# HEALTH COMMITTEE

Tuesday 9 September 2003
(*Afternoon*)

Session 2

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## HEALTH COMMITTEE
### 5th 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

**COMMITTEE SUBSTITUTES**

Ms Sandra White (Glasgow) (SNP)
Mrs Nanette Milne (North East Scotland) (Con)

**THE FOLLOWING GAVE EVIDENCE:**

Dr Kate Adamson (Scottish Association of Health Councils)
Malcolm Chisholm MSP (Minister for Health and Community Care)
Lorna Clark (Scottish Executive Health Department)
Andrew MacLeod (Scottish Executive Health Department)
Bob Stock (Scottish Executive Health Department)
Margaret Watt (Scotland Patients Association)
Dr Hugh Whyte (Scottish Executive Health Department)
John Wright (Scottish Association of Health Councils)

**CLERK TO THE COMMITTEE**

Jennifer Smart

**SENIOR ASSISTANT CLERK**

Peter McGrath

**ASSISTANT CLERK**

Graeme Elliot

**LOCATION**

Committee Room 2

# Scottish Parliament

## Health Committee

*Tuesday 9 September 2003*

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:01*]

**The Convener (Christine Grahame):** I open this meeting of the Health Committee and welcome the witnesses, who are here for the third agenda item. I ask them to bear with us while we attend to some preliminary business.

No apologies have been received. I remind members, and anyone else who might have them, to switch off bleepers and mobile phones.

I also welcome Iolo Roberts, who is sitting in the public gallery and who is the deputy editor of the record of proceedings at the National Assembly for Wales. I hope that I pronounced the name properly.

## Item in private

**The Convener:** I ask members to agree to discuss in private agenda item 5 on our forward work programme. We simply have to consider our priorities—once we have debated the issue and the programme has been finalised, we will publish it on the web. Are members content to discuss that item in private?

**Members** *indicated agreement*.

## Subordinate Legislation

14:02

**The Convener:** Item 2 on the agenda is subordinate legislation. As members will be aware, we have eight statutory instruments to deal with. We will take the first six together.

### Contaminants in Food (Scotland) Regulations 2003 (SSI 2003/289)

### Cocoa and Chocolate Products (Scotland) Regulations 2003 (SSI 2003/291)

### Fruit Juices and Fruit Nectars (Scotland) Regulations 2003 (SSI 2003/293)

### National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment (No 2) Regulations 2003 (SSI 2003/295)

### National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2003 (SSI 2003/296)

### Collagen and Gelatine (Intra–Community Trade) Regulations 2003 (SSI 2003/299)

**The Convener:** Members have had the opportunity to read the Subordinate Legislation Committee's comments. No motion to annul has been lodged and no comments have been received. Is it agreed not to make any recommendation on the regulations?

**Members** *indicated agreement*.

### National Health Service (General Medical Services Supplementary Lists) (Scotland) Amendment Regulations 2003 (SSI 2003/298)

### Cremation (Scotland) Amendment Regulations 2003 (SSI 2003/301)

**The Convener:** There are no comments from the Subordinate Legislation Committee on the regulations. Again, no comments have been received and no motion to annul has been lodged. Is it agreed not to make any recommendation on the regulations?

**Members** *indicated agreement*.

**The Convener:** I point out that the Executive must deal with the Subordinate Legislation Committee's comments.

# Primary Medical Services (Scotland) Bill: (Stage 1)

14:04

**The Convener:** I welcome the panel of witnesses.

I welcome John Wright and Dr Kate Adamson, representing the Scottish Association of Health Councils, and Margaret Watt, the vice chair of the Scotland Patients Association. I refer members to paper HC.S2.03.05.1 from the Scottish Association of Health Councils, which has been circulated. The Scotland Patients Association has not made a written submission. Do you want briefly to say something about who you are and who your members are?

**Margaret Watt (Scotland Patients Association):** Scotland Patients Association is a registered charity that exists to help people who have difficulty in achieving what they are trying to achieve. We do not wish to demolish the NHS or do anything to it; we are complementary to the NHS. We have been going since 1981 and our head office is in Stirling. This is the first time that we have appeared before the committee. The next time that we do so—if there is a next time—we will submit to you something in writing. I apologise.

**The Convener:** That is not a problem; it is good to see you here. It would be helpful if one person could act as the principal speaker for the Scottish Association of Health Councils, with the other adding to what has been said, and Margaret Watt could represent Scotland Patients Association.

Was the Scottish Association of Health Councils consulted on the contract or the bill? Do you have any comments on the consultation process?

**John Wright (Scottish Association of Health Councils):** We were consulted on the proposals for the bill and we have no difficulty with the timing of the consultation or the opportunity to comment on the bill, which we have done. We have been happy with the process.

**Margaret Watt:** I concur with that.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** Last week, we heard from general practitioners how well they had been consulted and involved in the process. The question that I asked of them last week is perhaps more properly directed at today's witnesses. I am interested in finding out how the patients have been consulted throughout the process. How effectively have the patients been consulted?

**John Wright:** I can comment only on behalf of the Scottish Association of Health Councils. The committee will be aware that there are 15 local health councils in Scotland, of which our association is the membership organisation. The members of the local offices of the health councils are drawn from among their local communities and patients.

There is an issue about whether organisations of their size are truly representative of all patients. The committee will be aware that that is being taken on board as part of the proposals for reorganisation, which may result in the creation of a new national organisation. The association works through the local health councils, drawing on local offices' views which, in turn, we expect to have been drawn by local members from the views expressed in discussions and negotiations with the communities. Insofar as our networks are in contact with local people, that is as much as we can do in terms of contacting patients. Therefore, I would not claim that the views that are expressed by the association and member health councils can claim to be fully representative of all patients. That is the mechanism through which we work.

As far as possible, we ensure that we are inclusive in the processes that we follow and the way in which we operate. We try to take into account the views that are expressed by all our member health councils. However, only 14 of the 15 health councils in Scotland are members of the association.

**The Convener:** Does Margaret Watt want to expand on that?

**Margaret Watt:** No, thank you.

**The Convener:** Okay. Does David Davidson—

**Mike Rumbles:** May I pursue my question, please?

**The Convener:** Sorry. Yes.

**Mike Rumbles:** I am surprised that Scotland Patients Association does not want to comment. My question concerns the way in which the patients—the end users and the consumers—are involved in the process. Are we just implementing an agreement between employers and employees? Where are the patients in this? I thought that Scotland Patients Association would have a comment to make.

**Margaret Watt:** It is difficult for people to understand fully what is going on with health issues; it is difficult for people to take on board all the changes. In fact, some national health service staff do not understand the changes.

**Mike Rumbles:** From the patients' perspective, do you feel that the consultation process has been flawed or non-existent?

**Margaret Watt:** The patients want to know only that they can go to the doctor, full stop. They do not want to be bothered with all the different

changes. People understand no more than the rudiments of the NHS; they do not understand how the rules and regulations work. They want only to see their doctor when they need to and they do not understand why they are given appointments a week, a fortnight or three weeks away.

**Mike Rumbles:** May I pursue this line for a little longer, convener?

**The Convener:** Is David Davidson's question on the same subject?

**Mr David Davidson (North East Scotland) (Con):** I have a question on the same topic.

**The Convener:** You may ask your question, Mr Rumbles.

**Mike Rumbles:** One of our primary tasks is to check up on the consultation process on the bill. It strikes me that the key player in the process is the patient, who is the end user. Perhaps I do not understand your organisation properly—

**Margaret Watt:** Possibly.

**Mike Rumbles:** Perhaps you could enlighten me, then. I find your comment to be strange, given that your organisation is called the Scotland Patients Association. Do you not believe that consultation is important on this area? Is not it the key issue as far as patients are concerned? If patients are to use the new service, surely they should have had an input into it.

**Margaret Watt:** The Scotland Patients Association does not have members as such; we can voice only the opinions of the people to whom we speak from time to time. We have no members; we have only our board. If someone has difficulties with the NHS, they can get in touch with us. That is the only basis on which we can give you information.

**Mike Rumbles:** Can you suggest to the committee who could give us the patients' view?

**Margaret Watt:** The patients.

**Mike Rumbles:** How do we speak to the patients?

**Margaret Watt:** Through the media?

**The Convener:** I would like to move on now. I appreciate that your organisation has not been before the committee before. I think that it is a bit of a learning experience for you and, perhaps, for the committee. We will address the matter in due course.

Mr Rumbles, I accept the validity of your questions, but I think that we have pursued the matter as far as we can at the moment.

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** I would like to take a different approach and ask what was done during the consultation process to raise awareness of what will be done. I accept that that would be difficult, given that the negotiations were somewhat difficult, but what opportunities will patients be given to make them aware of the possible implications of the GP contract?

**Dr Kate Adamson (Scottish Association of Health Councils):** The local health councils have a network that involves volunteer members of the public who have become extremely knowledgeable on issues such as this. Certainly the problems arising from the bill and its implementation were discussed by my health council. The health council movement represents a public patients' network. In different areas, there are different biases towards the public. That is a reason why the system should be much more inclusive across the board.

14:15

**The Convener:** I suggest to the Scotland Patients Association that, if you wish to be more prepared for certain questions, it might be useful if we send them to you so that you can submit the answers to us in writing before our next meeting.

**Margaret Watt:** That would be excellent.

**The Convener:** In fairness, it might be useful for us to give advance notice of certain questions to people who are not used to giving evidence to committees.

**Mr Davidson:** The Scotland Patients Association is more of an advocacy group for individuals who have difficulties, rather than a sounding board throughout Scotland.

**Margaret Watt:** Yes, it is.

**Helen Eadie (Dunfermline East) (Lab):** I want to explore the issues about opting out of provision of the so-called enhanced services. Do you have evidence on practices in Scotland that are likely to opt out of the provision? Will you also comment on the out-of-hours services?

**John Wright:** We welcome many things in the proposals, but the out-of-hours services are in the area of greatest concern to us, which is the overall capacity in the system to deliver. If practices are able to opt out of providing certain services, including out-of-hours services, we understand that it will be down to the NHS boards to provide for the services so that people will still have their entitlement. However, against a background where there appear to be GP vacancies in Scotland, there is a shortage of new entrants to the medical schools who are willing to go into general practice. Where are the NHS boards going to get that extra capacity to provide the services that local practices might decide to opt out of?

Although there are considerable benefits from the additional finance, it might be some time before the new arrangements make an impact on recruitment and retention problems. We have two concerns about practices' opting out. There is a proposal to move some services from secondary to primary care. We are concerned that there is, until that happens, a possibility that the situation could lead to a chronic under-capacity in primary care provision. It will take time for the changes to come through the system and we are able to stabilise and generate new capacity in the system over the next three to five years.

**Helen Eadie:** I hear what you are saying, but I would like to go a stage further and ask whether you have evidence of the number of practices that are likely to opt out?

**The Convener:** I feel a confession coming on here.

**John Wright:** I was going to say that I do not have any knowledge of what the situation is at national level, but Dr Adamson might be able to speak about the local level.

**Dr Adamson:** As far as the local situation is concerned, we have evidence—

**The Convener:** Where is local?

**Dr Adamson:** Local to me is the Highland NHS Board area. There are big issues in the Highlands concerning the services because of the rural problem. The situation will depend on how the health boards view the matter. A considerable number of practices have already stated that they will opt out of providing out-of-hours services.

**The Convener:** Can you give us a figure for "considerable"—a number of practices or a percentage?

**Dr Adamson:** I would prefer to be completely sure of my facts. I can provide that information early next week, but I would prefer to be absolutely certain before giving you a percentage.

