HEALTH COMMITTEE

Tuesday 25 November 2003
(*Afternoon*)

Session 2

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HEALTH COMMITTEE
14th 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)

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mrs Nanette Milne (North East Scotland) (Con)
Ms Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING GAVE EVIDENCE:

Lorna Clark (Scottish Executive Health Department)
Mr Tom McCabe (Deputy Minister for Health and Community Care)
Jim Patton (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Graeme Elliot

ASSISTANT CLERK

Hannah Reeve

LOCATION

Committee Room 3

Scottish Parliament

Health Committee

Tuesday 25 November 2003

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:06*]

Primary Medical Services (Scotland) Bill: Draft Regulations

The Convener (Christine Grahame): Good afternoon and welcome to the Health Committee's 14th meeting in session 2. I have received no apologies. I remind members to turn off their mobile phones and pagers. Regulations are turning out to be of popular interest to audiences—the room is full.

I welcome Tom McCabe, the Deputy Minister for Health and Community Care, and Lorna Clark and Jim Patton, who are bill team leaders. Tom McCabe will give a short background introduction to the draft regulations in relation to the Primary Medical Services (Scotland) Bill and Lorna Clark and Jim Patton will assist him in answering members' questions. The debate will not be formal, so members can ask questions.

I thank the minister for providing the Scottish and United Kingdom regulations. The UK regulations came a little late, but we understand the difficulties that are involved and we do not have a huge problem with that. We would like to hear what you have to say about them, but we want to reserve our position until next week's meeting. If issues arise, we will write to you. I invite you to say something about the regulations.

The Deputy Minister for Health and Community Care (Mr Tom McCabe): I thank committee members for giving me the opportunity to discuss the regulations with them. I am aware that the documents are complex—in fact, the regulations that members received only yesterday are perhaps even more complex than the others. As is the nature of such documents, they are perhaps not written in the clearest language. Dealing with them is not easy for anyone, so I appreciate the opportunity to say a few words to the committee about them.

Members are aware that the regulations will not be laid until February next year. I do not expect any major policy revisions between now and then, but I expect some rewording, which I hope will provide greater clarity about what the regulations are designed to achieve.

I see this meeting as an initial exploration of the regulations. Work is in progress. I would be happy to supply the committee with further drafts as the regulations are reworded and I would like the drafts to highlight changes that have been made for the committee's ease of reference.

I would be more than happy to continue the dialogue over the weeks and months before the regulations are laid. As work progresses and there are changes in wording, I will be perfectly happy to come to meetings whenever the committee thinks that it is appropriate to discuss matters.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Before I ask questions, I want to add to what the convener said. The situation is quite remarkable. The Executive has bent over backwards to help the committee with the regulations, which is an unusual step that I certainly welcome. It is a positive step towards co-operation between the Executive and the Parliament. The minister has addressed many concerns that committee members had simply by producing the documents.

I am quite happy with the Scottish regulations, which are under the Executive's control. I want to focus on the UK regulations—in particular, part 2, which is on contractors, on page 7. Regulation 4, which is entitled "Conditions relating solely to medical practitioners", begins:

> "In the case of a contract to be entered into with a medical practitioner, the medical practitioner's name must be included in the General Practitioner Register".

The exceptions are then identified. Paragraph (3) states:

> "In the case of a contract to be entered into with a company limited by shares—
>
> (a) at least one share in the company must be legally and beneficially owned".

In what way do those arrangements differ from the current arrangements, if they differ at all? At the moment, GPs are independent practitioners—if you like, they are in the private sector, because they are not employees of the national health service. Will the regulations set up a different system for GPs from the one we have at present? That is my fundamental question.

Mr McCabe: They will set up a different system in the sense that the current arrangements involve a contract with an individual GP or a lead practitioner. Under the new arrangements, the contract can be with a practice.

Mike Rumbles: Obviously, groups of GPs have come together to form partnerships, but are there any situations in Scotland in which groups of GPs have formed limited liability companies, or is that a new development?

Lorna Clark (Scottish Executive Health Department): Some of the GPs who come together to form out-of-hours co-operatives form companies limited by shares.

Mike Rumbles: That is the nub of the question. It is my understanding that, in that regard, the regulations do not change the legal basis on which contracts are held. In other words, the regulations do not introduce a new phenomenon—a company limited by guarantee.

Lorna Clark: No, they do not, because there are practices that are providing services that are constituted in that way.

Mike Rumbles: Thanks very much.

Mr David Davidson (North East Scotland) (Con): I want to follow up on that point. I presume that many of those co-operatives and companies limited by guarantee are covered by the old regulations for friendly societies.

Lorna Clark: I think that different co-ops are constituted in different ways. My understanding is that, at the moment, most of them are constituted as companies limited by shares.

