when doctors did such work it was not accepted that it improved the health of the community, even though that work prevented people going into hospital, which was good for the patient. GPs do a lot of work. I wonder whether the new contract will change anything. Maybe for a time, doctors will be paid more, but I am puzzled by how the new contract will get more doctors into the service.

Dr Love: At present, we have a terrible recruitment problem because people are not coming into the service and doctors are leaving at younger and younger ages. The average retirement age in Scotland is much lower than it is in the rest of the UK. There is a huge potential cohort of GPs who are on the verge of giving up and retiring early, but who are waiting to see what the new contract has to offer. Our survey, and surveys done by independent academics, show alarming figures about retirement intentions. That is a reflection of the current situation.

I accept Jean Turner's point that doctors traditionally did such work, but that has brought about the situation that young doctors do not want to go into general practice as a career and that those who are in it want to get out earlier and earlier. We must do something to reverse that situation, which is what the new contract attempts to do.

Dr Turner: I am still unsure what the special feature of the new contract is that will keep doctors in general practice. Is it the money?

Dr Love: It is the additional resource. For instance, the quality framework will deliver a huge proportion of the new money. The money will be delivered firstly as an aspiration payment, which, for example, will enable practices to employ another practice nurse.

When we did our survey of GP morale and the problems that practices were facing, a major complaint from GPs was that they did not have enough staff or nurses. With the quality framework, a GP can employ a nurse, or part of a nurse, to enable them to set up, for example, diabetic clinics in a more formal and structured way that will deliver better care for their patients. The money is there to allow GPs to get such services up and running and that has never happened before; as Dr Turner said, GPs just get landed with such work and eventually sink under the pressure. The results of that are apparent to everyone.

15:00

The new contract has the potential to reverse the decline, but it will take time. Young doctors are not going to go into general practice until they see that the current generation of general practitioners is a bit happier. That will have to percolate through the system over the first few years of the contract—if the contract is effective—and then it will encourage young doctors to take up their careers again, as they should. It is a fantastic job that is most challenging and rewarding. We know why it is also unattractive—increased bureaucracy, not enough staff and too much being expected of the doctors—but the contract addresses all those issues.

As Mary Church said earlier, the status quo is not acceptable. The system is on the verge of meltdown in some rural areas as well as in some of the inner-city areas, and there are a record number of unfilled vacancies in Scotland—that is where the current contract is leading us.

The Convener: You just said something that appears to conflict with something that you said to David Davidson earlier. When you were asked about remote services, you said something about a GP not being able to opt out. You then said that the health board, which will be responsible for delivery of services, will commission services from outwith the area. Have I picked you up wrongly? I got the impression that if a service was not going to be available through the GP structure, the health board would commission that service from outwith the patient's area.

Dr Love: I mentioned two things. One was about the out-of-hours service—

The Convener: Are you saying that there will be a rule that GPs cannot opt out of the out-of-hours service in certain circumstances?

Dr Love: There will be a mechanism whereby if the health board deems that it is not possible to allow the GP to opt out of responsibility for out-of-hours cover, the GP will have to continue accepting that responsibility. We accept that there are one or two situations where that will happen.

The other point I made was about additional services such as contraceptive care. A practice might lose a partner or two and be unable to cope with its basic work load; it would then be in crisis. As a short-term measure, that practice can then opt out of providing those additional services. The patients are guaranteed to continue receiving such services, but they might well be receiving them from a neighbouring practice.

The Convener: Imagine that I am Ms Brown. I like my GP and want to speak to him about such issues. However, I might get landed with a GP that I do not want to go to. Are you telling me that that could happen?

Dr Love: I hope that that would be unusual. It would happen only in a crisis situation where a practice does not wish to carry on providing additional services. It would be extremely rare and not something that a practice would normally choose to do. Practices provide such services at the moment and unless something dramatic happens to a practice, it would continue to provide those services.

Mr Davidson: I have a question about something that was said in a previous answer—we have heard a lot from you this afternoon, Dr Love. You made a brief comment that the new contract is not about GPs asking to provide enhanced services and that it is entirely for the health boards to commission those services. We could end up with health boards having complete control over which enhanced services they are going to seek, with GPs having no input, even though they might be willing to go through the procedures under the new contract to set up enhanced services. Is that the case?

Dr Love: We are concerned that either the policy memorandum or the explanatory notes to the bill indicate that health boards will commission enhanced services from selected practices. Enhanced services should be provided by the patient's practice, where it is feasible and sensible for that to be done. For instance, in the monitoring of anticoagulant treatment, it would not make sense from our perspective for the patient to be told to go to another practice in the town for their blood test.

Mr Davidson: I accept your point, but in accepting the contract, GPs must deal with the understanding—it is an understanding because you have not seen the regulations—that health boards will have total control over whether to seek delivery of any enhanced services in their area. If boards happen to be short of cash, your members will not see the money to deliver services locally. What is the BMA's official position on that point?