**The Convener:** I understand.

**Kate Maclean (Dundee West) (Lab):** I have a supplementary to Helen Eadie's question about enhanced services.

The enhanced service that is spoken about most is the out-of-hours service, which is obviously a big barrier to recruitment. It will be the most expensive and most difficult service for NHS boards to provide if practices opt out. However, have you had any feedback concerning other enhanced services or additional services—for example, on whether practices will opt out of providing contraception or flu vaccinations? We have not seen the complete list of such services; that list will be in regulations, which makes it difficult for us. Are you concerned that people might not be able to get a comprehensive package locally and might have to go to different places to access different services? It would not be fair of me to ask for details, but have you an opinion on whether a lot more additional resources will be required to provide the enhanced services if they must be provided at places other than GP practices?

**John Wright:** We are concerned about enhanced services generally; for example, where they will be provided and their accessibility. Equity of service provision throughout the country is another issue. All those issues concern us. It all comes down to the capacity to deliver the enhanced services. Without having specific details of the services that are likely to be problematic, I cannot make specific comments, but we are generally concerned about the delivery of enhanced services, about access to those services—patients might have to travel—and about when the services will be available. Another concern is that some enhanced services might have to be provided by NHS boards rather than by communities or practices.

**Dr Adamson:** That applies to additional services as well as to enhanced services.

**Mr McNeil:** The British Medical Association told us last week that we have to make changes to attract doctors and to sustain services over the next four or five years. I get the feeling that we have been here before with such agreements. We employed similar solutions in acute services, by reducing working hours and developing specialties, for example. In this case, we see the potential for GPs to move into specialties, attracted by additional finance. GPs may be attracted into increased private work. A consequence of the agreements might be that we compound the problem rather than solve it. Do you have any sympathy with such views?

**John Wright:** We certainly have sympathy with such views. The focus at the moment is on solving problems in recruitment and retention of GPs, against the background that we outlined earlier. We would like the programme to be more balanced. It should address not only the immediate problems of recruitment and retention, but the underlying capacity problem. We do not want a simple reshuffling of existing resources because that would create shortfalls in other areas. We would be more comfortable if there were a fundamental redesigning and streamlining of primary care provision involving greater use of practice nurses and local pharmacies. That should be underpinned by the use of information technology to reduce paperwork and to ensure faster appointments and referrals. We would hope that that would lead to, for example, quicker access to the GP of one's choice and to longer

consultation times. We would also like a greater number of training places to be funded by the Scottish Executive, which should make a conscious effort to encourage students from overseas not only to study at medical schools in Scotland but to practise here.

There should be an overall package to address the capacity problem. We accept that that cannot be done overnight, but we would like to know that there is a programme in place that will address the problem, so that primary care services do not find themselves, as the member suggested, back in the same position in four or five years' time.

**The Convener:** You have not had sight of this, but in his letter of 8 September the minister addresses in part the issue of moving

"from a GP led service towards a multi disciplinary approach"

such as you have described. We will ask him about that. You may want to hear what the minister has to say or to read his evidence later. It will be in the public domain today.

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** I am trying to envisage a situation in which someone lives in a rural community and is the known general practitioner, but has opted out. In those circumstances, what do people do if an emergency arises in the area? Have you held discussions in such communities? In the remote area that the committee visited—which was not particularly remote—many professionals, such as midwives, complained that there are not enough of them to do the job. Have you received any feedback from remote communities about their concerns about the general practitioner structure breaking down because GPs have said that they will opt out?

**Dr Adamson:** Such concerns have been expressed. Many areas are starting to be more open about asking what out-of-hours provision people want. Attempts are being made to assure the public that there will be cross-disciplinary out-of-hours provision as well as GP provision. However, it will always be a problem for people to get a commitment.

**Dr Turner:** Many people cannot opt out, even if they want to.

**Dr Adamson:** Yes.

**Mr Davidson:** Do the health councils believe that the bill will have a positive or a negative effect on rural practices and, especially, on patients in rural and remote areas?

**The Convener:** I wonder why the question has been passed to Dr Adamson.

**Dr Adamson:** Patients in remote and rural areas already have concerns about equity of care, because they already have distinct problems in accessing services. Transport problems are associated with providing additional services in one practice in an area that is 100 miles long. There is concern that people might not have access to additional services, let alone enhanced services.

**Mr Davidson:** Has the Scottish Association of Health Councils considered how it would like the core part of the contract to be delivered in rural areas? Might contracts in rural areas need to be different from those in urban areas?

**Dr Adamson:** The association has not really addressed that issue, but it is being addressed by GPs from rural and remote areas. They probably have a good perception of the problems, but we would be happy to comment where appropriate.

**Mr Davidson:** Will you liaise with that group of general practitioners?

**Dr Adamson:** That is already happening in some areas.

**Mr Davidson:** In paragraph 1.3 of your submission, you ask:

"Does the provision of the Minimum Practice Income Guarantee (MPIG) cover the existing funding provisions for the Induced Practices Scheme?"

Are you suggesting that the inducement payments should be retained?

14:30

**Dr Adamson:** It is not clear to me from the document whether that funding will come from the MPIG—if I may shorten it to that—or the Scottish allocation formula. I do not have enough detail on that. Although we are prepared to admit that single-handed practices, as many induced practices are, should be phased out, that would have to take quite a long time. The problem is on rather the same level as the problem to do with staff capacity. There will be a period in which those practices must continue. Otherwise, there will be no provision for patients in some areas, especially rural areas.

**Mr Davidson:** Is your plea for a sustained funding package as an interim measure to ensure stability in service access in those areas?

**Dr Adamson:** Absolutely. We are well aware that, as there are problems with single-handed practitioners, it is better that they are part of a consortium. However, yes, I would make a plea for sustainable funding as an interim measure.

**Mike Rumbles:** If I may pursue that point, I am interested in the response of patients, particularly in the Highland and Islands and in the remoter areas, to the minimum practice income guarantee. Last week, we heard evidence from the BMA and

from the general practitioners that they understood that the MPIG would cover the induced practices scheme. That was what they understood, but they had not seen the regulations because those are being worked on. Is there concern among patients in the islands, especially in single-handed practices, about the fact that we have not seen the detail? We have heard the GPs' concern, but is there concern among patients?

**Dr Adamson:** There is extreme concern among the public and patients in single-handed practices and in practices that are in the induced practices scheme. I could give examples of that.

**Mike Rumbles:** The response of the general practitioners was that 79 per cent of GPs UK-wide—they could not give us a figure for Scotland—were in favour of the agreement. My concern rests with the fact that the patients in the remoter areas of Scotland may not have had a full input into the consultation process. Do you think that patients in remote areas and in the island practices have had a chance to feed in their grass-roots concerns to the Scottish Executive?

**Dr Adamson:** There was no consultation with the public and the patients over the GP contract, which is not the same thing as the bill. It is not really appropriate for the public and patients to be in negotiations on GP contracts. I do not think that that was required. However, public and patient consultation is required on the implementation issues that are involved with the bill.

**Mike Rumbles:** I was going to leave it at that point but, having heard that response, I want to continue. You said that it was not appropriate for there to be consultation on the contract, but you emphasised that there should be consultation on the application of that contract. However, those two items cannot be separated. If the Parliament gets it wrong when it agrees to the bill, we cannot then go back and unpick it. We cannot then say, "Well, actually, it was the application of the contract that we were interested in." Do you see what I am getting at? The two things are absolutely linked together.

**Dr Adamson:** Yes, but the document makes it plain that the negotiations on the contract are separate from the bill.

**Mike Rumbles:** But the regulations implementing the contract have not even been published yet.

**John Wright:** A point of concern that we had is that paragraph 40 of the policy memorandum to the bill states:

"The Executive has not carried out further consultation on the contents of this Bill. This reflects the unique position of the Bill. It implements a UK contract for the provision of services negotiated and accepted by both sides to the contract. It would be inappropriate to subject this to further consultation as any proposed changes stemming from the consultation exercise could not be incorporated into the Bill without breaching the negotiated agreement."

Although we believe that there are linkages, that part of the bill seems to have been closed off in that the contract has been negotiated. We have therefore focused on the implementation issues. One of our questions was whether, if as seems likely the implementation could result in major service change, NHS boards would be required to consult members of the public before any changes were implemented. I accept the linkage, but we thought that it had been closed off by that paragraph of the policy memorandum.

**The Convener:** That might be because we are in the odd position of dealing with a bill that in some respects adopts a commercial contract.

**Mike Rumbles:** The policy memorandum sets out the Executive's position. You are not the Executive. That is why you are giving us evidence from your perspective and that is why we are questioning you. I was going to question the minister about paragraph 40. I always focus on consultation with the end user and it seems to me that you are saying—as I understand it you are the primary focus for patient input and that is why you are here—that because the Executive has published paragraph 40, thereby closing the consultation avenue off, you have decided not to go down that road either and to focus on something else. Is that correct?

**John Wright:** It is correct in the sense that we believed that the agreement was a fait accompli and that we would have to focus on the consequences or the implementation issues arising from the agreements as part of the GP contract.

**The Convener:** This might be something that you cannot answer, but do you know how many practitioners or how many practices are in the inducement payment scheme? It would be useful for the committee to know that.

**Mike Rumbles:** I think that we heard that it was about 80.

**John Wright:** I cannot give the answer right now, but we could find out.

**The Convener:** I was just asking into the air to see whether we could find out about the problems in this area and how many practices we are dealing with.

**Janis Hughes (Glasgow Rutherglen) (Lab):** My question is along the same lines as the previous questions. You are obviously aware that the bill is to facilitate the implementation of an agreed contract. However, the fact that we are going through the legislative process gives us an opportunity to consider the bill and the contract

and to consider whether amendments would be beneficial. Would you like the bill to address changes to the structure of general practice, possibly through amendments?

**The Convener:** You have 10 seconds to answer the question. If the question has really stumped you—I do not mean that in a rude way at all—we could perhaps ask you to come back on it after greater reflection. My colleague was just making the point that we are not stuck with what is there just now.

**Janis Hughes:** You have heard from previous members of the committee that we have concerns over how the contract has been agreed by the Government, the Executive and general practitioners. The committee has a responsibility to try to ensure that the bill improves the provision of general practitioner services in Scotland. I accept Dr Adamson's point about public consultation—although I do not necessarily agree with it—but I still feel that the committee must pursue whether there are areas in which the service might be improved. The witnesses will understand that the public are sceptical about the claim that they will notice an improvement when they go to see their general practitioner. Are there any openings for amendments to the bill that might improve the service?

**John Wright:** We have talked about the improved services for patients that the bill will provide and about the importance of quicker access to GPs, longer consultation times and quicker referrals. The wording that I used was that I would like the bill to be accompanied by a fundamental redesign and streamlining of primary care provision. You have put me on the spot by asking how we could achieve that. I would like to respond to that question because it is an important one.

We welcome the many positive measures, such as the provision for better equipment and facilities, but we would like more patient-friendly services because the culture of believing that the doctor knows best is still prevalent in the NHS. We believe that customer care should be an integral part of GP training. I would like to give some thought to that question before responding to the committee. I could respond in writing, if that is possible.

**The Convener:** That would be useful.

**Shona Robison (Dundee East) (SNP):** My question is about whether the new contract strikes the right balance between local and national needs. On the one hand, there are concerns about keeping the result of the negotiations on the contract intact—there have been difficulties with that—and not allowing the contract to unravel but, on the other hand, the deal will really have to be struck and signed locally. What balance should there be in terms of local variations? Are local variations a good thing for patients and, if so, how far should those variations go?

**Dr Adamson:** Undoubtedly, local variations should exist and health boards will have some flexibility, but there must be guidance to ensure equity.

**Shona Robison:** How can that be achieved?

**Dr Adamson:** That is another question that requires notice.

**Shona Robison:** Should there be monitoring to ensure that local variations are allowed in the best interests of patients but that the framework of the contract does not unravel?

**John Wright:** We welcome the fact that practices will be rewarded relative to what they deliver and that the measures of that will be qualitative as well as quantitative. Our submission expresses disappointment that the monitoring regime—for want of a better word—will not be mandatory. We would like patients, as consumers, and local offices of the Scottish health council to be actively involved in the monitoring of practices' performance. That would be helpful.