Mr Davidson: Under the Friendly Societies Act 1992?

Lorna Clark: I would need to check that out and get back to you.

Mr Davidson: Comments have been made on that aspect of the regulations. Under the regulations, it would appear that, as in other parts of Europe, some companies—for the sake of argument, let us say pharmaceutical companies—could, in theory, take over practices and employ medical people. The minister is shaking his head. That is fine, because that is really what we are asking about. Constituents have asked me about that issue.

Will it be the case not only that people will come together for accountancy purposes and to share facilities and support, but that such practices could be sold on the open market, especially as many of the premises that are used are privately owned by GPs?

Mr McCabe: As I understand it, there are provisions to take account of any substantial change in the contract arrangement, so, in the scenario that you have just outlined, in which a practice tries to sell itself on, the board could deem that as being one of the provisions that mean that it could withdraw itself from the contract.

Lorna Clark: It is also covered in the primary legislation. Proposed new section 17L of the National Health Service (Scotland) Act 1978 sets out who can hold shares in a general medical services contract, and limits it quite specifically to health care professionals, so large private companies would not be able to hold shares in a general medical services contract.

Mr Davidson: Does the definition of "health care professional" include dentists, opticians and pharmacists?

14:15

Lorna Clark: I do not think that it includes pharmacists, but it does include some of the other health care professionals.

Mr Davidson: Perhaps it would be helpful to get a note from the Executive to clarify that issue, because a number of people have raised it, including other members.

Lorna Clark: Okay.

Janis Hughes (Glasgow Rutherglen) (Lab): In schedule 2, which concerns opt-outs of additional and out-of-hours services, paragraph 6 mentions—

The Convener: Could you give us the page number?

Janis Hughes: It is on page 30.

Mr McCabe: Is this the second set of regulations?

Janis Hughes: Yes, it is the UK regulations. paragraph 6 talks about informing patients of opt-outs, and states:

"The contractor shall, if requested by the Health Board inform the contractor's registered patients of an opt out … by—

(a) placing a notice in the practice's waiting room; or

(b) including the information in the practice leaflet."

Is that saying that patients will not be told individually when their practice decides to opt out of providing an additional service?

Mr McCabe: There is an obligation on the health board to ensure that patients are aware of the arrangements that are put in place. Quite apart from individual practices, the health board has an obligation to ensure that everyone is aware of exactly where they can access facilities and how they can do that.

Janis Hughes: It is just that the paragraph does not make that clear. It states:

"the Health Board and the contractor shall discuss how to inform patients … The contractor shall, if requested by the Health Board".

Perhaps you are right to say that there is a duty on the health board to inform patients, but from my reading of the regulations, it looks as if the only information that will be given will be in a notice in the waiting room and perhaps in the information

leaflet. If people are not going to be informed individually, particularly if we are talking about contraceptive services, for example, which people rely on regularly, that is of concern.

Mr McCabe: Yes. Perhaps we could get back to you on that. There is reference somewhere else to the duty on health boards, which may expand on that.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): It is on page 28.

Helen Eadie (Dunfermline East) (Lab): Yes, there is clarification in paragraph 4(7) on page 28.

Janis Hughes: I am not disputing that under the proposed legislation the health board will have a duty to provide the service, but where a particular practice withdraws a service, the issue is how people will find out that the service is no longer available.

Mr McCabe: If I understand you right, you are saying that the situation would be more robust if the arrangements in paragraph 4(7) were repeated in other instances. In other words, it would be more robust if there was a specific requirement on the health board to ensure that people knew about the situation.

Janis Hughes: If individual patients are receiving an additional service, they should be notified if the service is withdrawn and relocated, or whatever the case may be.

Lorna Clark: The regulations will be underpinned by a substantial set of guidance, of which we expect to have the first draft soon. We could consider putting something in the guidance to specify best practice and to specify that health boards should let individual patients know about changes.

Janis Hughes: That would be helpful.

The Convener: In regulations, does one usually refer to the fact that guidance will be issued?

Lorna Clark: I do not think so.

The Convener: So you do not.

Mr McCabe: If the committee takes the view that that would be helpful, it should express that.

The Convener: Janis Hughes makes an important point. Our concern is that we want there to be a level playing field throughout Scotland. A mandatory obligation could be placed on health boards. We are kind of in the dark, apart from knowing about what look like de minimis provisions in schedule 2. Guidance should be issued, because it has value in itself—if it is not used, there will be some comeback. I do not know whether guidance is referred to in regulations, but I would have thought that it might be.

Mr McCabe: As I tried to indicate at the start, I do not think that the regulations are written in tablets of stone, and we do not expect there to be any great policy differences. However, if things can be done to make the intention behind the regulations more clear, we will be more than happy to consider them.

The Convener: The point is a good one. Not everyone will pass notices in the waiting room at the appropriate time or pick stuff up.