Dr Love: Funding for enhanced services is allocated to boards, which must spend up to an expenditure ceiling. The agreement in the contract says that boards should discuss with their GP sub-committees and any other interested parties which enhanced services should take priority, because not all boards might want to fund all enhanced services, or they might not have the funding to afford all the enhanced services. In the final analysis, it is for the board to decide how to spend its enhanced service money. However, it cannot use the enhanced service money to fund something else. The money must go towards providing enhanced services for patients.

Shona Robison (Dundee East) (SNP): I will discuss the uniform application of the contract. In your submission, you express concerns about opening up local negotiations and say:

> "Mechanisms must be provided to protect the contract from unnecessary and potentially destructive local negotiations."

It is obvious that you feel strongly about the matter. Could the lines be blurred between a part of the contract and the provision of enhanced services? Could there be a muddying of the waters in interpretation? Would myriad local variations appear throughout Scotland?

Dr Love: As has been said, much scepticism is felt among GPs about the new contract. The negotiating process has been fairly tortuous and has had lots of ups and downs. Much cynicism is expressed about it. The contract is nationally negotiated and we fear that some national agreements might be undermined locally and that the resources that practices expect from the new contract might not be delivered in the final analysis. That is why we would like local negotiation of the nationally negotiated contract to be kept to a minimum.

Practices have the option of a locally negotiated contract through the personal medical services scheme, but only a minority of practices in Scotland have chosen that route. Practices very much prefer a nationally negotiated contract. Elements will have to be discussed locally, such as the enhanced services that a practice should provide, but the contract's basic structure and the nationally negotiated agreements must be adhered to. We would not like them to be undermined by local negotiation.

Shona Robison: How can that be ensured? The policy memorandum to the bill says that the contract between practices and boards

"will be negotiated at a local level".

Although it says that contracts will

"have a degree of uniformity",

the position sounds flexible. I presume that discussions continue about the mechanisms that can be put in place to ensure that 101 varieties of contract interpretation do not appear. What mechanisms are being discussed?

Dr Love: No mechanisms are being discussed, because we are not yet negotiating to have contracts signed off between practices and boards. The model contract will not be available as a legal document until early next year.

Shona Robison: Are you confident that those mechanisms will be put in place to avoid that situation? That relates to earlier points. We are creating the potential for things to get messy. Is the policy memorandum wrongly worded? Should the position be tightened up?

Dr Love: The wording in the memorandum gives us concern.

Shona Robison: Could the wording in the policy memorandum lead to confusion throughout Scotland about local negotiations, to say the least?

Dr Love: Yes.

The Convener: We have concluded our questions. Do the witnesses have any short comments on issues that we might not have asked about? You might think, "I wish they had asked me about such and such." You are not obliged to answer—anything you say will be taken down and used in evidence against you, Dr Love.

Dr Love: We have nothing to add—we have had a good grilling. The only issue that we have not discussed is the minimum practice income guarantee, which was more the Finance Committee's concern. That is a crucial element of the contract for ensuring practice viability. The financial memorandum contains a worrying sentence about the MPIG's long-term future and we would be extremely alarmed about any threat to it, because the viability of 80 per cent of practices in Scotland depends on that guarantee. We want the MPIG to continue as long as it is needed.

The Convener: I ask Kate Maclean to confirm that the Finance Committee has discussed the MPIG.

Kate Maclean (Dundee West) (Lab): The guarantee was discussed at the Finance Committee's meeting this morning.

The Convener: That will form part of that committee's report on the bill to us as lead committee. I thank the witnesses for attending.

I suggest that we have a short break of five or 10 minutes, after which we will take the next witnesses. All the witnesses are welcome to have a coffee with us.

15:11

Meeting suspended.

15:21

On resuming—

The Convener: After that jolly interlude, I welcome the witnesses from the Royal College of General Practitioners, Dr Bill Reith and Dr Jenny Bennison—I know that they sat through the previous evidence-taking session. I refer members to the RCGP's written submission.

Janis Hughes: As you heard the previous evidence, I think that you will find some of the questions pretty similar, but we obviously want to get a comparison. Is there any evidence about the number of practices throughout Scotland that are likely to opt out of the provision of so-called enhanced services, such as out-of-hours services?

Dr Bill Reith (Royal College of General Practitioners): Our answer is really no different from that of the witnesses from the SGPC. The way in which the negotiations went and the delay in the ballot clearly means that there has not been a survey of practices and intentions. However, I know that contract implementation groups have been set up in a number of health board areas and that a questionnaire is going out to practices in my own area, Grampian, to get a handle on which services people think that they might opt out of or into. David Love gave you a snapshot of out-of-hours provision, and I understand that that is a particular concern. I have certainly been impressed by the way in which all aspects of the service have been working together to ensure that the transition to the new arrangements for services such as out-of-hours provision goes smoothly, so that such services are in place.

Janis Hughes: I appreciate that you are still gathering that information, but are you concerned about the figures on those opting out of responsibility for out-of-hours services, such as the 50 per cent that has been quoted for Glasgow, although some might continue to provide those services?

Dr Reith: Earlier this afternoon you had quite a discussion about various aspects of out-of-hours services. That is one of the key problems for recruitment and retention in general practice, and the current position is clearly untenable for both patients and doctors, as problems of tiredness come into play, as Mr McNeil highlighted. I think that we will see different ways of doing things.