14:45

**Dr Adamson:** Although we advocate that the quality payments should eventually cover all practices, we recognise that some practices might have problems with implementation of the systems of assessment. We would therefore like there to be a provision that, in five years' time, all practices have to be involved in the quality scheme. However, it might be impractical to expect that to happen immediately.

**Mr Davidson:** When the GPs were before the committee, they talked about regional and local variations. However, earlier in your evidence, you said that you were uncertain that health boards would be able to step in and fill any holes in service provision. Have any of the health councils discussed with their local health boards how the boards would be able to play long stop if certain services were not offered on a local or regional basis?

**John Wright:** I am not aware of any discussions on that issue between local health councils and boards. We have said that we are concerned that that might be the case and that we should be looking out for it happening, but at this point I am not aware of any such discussions.

**Mr Davidson:** In the hope of magnifying the responses that you will make to the committee on other issues, I wonder whether it would be possible for you to contact the health councils

across Scotland to check on that point. You made the point strongly at the beginning of your evidence and it is in your submission. Could you get local health councils to make contact on that point and submit the results through you?

**John Wright:** Absolutely; I am happy to do that.

**Dr Adamson:** Highland NHS Board asked the health council to run two pilot schemes on out-of-hours provision and how it could be covered with the bill in mind, and I suspect that similar schemes have been taking place elsewhere. However, they will be studies in pilot areas rather than definitive studies across the board area.

**Dr Turner:** I noted that your evidence shows that you believe strongly that patients should be actively involved in the quality review of general practices. Do you have any suggestions as to how there could be an efficient mechanism for doing that?

Having worked in general practice, I know that there could be a huge health centre where every practice works differently and that the patients' perceptions of what GPs provide would also differ. It might be difficult to figure that out. With the new trend for everyone being split up and seeing a different service provider, patients might have to see the nurse for one thing, the pharmacist for something else, and the physiotherapist for something else again. There is no joined-up medicine; if Mrs Bloggs has a rash but is seeing one of the other service providers, she might not be able to get that rash seen to on that day and she will have to make another journey. It is bad enough in the inner-city practices when someone has to come back to the practice again. Patients do not like that sort of thing. I imagine that it is even more difficult in rural and remote places, although it might not happen to the same extent.

It would be good for you to think about that. I do not know whether you have any ideas about how the way we are going to be working should be monitored so that we can see how to provide a more joined-up service. It seems to me that the service will be quite fragmented.

**John Wright:** I agree whole-heartedly. We are concerned that the service might become fragmented. We should consider the service from the point of view of the patient's journey. We are talking about access. That was what I was referring to when I spoke about trying to streamline and redesign the delivery of primary care. We are not just talking about the issue of the recruitment of GPs; we are talking about other ways of addressing such issues through the use of practice nurses and others. The way in which that is implemented and delivered needs to be planned carefully. That goes back to our call for longer-term issues relating to capacity and the planning and monitoring of service delivery to be considered not as an afterthought but bearing in mind the type of scenario that we are going to enter. We should be asking how services can best be delivered for patients, and the examples that the committee has heard are exactly right.

**Dr Turner:** The Executive always seems to be very interested in involvement on the part of the patient and the public. If we can find a way to allow the patient to have a say in such matters, that is not before time. I do not think that patients have in fact had much say until now, despite your involvement. Many people carry on taking whatever comes when they go to their doctor but then, when they cannot get something, they complain about it.

You must have some financial concerns about the provision of services where doctors opt out. If doctors are to opt out, health boards will have to find the money to provide the services. In towns, extra services can be provided through pharmacies, which might help in the everyday life of the doctor, for example by checking blood sugar levels or blood pressure. That would need to be worked on among practices, and joined-up information is required if patients are to obtain services somewhere other than at their doctor's. The most concerning point is practices' opting out of services, with patients discovering that many services are provided by other doctors and not at their own general practice.

**John Wright:** We have addressed that point about opting out: I think the question was about how health boards are to obtain the capacity in terms of GPs to deliver the services. The other issue, which we also covered in our paper, is whether funding will be available to enable boards to provide those services. Resourcing and funding go hand in hand, and we have concerns about those areas.

**The Convener:** I seem to remember that we have been told that some practices simply will not be allowed to opt out. Could you clarify that? What would morale be like in practices that cannot opt out because there is no alternative cover or provision, no matter how things are restructured? I may have understood this wrongly—I see sceptical looks around the table—but I believe that we had evidence to that effect.

**Dr Adamson:** There are concerns among GPs that health boards could refuse to let practices opt out because there is not the capacity to cover services otherwise. In urban areas, GP practices can amalgamate on out-of-hours services much more easily; that is very difficult in rural areas. The health boards in rural areas are considering the matter, but there is an awareness that there is not sufficient staff capacity to cover practices opting out. We do not know what the answers are at the moment.

**The Convener:** I am conscious that I might have missed Duncan McNeil out earlier.

**Mr McNeil:** In your written submission, you state that you

"welcome the proposals for an evidence based quality and outcomes framework."

You have confirmed today your disappointment that the scheme is not mandatory. You also question the case for practices that decide to opt out of the quality assurance audit and ask

"whether they should automatically continue to be eligible for MPIG".

Could you elaborate on that?

**John Wright:** That touches on the issue of equity of service. I accept, as Dr Adamson said earlier, that there may be good reasons why that cannot happen overnight, but if the agenda is about improving services for patients, we cannot take it at face value; it has to be monitored. The best people to judge and assess that are the consumers of the service. If we are going to have equity of service, patients in all parts of the country should have an equal opportunity to have an input, and to make their views known about the performance of GP or primary care services in their areas. That is why we feel strongly that all practices should be part of that review process, if not from day one, then as soon as possible.

**Mr McNeil:** How would you implement that? What would be required to take away that minimum practice income guarantee in a year's time? How would you judge that?

**Dr Adamson:** The impact of taking away the—

**Mr McNeil:** You said that you

"question in the case of practices which decide to opt out of the Quality Assurance audit, whether they should automatically continue to be eligible for MPIG."

I presumed that you meant that there should be some financial implication if they do not participate. Is that what you mean?

**John Wright:** We are saying that if there is to be a minimum practice income guarantee, practices should be able to justify why it is paid to them. The performance of the practice, in terms of the services that are provided to patients, should be a key issue. I question why practices might want to opt out of that review. I do not see why they should want to opt out, and I do not see why they should be able to opt out of that process.

**Mr McNeil:** It could empower patients if they had a say over the quality of services in GP practices.

**John Wright:** Yes.

**Mr McNeil:** They could actually affect practices' income. Why do you not support that?

**John Wright:** I am not clear what you mean.

**Mr McNeil:** Am I wrong? Have I misunderstood? I presume that the minimum practice income guarantee gives a base level. If doctors opt out of quality frameworks, you suggest in paragraph 3.2 of your submission, under "Service Monitoring", that they should not automatically continue to be eligible for the minimum practice income guarantee. What does that mean? I think that that should have been my first question.

**John Wright:** We think that all practices should be involved in the monitoring. That is what we are saying. All practices should be involved, and patients should be actively involved in the monitoring process.

**Dr Adamson:** I said that there is a problem over the time period because, at the moment, it appears from the notes on the bill that the assessment for quality assurance will be done on numbers of diseases recorded by the practice. That is easy for the practices that have good information technology set-ups, but it is much more difficult for the practices that do not. I was merely flagging up the need for a big capacity-building exercise involving the practices that do not have information and communications technology set-ups that are efficient enough to collect the figures. That is the other reason why we advocate the inclusion of qualitative as well as quantitative assessment, which appears in the explanatory notes.

**Mr McNeil:** I seek clarity. Last week, we heard from the BMA that one of the issues was that the incomes of certain practices had to be guaranteed. You say in your submission that those practices that opt out of the quality audit should not automatically be eligible for that MPIG money. The implication is that unless they come up to the standards, they will not get the benefit of the agreement. Is that what you mean? I do not think that it is now, is it? Should they be allowed to opt out? The words are yours.

**John Wright:** The point that we are trying to make is that all practices should be involved. Whether it is from day one or within an agreed timetable, we should endeavour to ensure that all practices are subjected to the monitoring regime.

**The Convener:** You do not go as far to say that they should be penalised if they do not, but you are raising the issue.

**John Wright:** We accept the situation. As Dr Adamson said, there are implementation issues and so on. However, we feel that it should be an objective for all practices to come into the monitoring scheme and that there should be a commitment on the part of practices to do so.

15:00

**The Convener:** I think that we are as far forward as we are going to get.

**Mr McNeil:** We are not going to get there. If GPs walk away from the quality audit, there should not be—

**The Convener:** I think that it is an argument of persuasion.

**Dr Adamson:** We are not talking about an immediate penalty.

**Mr McNeil:** I am not suggesting that there be an immediate penalty.

**Dr Adamson:** The issues have potential for the future.

**Mr McNeil:** Okay, I give up.

**The Convener:** Can we move on? I think that we have dug that seam—

**Mr McNeil:** To death.

**The Convener:** Your words, not mine, Mr McNeil.

Bearing in mind the fact that we have still to speak to the minister, we have time for only two more members to ask questions.

**Helen Eadie:** I would like to come back to the issue of balancing the need for out-of-hours care with the new working patterns for doctors, particularly with regard to the ability to opt out of the services. Will that have a beneficial effect on recruitment and retention in the profession?

**Dr Adamson:** I agree with what you say about the need to strike a balance. It will take some time after the GPs' working lives have improved before there is an increase in recruitment and retention. There will be considerable problems until that point.

**Helen Eadie:** How will the patients perceive the changes? How will the GPs be able to strike the balance that we are talking about? After all, there is no blueprint for this.

**John Wright:** That is the difficulty. We support the objectives but accept that it will take time to deliver them. As I said earlier, if the implementation of the contract leads to a chronic shortage of resources, that will be detrimental to patients and will exacerbate the problems with GPs and people's dissatisfaction with the NHS in general. We accept that the resourcing situation cannot be resolved overnight. We would like firm plans to be in place to ensure adequate resources in the long term. If we go down this route without trying to increase capacity in the system—whether through practice nurses, GPs, pharmacists or whatever—we will end up in the same situation in four or five years' time. It is not sufficient simply to provide additional funding for practices. The Executive must take the initiative and consider the longer-term issues of capacity planning and how we are going to get more people into medical school to ensure that we have more doctors, GPs and nurses. Unless there is such a twin-track approach, the GP contract will not resolve the problems that we face—indeed, it could make them worse.

**Dr Adamson:** That relates to the question that Janis Hughes asked about how the situation could be improved, because all the improvements depend on the approach that is taken.

**Shona Robison:** In your written evidence, you say that you are concerned that the bill appears to introduce private health care into primary care, as has already happened with dentistry and secondary care. Could you elaborate on that?

**John Wright:** Our concern came from a question: what is to stop general practitioners opting out of the contract or NHS provision and setting themselves up as a private organisation that offers its services to the NHS? My concern is that, if there is undercapacity in the NHS, the NHS might have no option but to employ private GP practices as has happened with secondary care. I do not know the likelihood that that scenario will develop, but the possibility was put to us and we are raising it as an issue of concern.

**Shona Robison:** GPs are essentially self-employed professionals who contract their services to the NHS. Are you saying that they would opt out of contracting with the NHS?

**John Wright:** Yes. It may be a local issue or what have you, but if a sufficient number of GPs decided that they were unhappy with the contract, for any reason, there is a possibility that they could decide to opt out of it and set themselves up as a private organisation and be available to provide services to the NHS on that basis rather than as part of the NHS contract.

**Dr Adamson:** The explanatory notes to the bill state specifically that the health boards would not be allowed to commission GPs privately. However, the problem is with additional services. Let us take immunisation against measles, mumps and rubella as an example. What would happen if all the practices opted out of providing that but there was a private group of GPs who were prepared to do it?