Mr McNeil: I have a reservation. GPs who decide to opt out have a clear responsibility towards their patients. Patients should not be transferred solely to the health board. The emphasis is on the health board and the contractor—the GP—to discuss how to inform patients. Placing an undue responsibility on the health board would be going too far. The regulations need to say more than they currently say—they need to say that it is not the health board that is opting out, but the GP.

Mr McCabe: I take the points that are being made. As they are worded, the regulations suggest that a patient has to attend the surgery to find out the information. Perhaps that is a point that we need to bear in mind and reflect on.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Patients can usually get all the information they need by phoning up the health board. The fact that not everybody comes to the surgery is quite an important point. Usually, when there is a change of doctor or anything like that, everybody must be notified in writing. That might become quite expensive, but it has to be done because people do not always come to the surgery. It is right to have a list of services that are provided in each surgery, but it is amazing how many folk do not darken the doctor's door until they need something. They may not be in the habit of phoning up the health board. NHS 24 might have a list of the services that are provided in each surgery and could perhaps help out by supplying that information.

Mr McCabe: We have acknowledged the point that the dissemination of information could be more robust, and we will reflect on that.

Mr Davidson: Forgive me if this question is aye silly, because I have not looked at the small print, but is there a definition in the regulations of practices that will not be allowed to opt out? I appreciate the fact that paragraph 59 of schedule 5, which talks about out-of-hours services, has not yet been published.

Mr McCabe: Which page is that on?

Mr Davidson: It would be on page 60, but the minister's letter says that it is not available yet.

Mr McCabe: There is mention of situations in which it would clearly be more difficult for practices to opt out, such as in remote and rural areas, but those are not precisely defined, as far as I know.

Lorna Clark: The hook is that a practice can opt out only if there is an alternative accredited provider in the area that can take over its patient lists. We are working on the accreditation standards at the moment and have sent the committee drafts of what the standards might cover. It will be left to the health boards and individual practices to see what else is happening in local areas and to ensure that there are alternative accredited providers.

Mr Davidson: GPs in remote and rural areas will not have adjacent practices that are capable of joining a co-op or providing an alternative service. I presume that the onus falls back on the health board to provide those GPs with decent working conditions and to ensure that they have adequate time off by providing holiday cover, so that they are refreshed and able to do their job. Will that duty be introduced in a separate piece of legislation, or will it just be in the melting pot until, eventually, the world settles down? There is no attempt in the regulations to define what support GPs can expect to get and how it will be provided: it will be left to the individual practice and health board to come to an arrangement. Will there be an individual contract between the two, which the regulations do not cover?

Mr McCabe: I understand that, under the regulations on section 17C agreements, the facility exists for localisation of procedures in order to meet local needs. If a practice in a remote or rural area were to indicate that its preference was to step out of out-of-hours provision, that would generate a discussion between that practice and the health board about what alternatives the health board could find and how it could support that practice. There would always be a duty on the health board to provide the services. You are right that a practice cannot opt out unless an accredited provider is found, but a practice's indication that it would prefer not to provide out-of-hours cover would generate the discussion that would begin the process of finding local solutions.

Mr Davidson: The problem—I will exercise the point—is that many practitioners who have written to me do not see where they will get cover from and feel that they will be tied to providing cover 24/7, which they do not feel is appropriate. Is there nothing in the regulations that will give to those practitioners security that there will be adequate cover for them to keep to their hours of service if a health board simply decides that, because it cannot find somebody to do the cover, it will not offer it?

Mr McCabe: There is a dispute resolution process to which practitioners can refer if they feel that they are not being afforded the opportunity that other practices—perhaps mainland practices—are.

Mr Davidson: I find it disappointing that practitioners would end up in a dispute resolution process at that stage. Perhaps the minister could come back to us with a bit more information about how that procedure will be put together, because health boards are likely to be concerned that aggrieved practitioners will sue them or that practitioners will pick up their bags and go and work in cities. I would like a bit more clarity on the process.

Mr McCabe: I appreciate the point—

The Convener: Could you or your team take us through that a bit? Is David Davidson talking about part 7 on dispute resolution?

Mr Davidson: That is in the Scottish regulations.

The Convener: I am on the United Kingdom regulations. Is the minister on the Scottish regulations?

Mr McCabe: No—I think that we are on the UK ones.

Lorna Clark: The provisions on dispute resolution were part of the Scottish regulations that we sent to the committee earlier, but they are now incorporated into the main regulations—they are now part 7 of schedule 5.

The Convener: That is what I am looking at.

Would it be useful, David, if the minister or his team gave us an explanation about the matter to which you referred?

Mr Davidson: Yes—if only so that I can answer letters that I have received.