One of the important responsibilities for us all will be to ensure that the public and patients are informed of the changes as we go along. In the United Kingdom, we have become used to a primary care service that, certainly out of hours, has been provided primarily by the general practitioner. That will become less usual in the future, as a mix of professionals will provide that service. NHS 24 already has a role in some parts of the country, and other primary care professionals will become more involved, as appropriate, in front-line out-of-hours care.

Dr Turner: The NHS boards are taking on a great deal of power in commissioning services. Will they have difficulty covering the services that are covered at present?

I am not quite clear on something else, about which I should perhaps have asked the witnesses from the BMA. Most doctors do their own on-call duties during the day. The out of hours on-call duties, from 6 in the evening till 7 in the morning, might be covered by doctors in rural areas or by co-operative groups such as Glasgow emergency medical services. Do you envisage any change in that balance for general practitioners? I take it that they will still do their daily on-call duties—their home visits—during the day.

Dr Reith: It will be interesting to see how that pans out. In health board areas as well as at the national level, discussions are being held to consider ways in which out-of-hours provision will be provided in future. That almost inevitably impacts on the way in which we deal with in-hours emergency care in particular. What has been called unplanned care—non-routine emergency care—is also being examined in some health board areas. There may be better ways of providing some aspects of in-hours emergency care. For example, the Scottish Ambulance Service's role may be different in future because of the enhanced role of paramedics. We are at the stage of discussing alternative provisions and perhaps piloting them in some areas.

Dr Turner: You do not envisage a big crisis in out-of-hours commissioning.

Dr Reith: I certainly hope that there will be no such crisis. That is one of the things about which we all want to be able to reassure our patients. Although the numbers of contacts in out-of-hours care are relatively small compared to daytime care, by its nature, out-of-hours care is often more acute and patients who are ill or unwell out of hours become more anxious about it.

Mr McNeil: We can clearly demonstrate that the changes will benefit a lot of GPs who work long hours, but will they solve the associated problems that patients may face? They might see just another sleep-deprived doctor. Do you give your members any guidelines and advice on that?

Dr Reith: I am glad that we have the opportunity to respond to that question, because I hope that we can help with that concern. The General Medical Council sets out a framework of good medical practice, which highlights a doctor's individual professional responsibilities. That framework lays on us a responsibility not to undertake tasks in which we do not feel competent. By implication, that includes that we be fit and healthy enough to undertake care. If, for example, a doctor thought that he or she might have an alcohol problem, they should make others aware of that. I imagine that that responsibility now includes things such as undue tiredness. Such matters are beginning to come into that arena so that the individual doctor should be able to say, "Look, I just cannot cope with this sort of workload and with these hours."

The other point is that the RCGP was commissioned a little while ago by the Scottish Executive Health Department to consider how we might quality assure out-of-hours services. That was a few years ago when the co-operatives started up. That work has been undertaken, evaluated independently and submitted to the Health Department. It might form the framework of a quality assurance of out-of-hours services. As this is a UK-agreed contract, the UK dimension would clearly have to come in on quality assurance, but we hope that there would be—primarily for patient safety and for, if you like, doctor protection—quality assurance of whatever out-of-hours provision exists, whoever provides it.

Mr McNeil: Have you seen that piece of work? Does it mention working hours?

Dr Reith: I cannot remember offhand whether it mentions working hours. If it does not, it is not beyond the wit of man to consider that aspect.

15:30

Mr McNeil: We have heard evidence about a culture that takes the out-of-hours work for granted. We have heard about doctors who have

left home in the middle of the night when they are not fit to drive. If the responsibility is being transferred, you are expecting others to cover those duties during the night. I am concerned about the lack of focus on the patient. I have not been given a satisfactory answer about how we confirm quality of care when a patient has to call someone out in the middle of the night who is probably not their own doctor. How do we know that that person has not been working for the previous 48 hours? The attitude seems to be, "Hip, hip, hooray—it is not my responsibility." The focus is on the rush to pass the responsibility on.

Dr Reith: The way in which primary care services have been arranged hitherto is through a contract that is, let us face it, about 50 years old. The current arrangements are a result of the contract being tweaked 10 years ago and they make no allowance for the concerns that you mention. As an organisation we undertook that piece of work on quality assurance and we could examine it to ensure that it addresses all the issues.

At first sight, it may seem to be the case that work is being passed on to other people, but within the health service many other groups that would be picking up that work are salaried and are therefore subject to the European working time directive whereas, as David Love mentioned, as independent contractors we are not subject to it.

The Convener: I have a supplementary question on that point, as I represent the South of Scotland. What are the cross-border arrangements?

Dr Reith: Pass.

The Convener: You pass?

Dr Reith: Some practices cross the border and I assume that reasonable discussions are held about them. The bill requires health boards to co-operate with neighbouring health boards on various aspects of providing care.

The Convener: I was thinking about funding. I appreciate that it is a UK contract, but I am talking about the funding of the contractual arrangements. I take it that there will be funding arrangements between the Scottish Executive and the United Kingdom Department of Health. I regret that I did not ask that question previously, but it has just come into my head.