**Shona Robison:** I take your point.

**Dr Adamson:** Contracting that private group might be the only way of providing that service.

**The Convener:** That is interesting.

**Mike Rumbles:** I have a final question that arises from the evidence that you have presented

and the evidence that we received last week. You quote paragraph 40 of the policy memorandum:

"The Executive has not carried out further consultation on the contents of this Bill."

My question is for John Wright. You said that that closed that avenue off for you. When we asked the GPs about patient consultation last week, they said that we should really ask you. It strikes me that although there has been consultation, it has been between the Government and the GPs. Where are the patients in this? How do you feel?

The Parliament has a duty to examine any legislation that is produced. We are examining a contract between two parties. I feel that the patients have been left out of it. There is an opportunity for the Parliament to decide to consult on the bill, but that would mean delaying its implementation. Do you, as the representatives of the patients, feel that it would be worth while to delay the implementation of the bill to allow such a consultation to take place?

**John Wright:** The important thing in all this is to come back to basics and ask what we are trying to achieve, which must be the delivery of better services for patients. It is, therefore, important that we get the bill right.

As you said earlier, if we set off down this track and find that we have got it wrong and that the capacity is not—and is not going to be—in place, there is a danger that we will get stuck mid-stream. I would rather see the implementation of the bill delayed to ensure that we have got it right, addressed the issues, anticipated things and planned properly. That is the best way to deliver better services. I am concerned that we will get caught mid-stream, which is why I keep making the point about not focusing simply on the issue of existing GP retention and recruitment—although that is important—but on ensuring that we are looking forward and planning to have the capacity in place to deliver better services. I would prefer that Parliament delayed the bill and got it right to its going ahead and finding that we are caught mid-stream, with the credibility of the whole thing collapsing.

**The Convener:** No doubt, the minister will heed that point when the matter is put to him.

Thank you all for your evidence and for attending. We will write to you with questions, which will be in the public domain—the letter and your responses to it will be on our agenda. We look forward to receiving your answers as part of the consultation with patients.

**Margaret Watt:** I would like to say that I apologise most sincerely for wasting your time today. I am in way out of my depth.

**The Convener:** You have not wasted our time at all.

**Margaret Watt:** Could I ask one question, if that is not too impertinent?

**The Convener:** Yes.

**Margaret Watt:** I would like to ask all the MSPs what their constituents say about the bill.

**The Convener:** I do not think that we are here to act on behalf of our constituents.

**Margaret Watt:** Do you not get feedback?

**The Convener:** We get feedback, but that would be in another capacity. We sit on this committee in a cross-party capacity on behalf of the Parliament to examine legislation. However, we are very interested to hear what you have to say, and I have no doubt that members have been briefed by their constituents and have fed that into their questions in some way. Thank you very much.

15:11

*Meeting suspended.*

15:18

*On resuming—*

**The Convener:** I welcome the Minister for Health and Community Care. I thank him for agreeing to hold two evidence sessions with us, the first of which is on the Primary Medical Services (Scotland) Bill.

Thank you, minister, for your letter of 8 September, which has been circulated to committee members. It concerns some issues that we have raised, and I have no doubt that we shall come to that letter as we go through the evidence. My first question relates to the paragraph on regulations, which is an issue of concern to us. The paragraph says:

"Drafts of these elements should be with the Committee for the start of Stage Two. Other elements are more closely tied to a common UK line. These will be shared with the Committee at the earliest opportunity and we will do all that we can to ensure that a working draft is available during Stage Two and certainly before Stage Three."

I would be concerned if we did not have sight of what are pretty well comprehensive draft regulations, if I can put it like that, prior to stage 2.

**The Minister for Health and Community Care (Malcolm Chisholm):** Two distinct sets of regulations are referred to, some of which are totally within our control. It is a UK contract with Scottish variations, so we have certainly given an undertaking with regard to those that are completely within our control. However, there are obviously other issues with regard to the elements that are being drawn up on a UK basis. We will seek to supply those, but you will understand that they are not under my control in quite the same way.

**The Convener:** I understand. Could you prevail upon your colleagues at Westminster to provide those regulations? As there is only one committee here, and no revising chamber, the committee would like the opportunity to look at those regulations as soon as possible.

I would like to ask another preliminary question that arises from your letter. You say that you will

"introduce accreditation standards which every provider of out of hours cover must meet before they are eligible to provide such a service. I would expect these standards to ensure that the quality of care is provided in a way which is compatible with the health and safety of doctors and staff."

When will those accreditation standards be introduced? Will the committee have that information prior to proceeding with the primary legislation?

**Malcolm Chisholm:** I do not think that the accreditation standards will be in the primary legislation or in the regulations. I do not have a date for their introduction, but they will not require primary or secondary legislation.

**The Convener:** Given that we are talking about accreditation standards, it would be useful for the committee to have that material before we move through the later stages of the legislation.

**Malcolm Chisholm:** I am not sure which stage the standards are at. Perhaps Lorna Clark can help.

**Lorna Clark (Scottish Executive Health Department):** I think that the issue is being discussed at Scotland level. The accreditation standards will not be introduced until December 2004, when the opt-out provisions will come in. A lot of work is continuing, building on work that professional bodies have done. I do not have a detailed timetable for the accreditation standards, but we can find out more and let you know.

**The Convener:** That would be useful to the committee.

**Kate Maclean:** I have just a couple of questions on patient needs and balancing those with the need to improve recruitment and retention in the profession. First, do you feel that the correct balance has been struck between patient needs and improving recruitment and retention? I presume that you will say that that balance has been struck, but what do you base that opinion on? I must ask that as a preliminary question.

**Malcolm Chisholm:** I am not sure why you set the two areas in opposition to each other. Clearly, the Parliament, in a proxy role for patients and many others, often raises issues of recruitment and retention because the reality is that patients suffer if we have recruitment and retention difficulties either in primary care or in hospitals. The fact that the contract will help to address recruitment and retention issues is very much in the interests of patients, but that is not the only aspect of the contract. I am enthusiastic about the contract because I believe that, in the round, it is in the interests of patients. For the first time ever, funding for primary care will be based on patient need and not on doctor numbers. For the first time, not only in Scotland but in any country in the world, a substantial amount of funding will go into primary care on the basis of quality. In fact, two thirds of the substantial increase that is going into primary care on the back of the contract is for the quality elements of the contract.

Further, to pick up the point that the Scottish Association of Health Councils made, the contract is about facilitating redesign of and improvement in chronic disease management. Therefore, I believe that the contract is very much a patients' contract. I do not recognise the distinction that you made—certainly not in the stark terms in which you presented it.

**Kate Maclean:** I do not suggest for a minute that the needs of patients and the need to have better recruitment and retention are mutually exclusive. However, I think that you would accept, from the earlier evidence that you heard from organisations that represent patients and from members' questions, that there are concerns about the fact that the two areas can be in opposition. A concern that I have raised, not only in this committee but in the Finance Committee, is about the provision of enhanced services, the most controversial of which is probably the out-of-hours service. If practices opt out of that service, it can have a detrimental effect on patients. That is an area in which the needs of the patient can be diametrically opposed to the benefits of recruitment and retention in the profession.

To take the point further, I want to focus on the other enhanced or additional services that I understand practices will be allowed to opt out of for specific reasons, such as a member of practice staff's being off ill. I am concerned that, if patients are to receive a package of care, they might have to travel to different places to receive different parts of it.

The convener articulated the big problem, which is that the committee has not seen the regulations. We do not know what is going to be an additional service or an enhanced service so, if the bill goes ahead, it will be very difficult for us to say that patients will not have a poorer service.

I am concerned that the people who have given evidence to the committee today seem to be under the impression that the contract is a done deal, as that affected the evidence that they gave us. People are expected to give evidence and we are expected to take decisions without the full information. There are serious concerns about the

conflict between recruitment and retention of GPs and the service that our constituents will receive.

**Malcolm Chisholm:** I know that there are concerns, but I am simply saying that I do not accept the point. I would not support the contract if I did not think that it was in the interests of patients. I think that it is strongly in the interests of patients—it is a very good contract for patients.

I refer Kate Maclean to the patient services guarantee, as that might reassure patients. The bottom line of the guarantee states quite explicitly that there will be no reduction in the services that patients receive at present.

The reality is that the contract gives great opportunities for more services to be delivered in primary care. That is why I think that enhanced services, which are different from out-of-hours services, are among the most exciting areas to be addressed by the bill. They are a way of ensuring that money goes into primary care to provide additional services. I think that most of us accept the shift in health services and support that is going on in the changes in the delivery of services between secondary and primary care.

An issue arises about out-of-hours services. The reality is that new arrangements are already in place for those services. At the moment, people do not go to their own GP practice for that provision: in many parts of Scotland, co-operatives provide out-of-hours cover. It may well be that many GPs will continue to work through the co-ops. When the BMA gave its evidence, Dr Love said that, although a lot of doctors might give up responsibility for out-of-hours services, that did not mean that they would give up the provision of those services. It is likely that GPs might wish to work with the co-ops to provide such arrangements.

We have moved down the route of delivering out-of-hours services differently, but the important issue in terms of the contract is that GPs might not be forced to do that work except in exceptional circumstances. That point is important for GP work load and it is one that has arisen historically. That aspect of the contract is good for recruitment and retention. It will not be bad for patients, as those services will continue to be provided, albeit in a different way.

**Kate Maclean:** But what evidence do you have of the number of practices that will opt out of providing enhanced services? If you do not have the figures, how can you give that guarantee?

**Malcolm Chisholm:** We have to get our language straight. Out-of-hours services are different from enhanced services. We should be thinking about the enhanced services.

**Kate Maclean:** I am talking about both enhanced and out-of-hours services. The latter is included.

**Malcolm Chisholm:** Enhanced services are not an opting-out issue; they are services that boards will provide; they will be directed to provide some of those services, while local discretion will apply to other services. That is where some of the big shifts and redesigns will take place.

**Kate Maclean:** I am aware of that.

**Malcolm Chisholm:** Out-of-hours services are different from enhanced services. They will have to be provided. I talk to a lot of GPs and find that I get mixed reactions from them. What Dr Love said last week might be a quite typical response. He said that GPs might opt out of responsibility for out-of-hours services, but they might not necessarily opt out of the provision of those services.

I accept that some GPs will opt out, but the service will continue to be provided. The issue is not about what other GPs do but about the redesign of the out-of-hours service.

When I visited Grampian two or three weeks ago, I was struck by the way in which the issue is being tackled through new roles for people. In Moray, for example, I was struck by the roles of paramedics, whom I saw in action. New ways of delivering such services are already being thought of. The guarantee is there for patients—that is the bottom line.

15:30

**Kate Maclean:** I am aware of what additional services, enhanced services and out-of-hours services are, but I do not think that you have answered the question. I asked whether you knew the number of practices that would opt out of providing enhanced services or out-of-hours services. Unless you know that, how can you guarantee that patients will not receive a lesser service?

**Malcolm Chisholm:** There is an issue, not about opting out of enhanced services, but about opting out of out-of-hours services. The nature of things means that it is impossible to know at this stage how many practices will opt out, but the patient services guarantee is there irrespective of how many GPs opt out of the out-of-hours service. There is a duty on boards to provide that service. If alternatives cannot be provided in certain parts of Scotland, the GPs will not be able to opt out. That is the final guarantee of the patient services guarantee and it is central to the contract.

**Kate Maclean:** I have another question on a different matter, but the convener might have a supplementary.

**The Convener:** I do. In your letter, you said that

"A national working group has been set up to look at the issues around out of hours."

That is a big brief. When will the working group report?

**Malcolm Chisholm:** I do not have a specific date for that, but Hugh Whyte might have one.

**Dr Hugh Whyte (Scottish Executive Health Department):** We expect that the group will be able to issue some interim guidance by the end of October. It will go on to develop models of alternative provision, which should be ready for the transfer of responsibility by the end of 2004.

**The Convener:** Please bear with me—I am just checking where that fits in to our consideration of the bill. The stage 1 debate will be on 28 October. Will we be in a position to have the group's report made public by then?