Lorna Clark: In addition to the general dispute resolution process, there is set out on page 28 of the regulations a process by which practices can opt out of providing services. I will summarise briefly that dispute resolution process, but we would expect the vast majority of disputes to be solved locally by the practices and health boards that were discussing the issues.

The Convener: What are we looking at? Is it paragraph 4?

Lorna Clark: We are looking at paragraph 4 onwards. That regulation sets out the processes that practices and health boards must follow when a practice wants to opt out, and the regulation sets out the steps that each needs to take. There is also a dispute resolution process whereby if agreement cannot be reached locally, either

side—particularly the practice—can refer the dispute to Scottish ministers. Part 7 of schedule 5 to the regulations sets out the process by which that will work. Basically, Scottish ministers will convene a panel of three members who will hear the dispute and make a decision on which side has the better-justified argument. In the case of an opt-out, one would expect a dispute panel to examine whether the health board had taken all reasonable steps to find alternative accredited provision. One would also expect that the adjudicator would examine the guidance that is now being drafted by the national working group on out-of-hours services. That guidance will set out models and will help health boards and practices that are looking into new out-of-hours arrangements.

There will be a raft of national guidance, to which health boards and practices will have access. It will deal with alternative models and will help health boards and practices look more creatively at how out-of-hours services will be provided in the future so as to ensure that health boards are not saying that it is not possible for practices to opt out in an area where there is no co-op, for example. Instead, boards should try to find out whether there are other support mechanisms that can be put in place to help practices to opt out. The policy intention is that the vast majority of practices will be able to opt out of out-of-hours provision.

14:30

Mr McCabe: We have almost leapt to the worst-case scenario. We are introducing an entirely new way of working and we should take into account the fact that there is an obligation on health boards to seek innovative solutions that they might never have needed to seek in the past. An awful lot will happen before we ever get to a dispute resolution process.

Mr Davidson: I do not dispute your saying that that would be a worst-case scenario, but regulations must cover all eventualities. It is a matter of giving guidance to health boards at an early stage on how they are to prepare for their duties in a way that not only serves the needs of the patient but which looks after the longevity and attraction of practices, particularly in rural and remote areas. You are saying that a set of guidance will come out.

Lorna Clark: Interim guidance has already been published by the out-of-hours services working group; we can send the committee a copy of that. That will be followed over the next few months by more substantive guidance and practical models.

Mr McCabe: As we mentioned in the recent stage 1 debate, considerable work is going on among health boards throughout Scotland to examine what the out-of-hours arrangements could be if practices decide to opt out of them. It is not as if work on implementing the eventual act will kick off just the day the act comes into force—work is going on as we speak.

Shona Robison (Dundee East) (SNP): On dispute resolution, who would make up a panel? Is that defined?

Mr McCabe: No. Panels would be appointed by Scottish ministers.

Lorna Clark: The policy intention is to have a panel of three members, one of whom would be a representative of the medical profession. We would expect the Scottish General Practitioners Committee would help us to populate the list from which panel members will be drawn. We would also expect an independent member to be present on a panel to ensure that somebody with an independent view was there. We would expect some local input, too.

Exactly who would be on a panel would be determined by the nature of the dispute. If a dispute concerned a particular location, it might be advisable to ensure that somebody from that area was on the panel. If the dispute was about opting out of an additional service, it might be worth ensuring that one of the panel members had the expertise to explore the relevant clinical issues. The same three people would not make up a panel to hear every dispute; panel members would be drawn from lists of names. We would choose one name from each list, according to the nature of the dispute.

Janis Hughes: I return to a point that Lorna Clark made a while ago about GPs' being able to opt out of out-of-hours services only if there is another accredited provider in the area. Does that mean a health board area?

Lorna Clark: That would depend on access—how quickly GPs could get to the patient or how quickly patients could get to the GP. A smaller area would pertain to an accredited provider in Glasgow, while different arrangements would apply to an accredited provider that covered a remote and rural area. The areas will not be defined, but will be based on—

Janis Hughes: Who would determine that?

Lorna Clark: That will be governed by accreditation standards, which will contain details of how quickly one would expect a GP to be able to deal with a call.

Dr Turner: I wonder how opting out would affect salaried and non-salaried doctors respectively. Looking at the worst-case scenario, it occurs to me that more people would opt for the salaried route than would opt for the normal contract route.

Are there any safeguards for patients and for doctors who may not have opted out to become salaried partners but instead have remained as normal contracted general practitioners? Is there anything to safeguard the hours that they work?

My thinking is that, although salaried doctors have to work to certain hours, other doctors—like I used to be—have no limit to the hours that they work: as the work comes in, they have to pick up all the loose ends. Can you clarify whether any work has been done to guard against that sort of scenario?

Mr McCabe: I am not entirely sure that that would apply. My understanding is that it will be the practice that opts out.