Dr Reith: I presume that arrangements are in place for practices that are based in Scotland but which cover patients in Scotland and England, and that such arrangements will be in place in future.

If the committee would find it helpful to have a copy of our study on quality assurance, I am sure that we could arrange for it to be forwarded to you.

Mike Rumbles: There are 80 or 90 practices throughout Scotland that are essential. We heard from the previous witnesses that one option for those areas is salaried GPs. Do you see that option as being the future in those areas? I am not sure whether that would go down terribly well with the GPs who are currently there. Do you feel that the minimum income guarantee—if I can use that phrase—represents the future?

Dr Reith: The current situation is increasingly unsatisfactory and untenable. As David Love highlighted earlier, in Scotland we have the highest rate of vacancies for GPs. The rate is significantly higher in remote and rural areas because of the out-of-hours commitments that GPs are expected to meet. We are trying to put in place a system that is much better than the present one, for patients and GPs. What happens will depend to some extent on exactly where the remote and rural practices are. In Grampian, out-of-hours provision is substantially provided by two co-operatives—Grampian doctors on call and Moray doctors on call. In considering out-of-hours provision after December 2004, the board is considering not only the situation in Grampian but the situations in Tayside and Highland. The boards are discussing out-of-hours provision across board areas. It might be that one board can help another.

That may not answer the question about island communities, but there are examples of communities in Shetland and Orkney where the population is not big enough to support a resident GP but where there is a resident nurse. There are different ways of doing things. The salaried practitioner option is one that some will find attractive; it will go far. I presume that such practitioners would come under the European working time directive, so out-of-hours work would be supported. The minimum practice income guarantee reassures people that at least they will be no worse off financially.

Mike Rumbles: Are you content that the MPIG will be agreed on? As I understand it, it is not agreed on at the moment. Will that happen?

Dr Reith: The result of the second ballot came about because of the reassurance given to GPs that the MPIG would be in place. The assumption is that that will happen. I suspect that a number of questions will be asked if it does not.

Mr Davidson: My question has been partly answered by that exchange. You heard the evidence of the BMA, but what work has the Royal College of General Practitioners done to examine whether the contract will maintain the viability of rural practices? We have heard one view about money but, obviously, the college will look at things differently from the BMA. Are you considering doing any work to examine the effect

of the contract on the quality of care in remote areas? We have all received letters and emails about problems that people do not understand—the lack of regulations for people to look at had an impact on that. Has the college taken a step back to get a global view?

Dr Reith: We have not considered remote and rural practices specifically. Our starting point is that to provide a safe high-quality service, as the population deserves, we have to ensure that there is a well-trained and adequate work force—not only doctors but nurses and other health professionals. Sadly, in the UK as in many other countries, there is a shortage not only of doctors but of many health professionals. We have to consider people's roles and how to make the best use of their skills. We have tried to encourage specific training for young doctors and other health professionals who might practise in remote and rural areas. That is a fairly new, and international, phenomenon. Indeed, in some countries, such as Australia and Canada, there are now schools of remote and rural medicine in which the particular extended skills that might be needed in those communities are developed.

Mr Davidson: If those systems are going to be delivered to Scotland's remote areas and outer limits, does the bill—which, as everyone has mentioned, we are considering without having seen any draft regulations—completely cover the issue of people's qualifications, even into the area of telemedicine facilities?

Dr Reith: I do not think that the bill per se will cover such aspects. However, that is not the intention behind it. As the committee will be aware, regulation of the medical profession and of the postgraduate training of doctors is undergoing massive change at the moment. We have just announced the chairman of the new Postgraduate Medical Education and Training Board and interviews for its membership are on-going. It will be up to that board to set the standards of training for whatever specialty. Interestingly, and crucially, the legislation that enabled the board to be set up—which I think was one of the last pieces of legislation to be passed in the previous parliamentary session—regarded general practice for the first time as a specialty equivalent to all other specialties. At the end of the day, the new board will determine the training and competencies that a doctor requires, which is only appropriate.

Mr Davidson: Do you feel that the bill's enabling aspects are sufficient to allow for further negotiations not just on money but on service provision?

Dr Reith: Yes.

Helen Eadie: My questions are very similar to the questions that I asked the previous witnesses. Some sections of the bill, which seeks to amend section 17 of the National Health Service (Scotland) Act 1978, might themselves be open to amendment. For example, section 4 of the bill seeks to insert into the 1978 act proposed new section 17L, which requires at least one member of a partnership to be a medical practitioner. Partners who are not medical practitioners must be NHS employees, section 17C or section 28C employees—that is, providers of pharmaceutical services—health care professionals or persons providing

"personal dental services in accordance with section 17C"

of the 1978 act. Given all that, which you have stated in your written evidence—

The Convener: I do not know whether the witnesses stated that, Helen, but plough on.

Helen Eadie: Given all that and the fact that the bill will be underpinned by a contract agreed by the vast majority of GPs, do you have any amendments to suggest?

The Convener: That is part one of today's examination, Dr Reith.