**Dr Whyte:** The group expects its initial guidance to be out prior to the end of October.

**The Convener:** Will that be available in public?

**Dr Whyte:** Yes.

**The Convener:** Jean Turner, David Davidson and Janis Hughes want to pursue the same line.

**Dr Turner:** At the moment, doctors in general practice sometimes pay themselves to provide out-of-hours services—they make extra money that way. That happens with Glasgow emergency medical services. People in small practices, as I was, pay themselves to provide out-of-hours services. I did most of my on-call work myself, from 7 in the morning until 6 in the evening. Very little of my out-of-hours work was provided by another service.

Under the new rules and regulations, is it possible that many people would opt out of general practice to provide out-of-hours services? Provision of out-of-hours services is bad at the moment, as it is a 24-hour responsibility. Although I paid someone else to provide those services, I was still responsible for them, so if there had been a problem, I would have been involved. The health board will now take over that 24-hour responsibility and pay the doctors, and that might mean that there could be a shift of doctors who wish to work in that area, as it could be more lucrative. That has been the case; many doctors enhanced incomes that were below the national average in the United Kingdom—never mind the average in Scotland—by providing out-of-hours services.

Do you have any figures for the shift of people leaving general practice? Patients think of general practice as a family doctor service. It could be that practices become depleted of doctors because they all want to shift out into the provision of out-of-hours services and other areas. That would leave general practice a little bald, or lacking in staff.

**Malcolm Chisholm:** The general point that you make is interesting and important. The pattern of service delivery will be different under the contract.

I think that you are suggesting that some GPs might find it attractive to concentrate on out-of-hours services. That is certainly possible.

The general issue of staff numbers, which has featured strongly both today and at other times, is important because one of the contract's key aspects is the 33 per cent extra funding that will be made available for primary care. Again, in picking up points made by the Scottish Association of Health Councils, I should highlight that for the first time the contract is team-based. As a result, it is not made with GPs, but with the practice, which means that there is scope for the practice to spend the money as it wishes. For example, the practice might wish to employ more specialist nurses. That is already happening.

Questions about capacity have also been raised today. Although I am never complacent about that issue, I want to reassure members about it. Last year, there was an unprecedented increase of 80 or 90 in the number of practice nurses. Moreover, I know that concern has been expressed about GPs, but we should reflect on the fact that since 1997 the number of GP registrars has increased by 18 per cent. I assure the committee that I will ensure that those numbers do not fall off over the course of the year. I should explain that the increase has come about because last year NHS Education for Scotland allocated extra money to boost the numbers. As I have said, I will ensure that that increase in the number of GPs in training is maintained this year, because I realise that capacity issues are important.

However, I reiterate that the contract is not just with GPs. As a result, we are already seeing a large expansion of practice nurses, which I also expect to continue on the back of the contract. One of the other really exciting features of the contract is that it is all about supporting team working. Indeed, that is really what modern health care is all about.

**The Convener:** What is your view on Dr David Love's claim that the number of GPs is going into meltdown?

**Malcolm Chisholm:** It was interesting to read Dr Love's evidence and then the newspaper reports. The context of his evidence was that, although there was a problem in general practice, the contract addressed it. However, I have read Dr Love's evidence and I accept his comment that there are problems. I recognise that in health, as in other areas, there are problems. That said, as

Dr Love pointed out, the purpose of the contract is to address those problems through increased funding for primary care.

As I have said, I know that there is concern about GP registrars. As a result, I repeat that I will ensure that the numbers are maintained. We know why NHS Education for Scotland increased the numbers, and I will ensure that they are maintained. I also repeat that the number of GP registrars has increased by 18 per cent since 1997.

**Mr McNeil:** I think that we are being slightly sceptical if we test the bill simply on the issue of capacity. After all, we could say much the same for the health service as a whole: we need more doctors, nurses and so on. We need to explore whether what might come out of the bill—the development of specialities, a potential increase in private work and reduced hours—represents a good deal for patients on the ground. Will it give us a situation that is similar to that in acute services, which have received massive resources but are not working out on the ground? Knowing what you know about what is happening in acute services, minister, how will you prevent the same thing happening in general practice?

**Malcolm Chisholm:** It is hard to justify a particular situation. Indeed, as far as recruitment and retention are concerned, it is hard to justify continuing to force GPs to work ridiculously long hours. We must address the issue in relation not only to doctors' welfare—and I know that the committee expressed concerns last week about GPs' working hours—but, more important, to the welfare of patients. As with the hospital sector, the issue involves not only some increase in capacity, but the redesign of care. We have to develop those two aspects simultaneously in order to deal with problems with working times.

**Mr McNeil:** What about the specific example of specialties? At the moment, a patient can receive a general view from a practitioner. Can we look forward to a situation such as that in acute services, where we would have to see three doctors before we actually received treatment?

**Malcolm Chisholm:** I make it clear that all practices have to provide the essential services. The expectation is that the vast majority will provide the additional services as well. The bottom line is that practices cannot opt out of essential services in the interest of specialism. However, within those parameters, many would see a lot of sense in certain GPs developing certain specialisms, along with their provision of general services, because that too supports the objective of delivering as much care as possible within primary care. That would only, of course, apply to services that are safe, and that make people feel safe. The underlying principle of all service change is that it must be based on services that are, and that make people feel, safe.

**The Convener:** That is why we require sight of the regulations.

**Mr Davidson:** I will take you back to an answer that you gave Kate Maclean earlier. You made reference to the patients guarantee. They way in which you phrased your reply seemed to suggest that patients would not see any diminution of services that they could access because of the guarantee. The next stage is that, if there is a problem, health boards will fill any gap. Then you went on to say that, if they cannot fill the gap, it is back to the GPs, who will not be able to reduce or withdraw from services.

That loop does not explain your understanding of what health boards will be able to do to back up service delivery loss—it may come to that in some areas—of where the capacity comes from and of the measures. You assured the committee just now that you will guarantee registrar positions. That is a brave statement, minister, but you are also putting a threat in that for the GPs.

We do not know what the regulations are. We are trying to make a decision that ensures good patient access to care; you are talking of a guarantee. We must have from you absolute clarity about how the guarantee will work in practice: who does what and where if there is a failure, what the next stage is and how that is backed up. The understanding of many GPs is not that they will be forced to provide a service if the health board cannot because it does not have facilities, support, resources or bodies.

The committee is working with no knowledge of the regulations or of what is an enhanced or additional service and you want us to make a decision on the bill. We need a definition from you.

**Malcolm Chisholm:** There are definitions of additional and enhanced services. Some of those are covered in my letter, and more can be given if you wish.

I will clarify the point about GPs having to continue to provide a service. We envisage that that will happen only in a small number of cases in remoter areas. Please do not take it as a general statement of policy for the majority of places in Scotland.

The reality is that there are financial mechanisms in the bill to support out-of-hours services. There is a significant increase in the out-of-hours development fund, which will build up to £10 million in the third year. Moreover, if a GP opts out of out-of-hours provision, they will, of course, lose part of their money as a result—£7,000 per GP.

A significant sum will be allocated specifically for the provision of out-of-hours services. It would not

be appropriate for me—and I am sure you would not think it was—to give one blueprint or even ten blueprints of how that is to be done, because the point of service redesign is that it should be led by front-line staff. As I said, I saw some of that in Moray recently and when touring through other bits of Scotland the following week. I saw much innovation from the GPs in Argyll.

The clinicians in the health service, supported by the managers, will develop the new models of care. My responsibility is to ensure that the money is in place for that and to ensure that the duty is placed on health boards to provide it.

**Janis Hughes:** I am sorry, but I must press you on enhanced services. We really are in the dark. In your letter, you quote a paragraph from "Investing in General Practice", which allegedly defines enhanced services. However, it does not actually define them: it gives examples of what they might be. Our understanding is that enhanced services are things such as the provision of contraception services—no, that is an additional service. Can we define specifically what an additional service is and what an enhanced service is?

You said that opting out of that provision would not mean a diminution of service, but from where we sit, that is what it will mean. If I have to go to another GP practice or to an acute facility for one of those services, that will be a diminution of the service that I currently receive.

**Malcolm Chisholm:** We can certainly spell out the additional services. There are lists of enhanced services, which I can read out, if you like.

**The Convener:** We accept that; we have a copy of the contract. We are interested in the enhanced services.

**Malcolm Chisholm:** We do not want to put a lid on the enhanced services. We have lists, but the possibility of including other services is in the nature of redesigning care. The mechanism is good. People have struggled for years with the question of having a financial mechanism that supports new services in primary care, because a legitimate complaint from GPs sometimes is that they are asked to do more, but not given the resources for that. The enhanced part of the contract is a financial mechanism, so that if more services are delivered in primary care, the resources follow to deliver them.

**Janis Hughes:** Will you give examples?

15:45

**Malcolm Chisholm:** The list in the general medical services contract includes flu immunisations; preparation of records for quality; childhood immunisations; more advanced minor surgery—the more simple minor surgery comes under additional services; anticoagulant monitoring; intrapartum care; and drug and alcohol misuse services. Lists exist, but my point is that they cannot be closed lists, because the nature of enhanced services is that, over time, there might be still more that can be done in primary care.

**Janis Hughes:** If I have to go somewhere other than the GP practice that I currently attend for those services, is that not a diminution of the service that is provided to me?

**Malcolm Chisholm:** I am not sure whether you would be able to receive all those services from your GP. Minor surgery is a good example—I would be surprised if that were available from your GP. Contraceptive services are one of the additional services, which might catch people's eye, but it is interesting that that is not part of the general medical services contract. It is not as if you have all those services and you are losing them. You are more likely to have more services in primary care as a result of the contract, rather than less.

**Janis Hughes:** That is what we need to know.

**The Convener:** Does Kate Maclean have another question, or will we move on to Mike Rumbles's question on rural practices?

**Kate Maclean:** I have another question that arose from the Finance Committee. Do you want me to ask that now? It is up to you.

**The Convener:** We will leave that now and move on to Mike Rumbles's question, after which we will return to your question.

**Mike Rumbles:** I have two questions, one of which is on rural practices. I am concerned about the minister's evidence that the Parliament is the proxy for the patient. It strikes me from the evidence that the patient has been forgotten somewhere and that the Parliament is a backstop. As you heard explained to the committee, paragraph 40 of the Executive's policy memorandum on the bill says:

"The Executive has not carried out further consultation on the contents of this Bill."

In effect, you are saying, "It's a done deal. The employers—health boards and the national health service in Scotland—and GPs have agreed the contract. If you guys in the Parliament amend that, you will breach the negotiated agreement, so we cannot really consult." That strikes at the heart of what the Parliament is about. As parliamentarians, we have a fundamental public duty to ensure a proper consultation process.

I will link that with my question about rural Scotland. How can we be sure that enough

consultation has taken place on rural practices in the Highlands and Islands and, specifically, on the practices that receive inducement payments? I understand from your evidence that those practices can be covered by salaried GPs, but many GPs do not want to be salaried. Can we be sure that the minimum practice income guarantee will cover those practices? I think that there are about 80 inducement practices.

**Malcolm Chisholm:** I repeat my point and extend it to say that politicians in general—including ministers—are, at their best, the proxy for the patient. That is the justification for our involvement in health. I accept that my operations as a politician will not intrude on some clinical matters, but I agree that that is sometimes a grey area. I listen closely to clinicians' advice on clinical matters; it is reasonable and correct to do that. However, I agree with your general point.

I also agree that the bill is something different from all the other bills that the Parliament has dealt with. To some extent, that is inevitable when the negotiation of pay and conditions is involved, but the second element is the UK dimension, which changes some of the dynamics.

You heard the representatives from the Scottish Association of Health Councils saying that they very much welcome the consultation on implementation, which is a central point. I understand the concerns about out-of-hours service provision—although I am seeking to reassure people about that—but all the implementation issues will be subject to public consultation. Obviously, it was difficult to conduct a negotiation and carry out a consultation simultaneously. There are some inherent difficulties there, and I know that members will want to come back to me on that.