Dr Turner: The practice will opt out of providing an out-of-hours service, but that has made me think about another option, which is a kind of opting out, in which somebody decides to do salaried work. I am not talking about opting out of the out-of-hours work. If a practice has a number of salaried practitioners and one who is not on a salary but is contracted in the normal way, that one person may have to cover all the emergencies during the day. What protection is there for people who have decided stay within a practice as non-salaried practitioners? How will their work load be protected?

Mr McCabe: Such arrangements would be agreed within the practice—it would be difficult for us to define such arrangements in the regulations.

Dr Turner: There could be a problem with levels of cover for patients. We are bending over backwards to ensure that doctors do not work excessive hours and salaried doctors will not work excessive hours, but how will the working hours of those who have decided to remain as they were be protected?

For example, it can happen in practices that part-time people work set hours, but all the work that comes into the practice between 7 in the morning and 6 at night must also be considered. The practice receives emergency work during the day as well as all the other things, such as elective appointments, for which it is known that people will come in. How will the extra work that needs to be done between 7 and 9 be covered? It could be that there are not enough doctors within a practice to cover the work because people will have been given the opportunity to be salaried. Perhaps I have the wrong end of the stick, but I want clarification.

Mr McCabe: I am sorry but I do not follow that.

The Convener: Perhaps Jean Turner could write to the minister to explain. If the minister can address that point, his answer would be useful to the committee. Perhaps he could respond through the clerks.

Mike Rumbles: I want to follow up my previous point about the composition of an assessment panel. I just want to make sure of what we were talking about. I was following what you were saying until you tried to make it clear. I hope that I have not got a hold of the wrong end of the stick.

I turn your attention to pages 26 and 27 of the draft regulations. Subparagraph (10), which deals with permanent opt-outs, states:

"A Health Board may, if it considers that there are exceptional circumstances, make an application to the assessment panel for approval of a decision to—

(a) refuse a permanent opt out".

Subparagraph (14), which talks about the membership of the assessment panel, quite clearly states:

"The members of the assessment panel shall be—

(a) the Chief Executive of the Health Board …

(b) a person representative of the contractor's patients; and

(c) a person representative of the area medical committee."

Is that what you referred to earlier?

Lorna Clark: No. The assessment panel is different from the dispute panel. The assessment panel is set up locally to consider opt-outs. The dispute panel works at national level. One would expect the assessment panel to work before a dispute.

Jim Patton (Scottish Executive Health Department): When the contract agreement was being drawn up, there was a feeling that certain issues require local knowledge, experience and input. The way that we looked at that in relation to the dispute resolution procedure was that we had met the obligation under the contract agreement by having a three-stage process of arms-round-the-shoulders mediation. The assessment panel, which has local input, decides on list closures, patient assignments and opt-outs. If the assessment panel does not result in agreement among all the parties, the issue would go to the full dispute resolution procedures, which come under a different schedule. The assessment panel is only for those three issues.

All other contract issues, such as disputes between contractors and health boards, will immediately be referred to the dispute resolution procedure, which starts at the very low level of having the two sides talk to each other. If necessary, the area medical committee will mediate between them. At the moment, the vast majority of disputes end there—very few go further than that under the dispute resolution procedure. We are trying to retain that position in the regulations, but also to ensure that local input can

be made before the full-blown dispute resolution procedure is initiated.

Mike Rumbles: That was what was confusing me; I thought that we were dealing with a good local means of resolving disputes, but we jumped to the national procedure.

Jim Patton: We missed a step.

Mr McCabe: It is anticipated that the national procedure will be used only exceptionally. The vast majority of disputes will be resolved at a lower level.

The Convener: You mentioned mediation. Will mediation be mandatory before a case is referred to the full-blown dispute resolution procedure, in which people may take up entrenched positions? Will there be a duty on people to involve themselves in mediation to find a mutually acceptable resolution, rather than move straight to dispute resolution procedure? That is happening more and more in court. We are not dealing with a judicial matter, but things will have reached a bad pass if a case has to be referred to dispute resolution procedure. Will you consider building mediation into the process?

Mr McCabe: As I understand it, the three stages must be gone through and the first stage could be skipped only by mutual agreement.

Jim Patton: Mediation is not mandatory in one sense—we cannot make people talk to one another. However, it is mandatory in the sense that the regulations stipulate that parties should make every effort to do so. We hope that most problems—I am not sure that we can call them disputes, because we will weed out pre-contract disputes—will be resolved at that level. We expect that contractors and health boards will take reasonable steps to talk to each other before engaging in a more mechanistic process.

The Convener: Would it be of interest to have cases referred to mediation procedures—involving not just the two parties to the dispute, but a mediator—before they reach adjudication? When there is adjudication, there tends to be a judgment. Mediation is not judgment; it is something to which both parties must sign up, not a decision that one side must accept.