Dr Reith: Thank you for that.

Proposed new section 17L, which is to be inserted in the 1978 act, seeks to allow practices to adapt to the needs of their local population. The committee will be aware that at the moment resource tends to follow the doctor rather than the patient, which means that if a principal leaves a practice a certain amount of resource stops. One could argue that that is the craziest thing in the world to do. It leaves a practice with fewer members of staff because it is down one doctor and might not be able to recruit; however, it cannot use resources to take on a nurse or someone else who might be able to carry out some work. Proposed new section 17L seeks to help to improve services in future.

Dr Jenny Bennison (Royal College of General Practitioners): It is all about flexibility. The practice as a team will be able to take care of a certain number of patients instead of being tied down to whether particular GP principals work three quarters time, full time or whatever. The key is that we have more flexibility to consider more team-working, to concentrate on quality aspects that we do well and to move some other stuff to other members of the team.

Helen Eadie: It is interesting to compare that response to previous witnesses' responses, in which there was a suggestion or hint that amendments might emerge on this matter as the bill progresses through stage 2. In essence, you are saying something similar—that you will wait and see, and that you are watching this space.

The Convener: I want to clarify the figures. Helen Eadie said that the vast majority of general practitioners voted for the contract, but in fact only 79.4 per cent of those who voted did so. Fifty-five per cent of GPs voted for the contract, which is not the vast majority of GPs. We must get the figures right. Is there a figure for Scotland?

Dr Reith: No.

The Convener: That might be useful, as it would enable us to know what the position is. You tell us that the contract is a hot potato for everyone and that everyone is in favour of it. However, when we pare away the figures we find that it is supported by 55 per cent of GPs in the United Kingdom. The percentage may be higher or lower in Scotland—who knows?

15:45

Kate Maclean: In the Scottish Parliament election, only 40 per cent of people who were eligible to vote bothered to turn out.

The Convener: We will not go down that road. However, we did not claim that the vast majority of people had voted. We want to get the words right.

Dr Reith: The convener is right. However, the important point is that 80 per cent of those who voted did so in favour of the contract. I understand that an absolute majority of GPs did so.

Splitting the vote by countries was discussed in various places, but it was decided that the ballot should be UK wide and should be reported in UK-wide terms. The committee will need to ask others whether there is other information available.

The Convener: We shall do that.

Shona Robison: I want to ask the same question that I put to the witnesses from the BMA, whose answer you probably heard. The question relates to the local and national tensions around the contract. How much flexibility will there be in local negotiations and how much do you want there to be? In your written evidence you say:

"while regional and local variations may be negotiated to meet specific local needs, the framework for GPs working in Scotland should be the same as for those working in England, Northern Ireland and Wales."

Do you want to comment on that?

Dr Reith: One of the basic tenets of the contract is that it is based on trust that the departments and health boards throughout the UK will play their part in negotiating and discussing with the profession, and that the profession will play its part in ensuring the contract's appropriate implementation. Many GPs probably feel that much of the high-level aspect of the contract should be negotiated nationally, so that GPs in one part of the country are not compromised in relation to others. At the end of the day, that would mean patients being compromised.

We must recognise that there are local differences and that there needs to be a certain amount of negotiation. However, I hope that if an errant health board wanted to do something different, the Health Department would encourage it to play ball. Similarly, practices should ensure that they are undertaking the responsibilities to which they have agreed. There must be negotiation both ways.

Shona Robison: So if things were going awry in a particular locality, the last port of call would be ministerial intervention.

Dr Reith: One hopes that that sort of situation will not arise, but I assume that ministers would intervene in those circumstances. At the moment, as principals we are answerable to the minister. Under the new proposals, we will be answerable to the practice and the health board. That is a fundamental change.

The Convener: I want to ask about a statement that you make in paragraph 3.1 of your written evidence. You say:

"It is our view that the existing GMS legislation has become a serious impediment to the provision of high quality care."

That is quite a serious allegation. What kind of impediment has it become, and what is the bill—which you go on to welcome because it

"repeals and replaces the existing legislation"—

curing?

Dr Reith: This relates to your earlier discussion about the lack of resourcing. I know that we could argue—and there is good evidence for it from the Wanless review and others—that there has been chronic underfunding of the health service, but there is a particular issue within primary care, where resources do not always follow the work in the way that they appear to do in the secondary care sector.

Many GPs, in particular over the past 10 or 20 years, have tried to improve the quality of services that they provide to patients, but that has been at an absolute cost to their practices. If one practice provides, for the sake of argument, a diabetic clinic, that means that it looks after patients locally, nearer their homes. That saves spending in the secondary care sector, but there is no way at the moment for resource to move towards that practice.

We touched earlier on that aspect of GPs doing more and more. To some extent, the Royal College of General Practitioners is involved in that, because we have encouraged general practitioners and primary care teams to aspire to

higher and higher standards, and many have done so, because they have the professional desire to perform well.

As I said, the existing legislation does not appear to allow for the shift of resource into primary care in the way that we anticipate the new contract will allow, in particular for quality elements. Recognition will be given and resource will follow, so that if a practice provides a diabetic clinic, resource will come into the practice for that.