On the second point, some of the detail about the inducement practice money is still to be agreed. The salaried GP option is not the only one. The bottom line on inducement practices is that the MPIG will apply to them, and no inducement practice will be worse off. Indeed, they will benefit from the ending of the existing arrangement, whereby any new income secured over and above the agreed national yardstick has, in the past, effectively been clawed back from inducement practitioners. Not only will those practices be guaranteed their present arrangements; they have the potential to benefit considerably from the new ones. That is the basic guarantee to inducement practitioners. Some of the detailed mechanisms are still being discussed and negotiated, but there is no doubt about the principles and the guarantee.

**Mike Rumbles:** I am delighted to hear that commitment from the minister, which has certainly answered my second point. I wish, however, to pursue the minister about what he said in relation to my first point. I will outline the problem in a nutshell. We are being asked to examine a bill that, on many pages, says that regulations will do this or that. The first bill that I had to deal with in detail was the National Parks (Scotland) Bill, which, like the Primary Medical Services (Scotland) Bill, was an enabling bill, setting the framework for regulations to come in later.

We pass the bill, and that is marvellous. The Executive then presents its regulations to the committee, but the committee might say, "Hang on a minute, we don't agree with a lot of these regulations." The committee might not see the regulations as providing for the effective service that we all hoped would be put in place. Members can only pass or reject regulations, and there are serious consequences if they are rejected.

As the convener said, the committee members feel—I am at least speaking for myself—that we must have the regulations before us well before stage 2, so that we know what the regulations and their impact will be. If we are to act for the general good, we would be abrogating our responsibilities if we did not have that information before us. Can you be a little more specific and say to us that we will have that information before we reach the detailed consideration of stage 2?

**Malcolm Chisholm:** That is my clear intention, as I spelled out in my letter. The only caveat that I mention, in the interests of realism, is the UK dimension to some of the regulations. We will press to get all of them done by stage 2 but, because of that UK dimension, it is right for me to advise you that it is not entirely within my control.

It is right for the Scottish Parliament to take the availability of regulations seriously, even if these matters were all debated in the House of Commons at report stage on 8 July. It is to our credit that we want to see the regulations in good time. I make that point to praise the Scottish Parliament rather than for any other reason.

**Dr Turner:** However the regulations turn out, much depends on the fact that the people have to be there to provide the services. I am concerned that, for every 100 general practitioners working under current arrangements, 150 replacements will be required. If the people are not there to relieve the doctors—I am thinking of island communities in particular—then how can the regulations be drawn up in such a way that the new contract will draw people into the service? I find it difficult to see how it will do that if people do not know the number of experienced doctors and nurses that there will be. As we know, it takes a long time for people to gain the necessary experience to work in remote areas. It scares me a little that we do not know the relevant numbers, never mind the regulations.

Patients expect to see more of their doctors under the new contacts. At present, it can be difficult for them to see their doctor for more than 10 minutes—or even less than that in some places. Fragmentation of the service and more specialisation always means that more doctors are needed. I suppose that is why it has been said that 150 GPs would be needed to replace every 100 GPs.

**Malcolm Chisholm:** I am not sure about the basis of the BMA's figures, but of course I accept that we need to expand not only the medical work force, but other parts of the health service work force too, which is why those are key commitments in the partnership agreement. We know more about work force planning than we did three or four years ago, but we still have much work to do to catch up in an area of the health service that did not feature at all in the past. I fully accept that we must do more GP work force planning, but I hope that what I have said about training numbers in the meantime will reassure people, given concerns that have recently been expressed.

There are many aspects to work force planning. I will soon meet Sir Kenneth Calman, who has been conducting a major piece of work on training the future medical work force. We are lucky that he and Professor John Temple—who are two of the most distinguished clinicians in the United Kingdom—are doing that work on medical work force planning. We have decisions to make and I fully accept that we must grow capacity for the contract to be successful.

The corollary is the redesign of services. We discussed nurse numbers at question time last week and the fundamental point that I made to Shona Robison was that vacancies can increase marginally, but that is because the work force and the service are significantly expanding. More than 900 newly qualified nurses and midwives joined the service in the latest six-month period, which as far as I know, is unprecedented. We are moving in the right direction, although people will want to raise concerns about the speed of progress. I fully accept that we must increase the service's capacity, which is why firm commitments are given in the partnership agreement about staff numbers.

**The Convener:** I want to move on. Helen Eadie has a question.

**Helen Eadie:** There may be disquiet about patients, but there is also disquiet in the committee about the size of the GP response in the ballot. I believe that 70 per cent of those who were able to respond did so and that only 79.4 per cent of those voted in favour of the contract. With such a response rate, it would appear that only 56 per cent of those who were eligible to vote voted in support of the contract. What do you think about those figures?

**The Convener:** Members do not want comments about Scottish parliamentary elections to be thrown in as a smokescreen, minister.

**Malcolm Chisholm:** That is the most salient comment to make because—

**Helen Eadie:** I have just come back from Sweden, where there was an 84 per cent response rate in elections.

**Malcolm Chisholm:** Ballots of any kind will give rise to the obvious comment that Christine Grahame pre-empted my making.

**The Convener:** This discussion is about the contract and other serious matters.

**Malcolm Chisholm:** We will leave electorates out of things. The reality is that by the normal standards of trade union ballots, for example, that would be a high turn out and level of support for a proposal.

**Helen Eadie:** Given that the matter relates so closely to GPs' pay packets, the results are surprising. Does the ballot represent some unease on the part of GPs? Do they not understand the issues that are involved?

**Malcolm Chisholm:** The same remarks can apply to the general public. Unease and concern can result from a total comprehension of issues, but it is not insulting to anybody if we recognise that there is also unease that is perhaps based on misunderstanding. In respect of the contract, such unease might be the result of people's not keeping up with all the developments. For example, the MPIG was quite a late part of the contract. Different views about the MPIG have been expressed this afternoon.

Many of the concerns that GPs voiced at a relatively late stage—perhaps two or three months before the contract was produced—were based on the absence of an MPIG. I still hear some stories from rural practices. Mike Rumbles was kind enough to say that he was reassured by what I said about the inducement practices and the MPIG. However, there are still issues about understanding how the MPIG will operate.

One positive feature of the contract, which is part of the Scottish variation, is that the Scottish formula takes more account of remote rural areas. It is not up to me to say why Scottish GPs voted against the contract, but, undoubtedly, some GPs have said things about the contract that did not take on board the latest developments on the MPIG.

16:00

**Shona Robison:** We have heard concerns that many of the proposals will be implemented by regulation. Given that, as the minister acknowledges, many GPs are not fully au fait with the proposals, is there not a danger that when GPs become aware of the exact details in the regulations, a significant number of them will not be taken with the process?

**Malcolm Chisholm:** The member will have heard last week the generally positive comments of the BMA and the Royal College of General Practitioners about the contract. It is difficult to speak about GPs in general because they have different views and they will want to see the regulations, which is understandable. However, the organisations that represent GPs are positive about the contract and, although it is not possible to speak for all GPs, the ballot suggests that the majority of GPs are positive about it.

**The Convener:** We have exhausted that subject for the time being.

**Janis Hughes:** I ask this question with the benefit of hindsight that I have gained through dealing with legislation in the previous committee. Given that the bill is unique because it is underpinned by a contract, do you expect Executive amendments to the bill?

**Malcolm Chisholm:** The bill might be a little unusual. At the moment, I do not envisage any Executive amendments, although my colleagues will correct me if they have something up their sleeves.

**Janis Hughes:** That is on the record.

**Malcolm Chisholm:** My colleague has just told me that there might be some technical amendments.

**The Convener:** That caveat has been stitched in for you, minister.

**Mr Davidson:** A minute ago, the minister said that the Scottish contract is different. I was going to ask whether we have the right balance between local and national needs, but I would like to know whether the minister feels that the contract deals with the geographical and demographic situations in Scotland, which are different from those in the rest of the UK. That is particularly true in rural areas, where the average age of the population is rising even faster than in other parts of the country.

**Malcolm Chisholm:** I feel that we have got the balance right in achieving a UK contract with Scottish variations. The distribution formula was one of the points about which we were most concerned and we think that we have achieved a formula that suits Scotland's needs better than the English formula would have done.

I note that, in the previous meeting, there was some discussion about bureaucracy and administration. It is worth saying in passing that a single funding stream will deal with half of the money that goes to GPs, compared with the present situation in which about 26 or 27 funding streams exist for the same amount of money.

The formula is more sensitive to Scotland's needs. Different dimensions are involved; there is the UK-Scotland issue, but there is also the issue of local areas within Scotland, which David Davidson touched on and which the BMA raised. The contract is a national one. The section 17C arrangements are local arrangements—they are the continuation of the arrangements for what at present are called personal medical services. The section 17J arrangements are the national ones. I think that the BMA picked up that matter slightly differently. We are talking about agreement between boards, but that is more to do with out-of-hours and enhanced services issues. The Scottish contract is fundamentally a national one.

**Mr Davidson:** As you know, I agree with you about the cutting of regulation, but do you think that you have carried the rural and remote practitioners with you? That seems to be where the great body of unease is sitting at the moment.

**Malcolm Chisholm:** I think so. The situation has moved quite quickly. Some, although not all, of the unease is due to the fact that the MPIG arrangements came late in the day, as did some of the agreements around the Scottish formula.

I can understand why the rural and remote practitioners would have been concerned up to a late stage in the negotiations. If, after having heard the full explanation of what was finally agreed, some of them still have concerns, I am keen to hear them. However, a lot of the concerns that I am hearing in relation to rural issues can be answered in relation to the MPIG and the Scottish formula.

**Mr Davidson:** I lodged a written question some time ago to which I have not received a reply. To save you some time in answering it, I will ask a throwaway question. Do you intend to meet rural practitioners to discuss their fears?

**Malcolm Chisholm:** I am always delighted to meet clinicians.

**Mr Davidson:** I will take that as a yes, minister.

**Malcolm Chisholm:** I met several rural practitioners over the summer and I will be pleased to meet more.

**Mr Davidson:** Having considered the financial memorandum, the Finance Committee raised a query about the fact that the funding mechanisms for practices may now have a consequence for other budget areas that are not covered by the

memorandum. In other words, it seems that there might be a change in who is delivering what and how that will be funded. There is a concern that that will result in some GPs pushing more and more into acute services and leaving other parts of the service to pick up the slack under the new working arrangements. That concern seems to have arisen as a result of inadequate clarity in the financial memorandum. Could you comment on the matter?

**Malcolm Chisholm:** As part of our distinctive approach to health in Scotland, we are trying to break down the barriers between primary and secondary care. That could work in several ways. My general take on the contract is that a lot of the movement will be in the opposite direction. For example, you could say that the enhanced services part, the quality payments that are promoting chronic disease management and other forms of service in primary care are rewarding people for shifting work into primary care. However, I suppose that you could also say that one quality outcome might be more referrals in certain cases to secondary care. I suppose that that would be possible.

**Mr Davidson:** Do you agree that funding will follow the treatment and the patient rather than being hidebound in fixed budgets?

**Malcolm Chisholm:** The health budget and the Scottish budget and so on are all fixed at a macro level and the issue is the directing of resources to the right places. I do not have in my head the precise words that the Finance Committee uses, so I am not entirely clear what it had in mind, but I do not envisage that there will be a major shift from primary to secondary care as a result of the contract. If there were to be a shift, I would expect it to be in the other direction, which is, of course, the intention and direction of policy in other areas as well.

**Kate Maclean:** As a result of the evidence that the Finance Committee heard, there was some concern that linking funding to quality targets might cause a problem if elements of the targets are outwith the practices' control. I think that the Finance Committee questioned whether linking to targets was the best way to allocate funding and wondered whether account would be taken of difficulties arising from that in certain cases.