Does the dispute resolution procedure follow on from another dispute resolution procedure that is already in place in the NHS, or is it new? On which model is it based?

Lorna Clark: It is based on the model that was agreed at UK level as part of the contract negotiations, with some modifications to take account of the fact that the bodies and organisational structures in Scotland are different from those elsewhere in the UK. I am not sure whether the procedure follows on from existing procedures.

Jim Patton: Parts of the procedure are taken from the section 17C regulations—on personal medical services—of 2002, which set out a framework for time scales and how issues should be progressed by correspondence between parties. The regulations refer to an adjudicator, but we are trying to introduce the concept of a panel, rather than one adjudicator. There are some difficulties with primary legislation, which are being addressed to ensure that the panel can handle all disputes. The procedure is not entirely new. We have tweaked it to ensure that it reflects the circumstances both of the new general medical services contract and of the new world that we hope will exist after 1 April 2004.

The Convener: Does having someone who is resistant appear before a panel comply with the European convention on human rights, which enshrines the right to a fair hearing?

Lorna Clark: The legal advice that we have received indicates that the regulations are ECHR compliant.

Mr Davidson: I want to ask a supplementary to Mike Rumbles's question. Paragraph 3(14)(b) on page 27 of the draft regulations deals with the assessment panel. Paragraphs 3(14)(a) and (c) define clearly where members of the panel will come from, but paragraph 3(14)(b) is not clearly defined. Under the National Health Service Reform (Scotland) Bill that we are about to consider, will appointment of a representative of the contractor's patients be a responsibility of the health council? Will there be a defined mechanism for deciding how an acceptable patient representative, rather than simply an agitator, can be obtained from every practice, so that each practice area can meet the provisions of paragraph 3(14)(b)?

Mr McCabe: I would have hoped that we would provide advice on how practices would go about securing patient representatives in the guidance that will be issued.

14:45

Mr Davidson: Fine. I am happy to look forward to that.

Will the regulations mean that budgets will still flow as they flow now? I take as an example a prescribing budget, on which guidance can come from the health board—there are prescribing advisers and so on. I presume that that will continue so that people use best practice. The health board currently ends up paying from its budget for individual prescribers' actions. Health boards are moving to have contracts held with them on a two-way basis, but the money belongs to the boards. Therefore, do the regulations give health boards more control over how, for example, prescribing is done by practices?

Mr McCabe: My understanding is that the regulations do not do that. They restate the existing arrangements—the parameters within which practices are currently expected to work.

Mr Davidson: Is there no intention to initiate a local formulary based on what the board wants to do, or would prefer to do, and to oblige GPs to follow that formulary?

Mr McCabe: No.

Mr Davidson: That is fine.

Mike Rumbles: I will follow up that point. I understand that the Executive's policy on prescribing drugs is to ensure that decisions whether to prescribe drugs are clinical and are made by the person who is responsible for prescribing, rather than their being decisions that are controlled by the health board.

Mr McCabe: We are moving away from the regulations, but a useful announcement was made yesterday about how the Scottish medicines consortium will work in future with regard to unique drugs. A system will be put in place that allows health boards a longer notice period for new drugs that are being developed in order to enable them to budget for them more appropriately.

Mr Davidson: That was not the basis of my question, if Mike Rumbles thought that I was referring to that. The formulary covers more than new drugs: it covers appliances and various other things. A particular appliance might be restricted in certain areas for various technical reasons.

Mr McCabe: The wording in the regulations indicates that prescribers would be expected to prescribe things that are appropriate and not excessive. That is the current situation.

Shona Robison: I would like another couple of points to be clarified.

We considered the out-of-hours opt-outs previously. I notice that paragraph 4(3) on page 28 of the draft regulations states:

"An out of hours opt out notice shall specify the date from which the contractor would like the opt out to take effect, which must be at least 3 or 6 months after the date of service of the out of hours opt out notice."

Is that the lead-in time for the opt-out? Why is it "3 or 6 months"?

Jim Patton: The first point that I should make is that the matter becomes extremely involved when we consider the various time scales that feature in the regulations. When we re-examine the regulations—they are currently in draft form—we will try to clarify those matters.

The "3 or 6 months" refers to whether the contractor is looking for a temporary opt-out or a permanent opt-out—those options involve different deadlines. We were going to supply the committee with a flow chart about how all that would work, but the flow chart was more difficult to understand than the regulations. That is why we are falling back on the promise that we will rephrase the regulations as much as we can to make it clearer which days are involved. At the moment the regulations talk about "A day", "B day" and "C day" and it is very difficult for people to follow through the process in their minds. We recognise that and we will endeavour to make things much clearer the next time we come to advise the committee.

Shona Robison: That is fine. I have a quick question on closed lists.