The Convener: Paragraph 3.4 of your written submission welcomes

"the introduction of supplementary lists in the Community Care and Health (Scotland) Bill and … the suggestion in this legislation that the three current lists for principals, non-principals and other suppliers … are streamlined into one."

I do not know what that means. Can you explain it to me? Why is that a good thing?

Dr Reith: The notion of supplementary lists was introduced in the last parliamentary session. Until supplementary lists were introduced, it was difficult for health boards to know who was working in a particular area as a non-principal, doing locum work and so on. Locums and non-principals had to register, and to be on the supplementary lists they had to be approved and meet certain criteria. That was fine for that point in time, but the bureaucracy is messy. The bill seeks to have just one list, rather than have, as we do at the moment, a principals list, a supplementary list and various other lists. The bill will bring all the lists into one.

The Convener: That seems sensible. I will take your word for it. One list is always better than three.

Dr Reith: We might have been asked why, if we think that it is better for them all to be in one list, we supported supplementary lists before, but previously supplementary lists were the only option.

The Convener: You were trapped, as it were, and we are releasing you.

Dr Reith: You could put it that way.

The Convener: Fine. I understood that.

Kate Maclean: Alarm bells are ringing. I refer to paragraph 3.5 of your submission. The issue is regulations. We are having to examine the bill without having seen the regulations. You refer to the need for adequate consultation on details, such as on what is and is not a primary medical service, or on the qualifications of people who are delivering services. That relates to Duncan McNeil's question to the previous witnesses. We do not have the lists of what will be primary services, additional services and enhanced services, although they will be in regulations.

However, we have already heard, for example, about contraceptive advice and flu vaccinations, which I would regard as primary rather than additional or enhanced services. What worries me is that, some way down the road, I will have constituents piling into my surgery to tell me that they used to be able to get this or that from their GP but can no longer get it. It just worries me that we are agreeing to regulations without seeing them. You talk about adequate consultation on the details, but should that consultation not include patients? Duncan McNeil also made that point. I think that patients will be rather surprised when they see the lists, so would it not be an idea for GPs to have to consult their patients prior to making their submissions on the bill?

Dr Reith: I think that this part of our submission is probably trying to cover two points. The first point relates to the services per se. I acknowledge that there has been surprise at the services that are included as additional services. However, some of those services are currently additional services, so in that sense there is no difference. For example, contraceptive services are currently not part of general medical services. They are a separate element and practices can opt in or out of them. There are other, similar examples.

The other point that we were trying make in this part of our submission is that if a service is developing in a particular practice or if a practice wants to take on a service and feels that it can offer it to patients in other practices, the doctors and other staff members who will provide the service will need to meet all the competencies that are required of them. Mary Church referred earlier to the example of endoscopy. Many GPs can undertake that procedure, which involves looking down into someone's stomach. Unlike some of my colleagues, I certainly do not feel competent or confident enough to do an endoscopy, so it is clearly important that I do not try to provide that service. Of course, there is also a professional obligation on me to ensure that I am competent.

What we were trying to get across is that there might be training needs. Certainly, as an organisation that is particularly orientated to education, we would hope that the college would be involved in any consultation that would help to determine or advise on the skills training that doctors might need, in addition to their general practitioner training, to undertake certain services. What we would not want is a situation whereby particular services were commissioned but the requirements on doctors undertaking such services precluded suitably trained GPs from undertaking them—for example, if a specialist-orientated route were taken. Similarly, we would not want training requirements to be laid down purely by a health board, for example, without its taking professional advice.

I guess we are saying that we think that we have particular skills in training and education that meet

the requirements to provide a safe service and that we would like to be involved in discussions. It is difficult to say that it should be a requirement for health boards to discuss matters with the profession, but we would hope that that would happen.

It is interesting that the Department of Health in England, in conjunction with our college, has instituted a doctors with special interests scheme. That is a way of acknowledging that some GPs already have specialist interests and that, as the commissioning of services and so on expands, some doctors will want to develop their specialist interests and so will need additional training. The standards of such training will be influenced and informed by our college.

Kate Maclean: What about the consultation of patients?

Dr Reith: In the English model, as far as I am aware, patients have not been consulted. Patients would obviously want the reassurance that standards were being met. However, I think that they would be met by the mechanism that has been described. I think that patients will want a say in what services are provided. However, that might create particular tensions.

Earlier this afternoon, it was highlighted that, if a practice is placed under extreme difficulties in terms of its work force, it might not have the capacity to provide certain services unless it is given additional support. Although the practice might want to provide a service, with the best will in the world it might not have the resources to do so.

Kate Maclean: I understand that, but the point that I am trying to make is that patients should be consulted about the sort of primary medical services that are provided. Patients' idea of what the most basic medical services are might be quite different from that of other people—the BMA or the Government, for example. It seems that patients are being left out of the debate. I welcome the bill, as it will do a lot of good, but I worry that people who do not have a choice of going elsewhere for services—those in rural areas or areas that suffer from deprivation—might end up with worse services than those that they are getting at present.