The Finance Committee raised the specific example of the MMR vaccination and pointed out that a practice might fail to meet a target not because of anything that it had done, but because of parents' fears arising from the publicising of health concerns. Will account be taken of such issues when funding decisions are made for the practice?

**Malcolm Chisholm:** In general, the tying of money to quality outcomes is new, not only in Scotland but throughout the world. It is an exciting development and something that I would promote. In relation to the contract, two thirds of the additional investment in the next three years is tied to quality outcomes. I am sure that patients will welcome that.

You home in on one aspect of the situation. However, all immunisations are dealt with in the same way as MMR. Historically, the payments for reaching certain targets have served to increase immunisation rates and, in general and public health terms, that policy has been successful. That part of the contract replicates what has been happening with the target payments for some time.

There are particular issues concerned with MMR. That is a subject to which I listen carefully—

**Kate Maclean:** I do not want an answer about MMR. The question was not meant to be negative. I was voicing the concern of the Finance Committee, in which the question was raised—it might have come from a witness who represented GPs. Let us forget about MMR and imagine that a target cannot be met, for a reason that is outwith the practice's control. Would that be taken account of in the funding?

**Malcolm Chisholm:** There is some allowance for exception reporting in relation to other issues, but most of the controversy concerns immunisation.

**Dr Whyte**: All the quality and outcomes framework clinical areas are subject to a degree of exception reporting, which takes into account the fact that some patients react badly to drugs or cannot tolerate maximum doses. Therefore, one cannot always achieve evidence-based practice. Practices will be allowed to have those patients accounted for in the level of achievement. One of the matters to be taken into account is informed dissent or informed non-consent.

**The Convener:** That concludes this evidence session. I thank Dr Whtye and Ms Clark. The minister will remain for the next session.

# Hepatitis C

16:12

**The Convener:** The minister will be joined for this agenda item by Andrew MacLeod, the head of the health planning and quality division in the Scottish Executive, and Bob Stock, the branch head of the health planning and quality division in the Scottish Executive. While we are waiting for the witnesses, I refer members to the background note that was circulated to them. Members might have received other material by e-mail and post and they might wish to refer to it, although they are not public documents.

I understand that the minister wants to make an opening statement.

**Malcolm Chisholm:** As I announced at the end of last month, I am pleased to bring good news to the committee about our proposed scheme. The United Kingdom Government has agreed that the Executive has the necessary powers under the Scotland Act 1998 to establish our proposed scheme. As members know, the Department of Health in Whitehall has stated that it will also establish a scheme. That means that we can get on with the detailed business of setting up our scheme.

We still need to ensure that the people who receive the payments do not lose social security benefits, but now that other parts of the UK are adopting a similar approach, I hope that that matter can be resolved without difficulty. There might be other advantages to the new situation and we will explore them.

I realise that the committee is concerned that matters are taking so long, and I share that concern. I hope that the discussions can be brought to a satisfactory conclusion, that the people affected will be able to receive the payments that we have proposed and that they will gain full benefit from them.

My final point is that it will take a little time to make the first payments. However, I want to make it clear that the start date of this particular scheme was the date of my announcement about it at the end of August; to be precise, Friday 29 August 2003.

16:15

**The Convener:** Committee members might want to ask more about the time that it will take to make payments.

The committee inherited the issue from the previous committee, which did sterling work on it. I understand that Lord Ross's expert group was set up by that committee to consider the issues and to advise. I also understand that the minister had that advice before him.

I hear the minister saying that he has good news, but it is so far from what Lord Ross recommended that I cannot believe that it is good news for those who have hepatitis C or for their surviving relatives and partners. Lord Ross recommended an initial sum of £10,000, and an additional lump sum of £40,000 to cover pain and suffering in those who develop chronic hepatitis C.

Importantly, Lord Ross's group recommended that the calculation for those who suffer serious deterioration in their physical condition—such as cirrhosis and liver cancer—because of hepatitis C infection should be made on the same basis as common-law damages, taking into account the two initial payments. Beneficiaries would not lose out, because they would inherit certain elements of that package, based on the Damages (Scotland) Act 1976.

I can understand why the minister does not want to call the payments compensation. That is a tricky legal word. The payment is an ex gratia payment. Why is the offer that is being made so far removed from what Lord Ross proposed? How was it calculated?

**Malcolm Chisholm:** That was discussed fully the last time that I came to the Health and Community Care Committee to discuss the issue. I fully accept that not everyone will agree, but I have to make a judgment about how health resources are to be allocated. In the previous session, there were implicit calls for more money.

We all know that there are many demands on the health service and I had to make a decision about the best form of ex gratia payment. The first principle was that it should go to those who are still alive and suffering, although I hope that my announcement of 29 August as the start date for the scheme reassures people that no one will be affected by the amount of time that it will take to get the administration of the scheme up and running. The main principle is that the money should go to those who are still alive and suffering.

The second judgment is about making a fair and reasonable payment to those people and weighing that against all the other demands on the health budget. That is the judgment that I had to make; Lord Ross and the expert group did not have to make that judgment because they were considering the issue in isolation.

**The Convener:** So the main issue was funding?

**Malcolm Chisholm:** That was one of the issues and I do not believe that there is anything very surprising about that. We would like to be able to give large sums of money for pay and ex gratia payments and all the other things that are

necessary for the health service. I have no difficulty in saying that funding is a consideration, because we have to ensure that money is used effectively. However, I believe that the payment is fundamentally fair and reasonable.

**The Convener:** Are you saying that the payments of approximately £300,000 that are being made in Ireland are being made because they are prepared to put more money into the compensation—or whatever word you would use for it?

**Malcolm Chisholm:** I am glad that you raised that point. In Ireland, the Government and everyone else have agreed that wrongful practices were used. The payments in Ireland were compensation. We are making an ex gratia payment. I know that certain people are raising controversy about that, and the Health and Community Care Committee in the previous session of Parliament did not, in particular, express a different view. The payment that we are making is ex gratia and that is the difference between Scotland and Ireland. It is important that people understand that.

**The Convener:** I understand the difference between ex gratia payments and compensation.

My second point was about the fact that the ex gratia payment does not transfer to surviving family members. Is that not a bit mean, to say the least, given that you have been limited in the amount that you can pay? Why not, at least, let the payment be transferred to surviving family members?

**Malcolm Chisholm:** I understand that that point will also be made. However, we want to target the resources on those who are still living and suffering. Obviously, people will take different views on that issue. However, I think that the money that is available should be targeted on individuals who are still alive. That is a fair and reasonable approach.

**Dr Turner:** I know of someone who might come into the category of people who received blood products in the '70s and '80s. This person, who ought to receive payments for hepatitis C, has a very sick wife who needs to be looked after by him and is dependent on him. It would seem cruel if none of the hepatitis C money were to pass to that person, as they are unable to work and make money.

**Malcolm Chisholm:** Perhaps I missed something there. Assuming that the person to whom Dr Turner refers is in the eligible category, the payment will be made.

**Dr Turner:** They may not be—that is a separate issue. However, let us say that the person concerned is eligible to receive payment but is ill. What happens if there is a tragedy and someone who is caring for another member of his family, who depends on him, dies?

**Malcolm Chisholm:** I have said that the scheme starts on 29 August. If someone is now in the eligible category, they will receive the payment, irrespective of the circumstances that the member describes.

**Dr Turner:** So they will receive a one-off payment.

**Malcolm Chisholm:** Yes.

**Dr Turner:** However, if their health deteriorated they would not receive any extra payments and their family member would be left high and dry.

**Malcolm Chisholm:** I am very sympathetic to the people in the situation that Dr Turner describes, but she raises issues that are for the social security system and which I cannot resolve. I am sure that the sick individual in question would be entitled to other benefits. However, we must focus on the group of people to whom the scheme applies. The Parliament has certain responsibilities, but so does the Department for Work and Pensions.

**The Convener:** Notwithstanding this ex gratia payment, remedies will still be open in the civil courts.

**Shona Robison:** You said that the scheme starts on 29 August. Perhaps it should have been backdated to January, when you made the announcement. If someone does not live long enough to receive the payment but dies after 29 August, will their relatives get the benefit of it?

**Malcolm Chisholm:** That was the point of the August announcement, which gave a definitive commitment to establish the scheme. I do not want anyone to be anxious about whether they will receive a payment. If they are in an eligible category, they will get it.

**Shona Robison:** Will their relatives get it if they do not live long enough to receive it?

**Malcolm Chisholm:** Are you asking me directly about someone dying between now and the payment date?

**Shona Robison:** Yes.

**Malcolm Chisholm:** Their relatives will receive the payment.

**Shona Robison:** I have a question about the wider issue of relatives of hep C sufferers receiving money. Lord Ross recommended that they should. The financial package that he proposed, which included payments to relatives of deceased people, was worth £89 million. The package that you have announced is worth, I think, about £20 million—is that correct?

**Malcolm Chisholm:** We cannot be absolutely certain of the figure, because we do not know. Others may come forward, given the nature of hepatitis C. However, in terms of those who are registered with the Scottish Centre for Infection and Environmental Health, there are about—and I can be corrected—580 people, which works out at about £15 million, but we fully accept that the figure may be more than that because others may come forward. We are not saying that £15 million is the total amount, but that is the amount that we know we have to deal with initially.

**Shona Robison:** On those figures, out of around 500 families we are talking about around 150 who have lost relatives. Those were the figures that were before us previously. We are talking about a difference of £65 million to £70 million between the financial package that you are promoting and the package that was suggested by Lord Ross. This week, we learned that there is a £644 million underspend for this financial year, which is a significant amount of money. There is a moral obligation to the families. Rectifying the situation would amount to around 10 per cent of that underspend. Given the underspend figures that have come to light, and given that we are talking about one-off payments, is there not a moral imperative for your department to make a bid for some of the underspend, to give some recognition to the pain and suffering of the relatives of the deceased?

**Malcolm Chisholm:** Some people will make that point. I made my position on that clear earlier in the year, and from the point of view of my health budget I would not change my mind. I do not think that I should pre-empt what will be said about that budget on Thursday, but it would be fair to say—you will find this out on Thursday—that there is not a large amount of underspend lying around in the health department, and anything that is out there with the boards is very much committed. I am absolutely certain that you will not find anything that will meet your requirements.

People can always make competing arguments about the use of resources, but I have merely repeated today what I said before about the criteria that I use. First, I target the resources on those who are still alive, which I think people will understand. Secondly, I make what I regard to be a fair and reasonable ex gratia payment to those people.

**Shona Robison:** Do you appreciate how upsetting that is for the families? I have received correspondence, as I am sure others have. They want some recognition of what happened to their family members. Under this scheme, they will not get that. A one-off payment, which I suggest would be a good use of an element of the underspend that has been identified, would go some way—not all the way—to at least recognising what those families have gone through. Will you not reconsider?

**Malcolm Chisholm:** Shona Robison should wait until she hears what is said about health on Thursday, but I do not think that I am giving away any secrets when I say that the underspend is small in terms of what people expected in the past, which shows a well-managed budget. No doubt that will be repeated on Thursday when more information is available. However, I repeat the point that I made: we have to make hard choices all the time about the allocation of money.

You know as well as I do all the demands on the health budget. It is the nature of health. We all know about the increasing elderly population, big expansions in drug budgets and all the issues about doctors' hours that Duncan McNeil talked about recently. We know the demands on the health budget. Hard choices have to be made, and I think that the public will understand if we target the resources on those who are still living with hepatitis C as a result of blood products, and make them a fair and reasonable offer. However, that is a matter of judgment, and I accept that others will not agree with my judgment.

**Mike Rumbles:** Constituents who came to my surgery yesterday asked me the question that I am about to ask you, which you have gone part of the way towards answering. If someone had hepatitis C on 29 August, they need to come forward. What are the practicalities of the process? To whom do they come forward and what do they have to do to register a claim?

Secondly, you announced that the scheme in England would be the same or similar. To your knowledge, are the levels of ex gratia payments in England identical to those in Scotland?