Mr McCabe: Which page of the regulations are we on?

Shona Robison: The part to which I am referring starts on page 43 and goes through to page 49. I am trying to work out how it relates to what happens now and I suppose that this is where dispute resolution would come in. As I understand it, if a practice closes its list, the health board can make it reopen the list and take new patients, but that would be subject to dispute resolution in the same way as what we discussed earlier.

I refer to paragraph 29(5)(a) on page 47. It sounds as if the health board is expected to take reasonable measures

"to secure the provision of essential services … for new patients other than by means of their assignment to contractors with closed lists of patients."

Would the health board have to find an alternative practice for those patients? Would it insist that the practice reopen its list for the patients only as a last resort? In doing so, would it have to consider any additional support that the practice might require to reopen its list? This might relate to the more remote areas, although it could also relate to urban areas. If a practice is full and is not taking any more patients—I have certainly heard that people experience that with popular practices—and there are no alternatives, the health board would have to offer the practice support for it to take new patients. Is that right?

Mr McCabe: Yes.

Jim Patton: That support is written into the regulations, so it will be provided.

Shona Robison: What would that support involve?

Jim Patton: The health board might allocate a salaried GP for a short period to help the surgery to get over its problems. Contractors do not decide; they have to go through the process.

Shona Robison: I see that.

Jim Patton: On that basis, the health board would still have prime responsibility for providing primary medical care services to the people in its area. A number of surgeries in an area might have full lists; the health board would then be in a difficult position. It would have to bite the bullet and start to allocate patients even to closed lists on the basis that it would provide whatever support it could to ensure that the individual contractors could deal with those patients.

The Convener: I have not had a lot of time to read the draft regulations, so my question might be misdirected. I refer to page 76 of the draft regulations. Paragraph 102 states:

"The contract shall not create any right enforceable by any person not a party to it."

I take it that that refers to the board and the practice as the contracted parties. Paragraph 16 of part 2 of schedule 5 is on the removal of violent patients from the list. It states:

"A contractor which wishes a patient to be removed from its list of patients with immediate effect on the grounds that—

(a) the patient has committed an act of violence against any of the persons specified in sub-paragraph (2) or behaved in such a way that any such person has feared for that person's own safety; and

(b) the contractor has reported the incident to the police or the Procurator Fiscal,"

A series of things follow. I take it that the person who is removed from the list on those grounds has no enforceable rights as a consequence of the regulations. Let us say that a report to the police or the procurator fiscal has been misplaced, although the person might not have been charged. I am trying to get at the rights that a person would have if they found themselves off a GP's list. Would they have any?

Mr McCabe: Such people would have rights in as much as the health board would be under an obligation to find them an alternative list. They do not appear to have any rights to appeal the original decision.

The Convener: I am concerned about the line in paragraph 102 of part 9 of schedule 5, which says that

"the contract shall not create any right enforceable by any person".

I appreciate that paragraph 16(1)(a) of part 2 of schedule 5 in the regulations also includes the words,

"has committed an act of violence against any of the persons".

The GP or health professional might just say that a person has committed an act of violence against them and report it to the procurator fiscal. If it turns out that the health board grants the request to remove a person from a list, and that the request is malicious or the report is misplaced, the patient has no rights—they have simply been removed from a list on those grounds.

Jim Patton: It might be helpful to point out that patients have rights in the sense that there is a complaints procedure that is set out in part 6 of schedule 4 or 5—I cannot put my hands on it at the moment. The process is that the health board would investigate the circumstances, and it is also written into the regulations that an individual cannot be thrown off a list unless there are reasonable grounds for doing so.

There is also a philosophical aspect to the issue. If a GP has decided that, for whatever reasonable reason, it is no longer possible to have a person on the list, that is a clinical judgment. It reflects the fact that the GP does not feel able to engage with the patient to the extent that he or she is able to provide proper medical and clinical services to that patient, and that it would be better for the patient and the GP if that patient was to receive primary medical services from another source. That is something else that the health board, the contractor and the individual patient will have to take into account. At the end of the day, patients have an absolute right: the health board in the area in which they live must provide them with primary medical services. There will be enhanced services and practices that will take on the specific role of caring for violent patients.

The Convener: Paragraph 16(5) of part 2 of schedule 5 says

"A removal requested in accordance with sub-paragraph (1) shall take effect at the time that the contractor—

(a) makes the telephone call to the Health Board; or

(b) sends or delivers the notification to the Health Board."

That is quite fast: if the contractor decides it, it is done. I raise that as an example that focuses on the fact that no third party has rights because of the way in which the contract operates. There might be circumstances in which a third party ought to have rights under the contract.

I also wanted to raise a point about paragraph 101 of part 9 of schedule 5. The heading is

"Compliance with legislation and guidance".