In Dundee, there are GPs who provide excellent services that are way beyond the range of services that they are expected to provide. I am not making a criticism of GPs in Dundee. However, I worry that, because we will have to agree to the contract without seeing the lists and categories of services, we are going into things blind. We could end up making a big mistake and people in the areas that we represent could suffer as a result.

16:00

Dr Reith: I have two points to make in response, the first of which returns me to a point that I made earlier. We are all—politicians and the professions alike—beholden to keep the public aware of what is happening. Part of the reason why this debate is taking place is recruitment and retention problems. The status quo is not an option. The health service in this country is under great strain, not least because of problems with the work force. We have to make changes. I dare to suggest that, in the past, the public's expectations of the health service have at times been enhanced to unrealistic levels.

The Convener: Kate Maclean made an important point. Perhaps in our letter to the minister we should say that we would like to see the draft regulations. We should also say that we are concerned about whether patients are to form part of the consultation process on the regulations. All that we have on the regulations at present is what is set out on page 5 of the policy memorandum, which says that they will

"set out definitions for 'essential', 'additional' and 'enhanced' services."

I agree that when those are fleshed out people will want to know what is involved and have the explanation made in ordinary language. We have exhausted the route that the committee might take.

Mr McNeil: My alarm bells also rang a bit when I heard specialist GPs mentioned. I am not sure what impact they would make on general practice. At the moment, in acute services, four specialists are needed to work together to treat one patient. I hope that we will not get into a situation in which general practitioners develop their own careers by concentrating over much on the specialisms that they develop and take great pride in providing. The result of that could be that they are not available for general practice. As we have found in other areas, that trend can acerbate the problem rather than address the issue of recruitment and retention.

Dr Reith: I am glad that Mr McNeil raised that point, as there is tension about that issue. A number of misconceptions exist about the difference between the specialist and the generalist. The roles are complementary—we cannot have the one without the other. Unfortunately, time and again, we hear rhetoric about the importance of primary care yet the resources go into secondary care. In the recent election campaign, although most manifestos and politicians of most of, if not all, the political parties highlighted the number of additional consultant posts that were needed in the health service in Scotland, they made no comment whatever on improving primary care.

Quite astonishing international evidence, particularly from the States, shows that the key fundamental in any health service in respect of issues such as quality and access is that it should have a strong primary care base. If we destroy that, we destroy the health service as we know it.

The Convener: I think that the committee would accede to that. No more pleading; we appreciate that. I am conscious of time and want to move on to David Davidson's question.

Mr Davidson: I would like to turn to section 4 of the college's written evidence on the consequences of the proposed changes. In section 4.2, the college raises some very serious concerns about quality and about the fragmentation and continuity of care, particularly for patients with a co-morbidity such as diabetes or asthma. Such patients might have hospital trips to see five different people, perhaps on five different days, and your submission states that you are concerned about opportunities for intervention. Could you define more clearly what it is that the college is concerned about? Perhaps you could link your answer to your comments about patient autonomy. As you will have gathered, the committee is interested in the patient interface.

Dr Reith: That follows on rather nicely from Mr McNeil's point about the balance between specialist and generalist services. In recent years, there seems to have been increasing currency and status in being a specialist, because specialist services can be defined carefully and with certainty. General practitioners carry a huge amount of risk, and our lot is to deal with uncertainty at the first cut. We deal with our patients, particularly those with chronic conditions, in an holistic, whole-person way. Patients with diabetes may also have high blood pressure and some of them will have alcohol problems or asthma, and what we do best is to integrate their whole care package rather than provide different bits of it. That is what we see as one of the potential risks of the quality framework, under which things are cut into disease-specific slices. As we improve aspects of treatment for specific conditions, we must ensure that we maintain our role in tying everything together. I see our nursing colleagues as being key to helping us to achieve that. With nurses trained in primary care, as well as general practitioners, we can achieve that linking in of services. Of course, general health care costs increase quite considerably with patients with co-morbidity.

I shall ask Jenny Bennison to talk a little about access and continuity of care. With all the emphasis on a 48-hour access target, that is one of the other tensions. I was very relieved to learn that, in Scotland, the target is for 48-hour access to a primary care professional. In England, the target is for 48-hour access to a general practitioner.

Dr Bennison: Access has certainly become an important issue from the patient's point of view. Patients want to see a doctor—ideally, their own doctor—as soon as possible. If we try to achieve that at the same time as letting GPs away to do a diabetic clinic or an asthma clinic, we cannot always guarantee that Dr Bloggs will be available on a specific day for those patients. One of the costs is that continuity of care for a particular patient with a particular doctor might suffer. In my practice, we are trying to offer advanced access, and we all have to be aware of the need to keep better records and to communicate better with one another, with regular multidisciplinary meetings, so that patients do not get lost if they are seeing individual doctors for different complaints.

If we offer clinics for chronic conditions within general practice under one roof, using one set of case notes, the patient is likely to be better off than if they are attending a different hospital clinic, possibly in a different hospital, with a different set of case notes, which may not be available when the patient is there. We have some concerns about that, but we must not lose sight of the fact that it is usually a lot better for the patient to attend a clinic in their own general practice with somebody who knows what they are talking about, rather than having to spend a whole morning sitting in a cubicle in a local hospital.