16:30

**Malcolm Chisholm:** I do not think that the second question is for me to answer; it is up to the UK Department of Health to make a statement about that matter when it is ready to do so.

On the first question, when we have finalised the arrangements, we will publicise them clearly and openly so that people know about them. I cannot outline every detail of those arrangements today. All that I am saying is that I now believe that we will be able to progress the matter quickly and will soon be in a position to produce the details of the scheme so that people can get their money.

**Mike Rumbles:** How will the situation be dealt with in the unfortunate circumstance that somebody dies between 29 August and the details of the scheme being announced?

**The Convener:** That question has been answered. My understanding is that they will receive payments.

**Malcolm Chisholm:** In those circumstances, the family will get the money. People will understand the reasons for that.

**The Convener:** I want to ask about the situation in England. I understand that the minister cannot speak for the English, but should we anticipate that the settlement figures in England will mirror those in Scotland?

**Malcolm Chisholm:** I had not read the Department of Health press release as well as my official has done; I have been told that the notes in the press release stated that the payments would be the same. I did not think that the Department of Health had made that announcement yet. I knew that that was the intention, but I did not think that it had been announced and I did not think that it was my place to make the Department of Health's announcement for it. However, since it was in the footnotes of the press release, I can repeat it to the committee.

**The Convener:** Perhaps that is why the settlement figures are the same in Scotland. It might have been possible for the Scottish Minister for Health and Community Care to come to a different arrangement with the money that is available, but that would not have complied with the scheme in England. Is that an unfair inference for me to make?

**Malcolm Chisholm:** It would have been an entirely reasonable inference had England made its announcement in January and I had made mine in August, but since it was the other way round, some people might draw the opposite conclusion.

**The Convener:** We will see.

**Mr McNeil:** I have not been asked, but I agree that that is an unreasonable assertion to make. Despite the fact that concerns still exist about the scheme, the committee should take comfort in having achieved this result for hepatitis C victims in Scotland and having led the way for the whole of the UK. We should celebrate that achievement rather than denigrate it.

**The Convener:** I think that that is more of a comment than a question; we are here to ask questions.

**Mr McNeil:** Be happy.

**The Convener:** The point is being made by members of the public. I am not speaking personally; I am speaking from evidence that we have received from hepatitis C sufferers and their families. They are not happy. It is the committee's duty to put those points to the minister on behalf of the people.

**Mr Davidson:** The minister visited the committee at its away day and on the journey back we heard him announce to the press that agreement had been reached within the UK devolution settlement. No mention was made of the fact that somebody from the Department for Work and Pensions had to comment on the potential clawback of benefits. When I got home that night, I discovered that I had received a flood of e-mails asking all sorts of questions. I had to respond and say that the minister had not commented on the matter and that they should be aware that it had to be dealt with. He has now talked about it. Where are we on the position of the Department for Work and Pensions? What difference might its current position make to the payments that are made?

**Malcolm Chisholm:** I repeat what I said in my opening statement, which was more or less what I said on the day. Now that the other parts of the UK are adopting a similar approach, I hope that the issue can be resolved without difficulty. That is certainly the view in Whitehall. We are talking about the technical arrangements and the details of the process rather than whether it can be done.

Obviously, there is still some work to be done on the social security side. Indeed, social security regulations may be required to bring the arrangements into effect. However, the key message that I am sending out today—in even stronger terms than I did on 29 August—is that there are no fundamental obstacles in the way of the scheme's being introduced.

**Mr Davidson:** I do not know whether you have had any negotiations directly about whether primary legislation will be needed at Westminster to change the position. Is your understanding that no deductions will be made if there is a United Kingdom agreement, or will there be some deductions?

**Malcolm Chisholm:** The intention is that there will not be any. There is a precedent for that in the Macfarlane Trust. I think that the assumption is that there will be social security regulations, which are reviewed regularly at Westminster. That would be the mechanism.

**Mr Davidson:** Presumably, if there is an interim clawback and the regulations are reviewed later, the arrangements will be put into effect retrospectively, from 29 August.

**Malcolm Chisholm:** That is one of the issues that we will take up with the Department for Work and Pensions, but that is certainly the intention.

**Mr Davidson:** My other question is about the Irish scheme, on which Christine Grahame has touched. Do you have any intention to set up a tribunal to deal with aspects of our scheme like the one they have in Ireland, which is called the

Hepatitis C and HIV Compensation Tribunal? It does not sound as though you will do anything like that. Will there just be a flat statement and if someone qualifies, that is it, or will there be a tribunal system to challenge rulings?

**Malcolm Chisholm:** We already have arrangements for HIV payments. The Macfarlane Trust is the main body for those, although it is not the only one—there is the Eileen Trust as well—because there are two parts to those arrangements. That seems to be the most obvious model to use in a Scottish and UK context. The matter is still being discussed. I do not know the details of how the tribunal in Ireland works. In the first instance, we are thinking about the model of trust that we know. Discussions continue on that.

**Helen Eadie:** My question is related to the earlier one about the number of people involved in the hepatitis C cases. You will be aware of an instance in Fife of people being infected with hepatitis B. Will they be included in the scheme too?

**Malcolm Chisholm:** No, they will not be included.

**Kate Maclean:** My question is linked—tenuously, I have to say—to David Davidson's question on the Irish compensation tribunal. Like all members, I have had many representations from constituents, including from one in particular who, along with his two brothers, contracted hepatitis C from tainted blood products. Thanks to the Scottish Executive and, in particular, to the Health and Community Care Committee, for pursuing the issue of payments of any kind, such people are in a far better position than they were before, but it seems from the e-mails that I have received that people are quite unhappy about the level of compensation and the fact that there will be no retrospective payments.

From your earlier evidence it seems that the difference between Scotland and Ireland is that the money from the Scottish Executive is an ex gratia payment, whereas the money that is paid in Ireland is compensation, which necessitates setting up a tribunal to consider levels of compensation, and is far more complicated than an ex gratia payment. Has a definite line finally been drawn under the debate about the possibility of compensation? Some kind of public inquiry has been asked for, as people are concerned about some of the evidence and about the fact that medical records have been lost. Is there any possibility of opening up that debate again? It would be useful for individual MSPs to be able to say when they are dealing with constituents whether there is any hope of further developments in the saga, which has been going on for a considerable length of time.

**Malcolm Chisholm:** The Health and Community Care Committee did not support a public inquiry, which is presumably what you are referring to. Throughout the previous parliamentary session the Executive's view on the matter was clear: if new evidence comes out, people can examine it and make a judgment on it. Like other committee members, I have seen the recent newspaper reports, although that is as far as it goes. Unless some very strong evidence emerges, I do not think that there is any reason to revisit the issue, given that the Executive and the Health and Community Care Committee took the view in the previous session that there should not be a public inquiry.

**Kate Maclean:** But you would not rule out such an inquiry if new and compelling evidence emerged.

**Malcolm Chisholm:** Obviously, if completely new evidence emerged, it would change the situation. However, I am not saying that that is the case.

**Shona Robison:** We must be careful and accurate about what the previous Health and Community Care Committee said about a public inquiry. I recollect that we said that a public inquiry was not the main issue at the time; instead, our main imperative was to resolve the issue of financial assistance. That is what the committee wanted to focus on. However, my recollection is that we left the door open for a public inquiry, particularly if new evidence emerged.

The issue of financial assistance has been resolved to some degree, although we still need to address some aspects about the level of compensation. I hope that the minister will meet organisations that represent hep C sufferers to discuss the matter. That said, sufficient questions about the whole episode remain unanswered. The Health and Community Care Committee's inquiry was able to pursue certain questions only so far, and I think that the minister will agree that a committee inquiry is not as able to probe matters as a public inquiry. For example, there are questions about when the health service knew about hepatitis C as a virus and whether, after tests were introduced and heat treatment became available, there was a period of time when it knew that blood and blood products were contaminated. Such questions remain unanswered and up in the air for hep C sufferers. Moreover, as Kate Maclean has pointed out, it has now been alleged that hep C sufferers have not been able to obtain their medical records.

Having a public inquiry now would potentially allow hep C sufferers to have some of those questions answered. Although, as a Health and Community Care Committee member, I felt that a public inquiry was not the way to go at the time,

because we wanted to get money into the pockets of people who were suffering, I think that it is now the right time to go down that route. Do you not accept that argument?

**Malcolm Chisholm:** I am not persuaded by the merits of that argument, although members might wish to pursue the point.

It is important that any new evidence that might have become available is produced so that it can be examined. However, the area is very complex. The reality is that a specific screening test was not introduced until 1991 and that although people knew about what was called non-A, non-B hepatitis, they might not have known about its exact longer-term effects. There were many issues to address. In fact, a critical issue was that doctors had to make a choice about giving certain blood products, because the alternative might well have meant death for the particular patient. I certainly cannot do justice now to the many complex issues that are involved.

If new evidence emerges, I am happy to consider it with an open mind. Indeed, Andrew Gunn, who is well known to members, phoned me today and I was happy to talk to him and tell him that any new evidence should be submitted for examination. At the moment, I have not seen anything that would make me change my general approach. I am sure that some members might wish to pursue the subject as a matter for discussion and debate. People must understand that my main focus is on ensuring that the money is paid out as quickly as possible to people who are suffering as a result of blood products.

**The Convener:** For the purposes of clarification, the article that appeared in *The Sunday Times* on 7 September—to which the minister might be referring among other things—mentions papers that refer to

"specific brands of blood-clotting agents during a monitoring project in the 1970s."

The article continues:

"The study, funded by what was then the Department of Health and Social Security (DHSS) found that 197 cases of hepatitis C were reported by haemophilia centre directors between 1974 and 1979."

In commenting on those papers, the Executive has stated:

"We are not currently aware of these documents and would not therefore wish to comment on them."

Has the minister now seen any of those documents?

**Malcolm Chisholm:** No, I have not seen the documents.

The Convener: I seek to separate the matter of the ex gratia scheme from the public inquiry. It will be up to the committee to decide whether to ask you back to discuss whether or not you would hold a public inquiry once those documents are in your hands and once you have considered them.

16:45

**Malcolm Chisholm:** I am open minded about it. Personally, I am quite happy to listen to any new evidence. It should be noted that all the products that we are talking about were licensed by the forerunner of the Medicines Control Agency—now the Medicines and Healthcare products Regulatory Agency—which operated under reserved powers. There might well be a question about whether the issue is for us or the Westminster Parliament. Without getting into that argument—

The Convener: Although you could take a view on that.

**Malcolm Chisholm:** In principle, I am quite happy to consider any new evidence, which is what I said to Andrew Gunn.

The Convener: Have you any idea when you might be in a position to tell the committee when you will have seen the documents that have been trailed in the newspapers?

**Malcolm Chisholm:** If somebody submits those documents, I am sure that people will be able to look at them.

The Convener: We can put out a call to *The Sunday Times*.

**Mr Davidson:** This point goes back to the days when Susan Deacon was Minister for Health and Community Care. Apparently, she made a statement that 20 people who had contracted hepatitis C as a result of NHS blood-product use would be compensated under the terms of the Consumer Protection Act 1987. Have any such payments been made?

**Malcolm Chisholm:** I ask Bob Stock to give an update on what has been happening.

**Bob Stock (Scottish Executive Health Department):** No payments have been made, although offers have been made. Understandably, legal representatives of the patients involved are reluctant to accept any payments while the ex gratia scheme is still up in the air. They are holding back, and we are unable to resolve the matter in a lot of instances. It has also taken a lot of time to pull together medical records and so on.

**The Convener:** I thank the Minister for Health and Community Care, Mr MacLeod and Mr Stock. We will discuss next week whether we wish to take the matter any further, given the issues that have been raised today—and which have been left hanging to some extent. We will have to wait and see whether the documentation that we have been

discussing reaches the minister. Is the committee content to wait?

**Members** *indicated agreement.*

The Convener: We will let members see any correspondence.

That concludes the public part of the meeting.

16:48

*Meeting continued in private until 16:49.*

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