Guidance is becoming more important. Sub-paragraph 101(b) says that the contractor shall

"have regard to all relevant guidance".

I would like a legal definition of "have regard to". We all know what "shall" means in "shall comply" but what does "have regard to" mean? How much force does that have?

Mike Rumbles: Less than "shall".

The Convener: If "shall" is 10 on a scale of 0 to 10, where is "have regard"?

Lorna Clark: We will have to consult our lawyers and get back to you on what that phrase means, and on the meaning of the paragraph on third-party rights.

The Convener: Thank you very much.

Shona Robison: I have a question on violent patients. If someone has been found guilty of an aggravated offence against a member of the health service—such as a GP or a community nurse—will special provision be made for treatment of such patients, who could not expect to receive treatment from a surgery in the normal way because of their behaviour? Did I understand you correctly that that will be the case? What kind of alternative provision would there be?

Lorna Clark: One of the directed enhanced services that all health boards must provide is support of staff who deal with violent patients. The detailed contract guidance contains a specification of what the service for people who support violent patients would look like and it sets out the sort of things that health boards would be expected to do—I can send the committee a copy of that. For example, a health board might have a surgery in premises that are geared up to deal with violent patients to ensure that staff are safeguarded.

Health boards will have to provide services to a certain standard and within certain costs. As that will be done as part of the provision of enhanced services, it would be best if I sent the committee the details of the enhanced services. There are rules that all health boards in Scotland must follow to ensure that staff who deal with violent patients are supported.

Shona Robison: Will those be new rules, or do they exist?

Lorna Clark: They follow on from guidance that was sent out, I think, last year, which advised health boards on what they ought to do to support staff who deal with violent patients. The process has been incremental.

15:00

The Convener: If the committee is content, I will give David Davidson one more question then bring the meeting to a close. We can come back to the UK regulations, which are still only in draft form. They might come back before the committee with changes—who knows?

Mr McCabe: As I said—given that the committee has had only a short period in which to read a complex set of documents—it would be helpful if, once the committee has had time to reflect on the documents, it submits questions in writing in advance. That would allow us to come back to the committee and to give more comprehensive answers. I am perfectly happy to continue the dialogue between now and when we lay the regulations.

The Convener: That is useful.

Mr Davidson: I accept the minister's comments that the process is on-going and will last for a while.

Paragraphs 2 to 8 of schedule 1, which is on additional services, all start with the words,

"A contractor w hose contract includes".

Is there a definition of which contractors will provide which non-core services, or will that be down to guidance?

Patient access to services is an issue for rural and remote areas. The situation will not be so bad in cities where practices are less than a mile apart—one practice can provide a particular service and another can provide another one for the community. However, that cannot happen in rural and remote areas. Will health boards decide on the definition of access and the distances that are used in that definition? I can think of two practices that patients live up to 50 miles away from and up cul-de-sacs in valleys. Those patients would have to travel perhaps another 30 or 40 miles to get to another GP's surgery. Will there be a clear definition of access areas for patients, or will the matter be in the hands of health boards, under guidance?

Mr McCabe: I understand that the guidance will mention what is considered to be a reasonable distance. We return to the point that, if patients are unhappy about an action of their health board, they have the right to take the matter through the complaints procedure. For instance, if patients feel that a service has been set up in a way that necessitates their travelling excessive distances—although it would be strange if a health board did that—they will have access to the complaints procedure.

Mr Davidson: Is it your understanding that, where a service is already provided, the health board will remove it only when it has reviewed patient requirements? Many practices in remote and rural areas already deliver loads of additional services, if not all of them, although the health board might send out people to provide one or two special screening services. In those circumstances, will centralisation or removal of such services be the exception rather than the norm?

Mr McCabe: With services such as contraception, the expectation is that the majority of practices will continue to do what they do at present. However, some practices will obviously decide to opt out of particular services.

Lorna Clark: The expectation is that practices that provide additional services at present will continue to provide them unless the practice chooses not to. The health board cannot decide that it does not want a practice to provide particular services.

Mr Davidson: The draft regulations state that a service can be removed if it is not provided with the correct equipment or from the correct premises. I presume that that would be defined by the health board.

Lorna Clark: That is more likely to happen in the territory of enhanced services. More than 90 per cent of community practices provide additional services and we expect that the vast majority of them will continue to do so. The enhanced services might require particular premises or equipment, but I imagine that under the new contract, the vast majority of additional services will continue to be provided by the practices that provide them today.

The Convener: To conclude, we have the primary legislation and the draft regulations, but not the guidance on the operation of the system. When will that be available?

Lorna Clark: I hope that it will be available by the middle of December.

The Convener: The guidance would be useful to the committee because it would allow us to follow the matter through to grass-roots level.

Meeting closed at 15:05.

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