Mr Davidson: Could the college send the committee something in writing to confirm the problem as you see it, and to quantify it? It sounds as though it is quite an ethereal, incalculable problem.

Dr Reith: We can send you information on the matter. It is presenting us with some challenges. It is easy to set an access target, but it is rather more difficult to express continuity of care in hard, quantitative information. We are attempting to do so, however, and have already done some work on that. It is interesting that some committee members have highlighted the tremendous value of the relationship between patient and GP. Although that relationship can be said to be valued, no price can be put on it. Therefore, it has tended to take second place to access. Clearly, there cannot be continuity of care if it cannot be accessed. However, there is a tension between the two.

For example, Jenny Bennison or I might see a patient whose blood fats we know we need to lower. We might decide at a given consultation that, because of that patient's other problems, that particular day is not the suitable time to introduce treatment. We would know that we would be seeing that patient again. For many GPs,

continuity will mean an investment in the relationship between patient and doctor on the part of both parties over many years.

Mr Davidson: Will the college be recommending some solutions to the problem?

Dr Reith: I hope that we will address the issues, although our evidence today is constrained by time.

The Convener: Could you write to the clerk on the matter? We can then circulate your correspondence to committee members and have it among our papers.

Dr Bennison: Our quality assurance programmes address that. Both the practice accreditation and the quality practice award for general practice take into account patient satisfaction data. We have evidence about empowerment, and we know that continuity helps with that.

Mike Rumbles: I wish to focus on the last part of your written evidence, on the consultative process. We heard earlier that almost 80 per cent of GPs in the UK who voted support the new contract. Your evidence states:

"Within the RCGP we have had the opportunity to discuss the details at both our Scottish and UK Councils."

What is the Scottish council and how representative is it? I assume that you are speaking on behalf of GPs in Scotland. How do you know that GPs in Scotland are in favour of the contract?

Dr Reith: The Royal College of General Practitioners is a UK-wide organisation. We celebrated our 50th anniversary last year, so we are relatively young for a royal college. We are, however, far and away the largest such college, with more than 20,000 members in the UK, of whom about 2,500 to 3,000 are in Scotland. The majority of Scottish GPs are members of the RCGP. Membership is achieved by passing an examination at the end of the three-year vocational training period. Some people, unfortunately, fail it, but the majority of them get through.

We are set up on a UK basis but, historically—because of the differences between Scotland and England—there has always been a strong Scottish council. There is a UK council and Scottish, Welsh and Northern Ireland councils. The responsibility of the Scottish council is to discuss issues pertaining particularly to Scotland. Since devolution, our Scottish council has had an even more important role.

We are based in five regional faculties. Those are local groupings of members, and offer all sorts of opportunities. Faculties run educational and other meetings, at which members may come together to discuss things. At this time, when huge change is likely to take place as a result of the introduction of the contract, those faculties have been among the fora of discussion. A number of meetings have been organised by the General Practitioners Committee and Scottish General Practitioners Committee. The meetings that I have heard about have attracted huge numbers of GPs, who have gone along to hear about what has been happening. About 200 GPs came to the meeting that I attended in Aberdeen. That is an enormous number of doctors for one meeting, which highlights GPs' not unnatural interest in the process.

Mike Rumbles: Are you telling us that, from the process of meetings and discussion that you describe, you are confident that a majority of Scottish GPs support the contract?

Dr Reith: Yes.

Mike Rumbles: What about the patients? Do they support it?

Dr Reith: It comes back to the point that I made earlier—we need to inform patients and the public about the new contract. I suspect that the public are not as aware of the contract as they might be. I do not think that the RCGP alone can inform the public. That is why I said earlier that all of us must put the situation to patients openly and honestly.

The Convener: Next week we will hear from the Scottish Association of Health Councils and the Scotland Patients Association, so we can ask them about patients' views. It is unfair to expect Dr Reith to answer that question.

Are there any issues that we have not addressed that you want urgently to tell us about before we conclude this evidence-taking session?

16:15

Dr Reith: Mr Davidson asked about patient autonomy, but I did not have time to answer his question.

There is always a risk that when targets are set, individuals may be treated as commodities, rather than as people. We must all be aware that as professionals we can only advise and recommend. At the end of the day, patients have an individual choice. It would seem iniquitous for general practitioners to be held to account for patients' choices when there is a target payment. Fortunately, the new contract makes provision for that. There is a system of what is called exception reporting, which sets out a variety of exceptions. If patients decide that they do not want to follow a line that is recommended to them, they can do so. We must be aware that that is a real issue for patients. Sometimes the notion of patient

autonomy is forgotten in the greater scheme of things.

Patient autonomy is linked to confidentiality. Despite the report of the confidentiality and security advisory group, there are still concerns and confusion about confidentiality. Those concerns come not just from the professions but from the public.

The Convener: Thank you very much for your evidence. That completes the public business for today. We have agreed that item 4 on the agenda will be dealt with in private.

16:17

Meeting continued in private until 16:20.

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