HEALTH COMMITTEE

Tuesday 2 December 2003
(*Afternoon*)

Session 2

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HEALTH COMMITTEE
15th 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 ALSO ATTENDED:

Carolyn Leckie (Central Scotland) (SSP)

THE FOLLOWING GAVE EVIDENCE:

Christine Brown (Royal College of Nursing)
Pat Dawson (Royal College of Nursing)
Dr John Garner (British Medical Association)
Mr Tom McCabe (Deputy Minister for Health and Community Care)
Dr Bill O'Neill (British Medical Association)
Elaine Tait (Royal College of Physicians of Edinburgh)
Dr Mike Watson (Royal College of Physicians of Edinburgh)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Graeme Elliot

ASSISTANT CLERK

Hannah Reeve

LOCATION

The Chamber

Scottish Parliament

Health Committee

Tuesday 2 December 2003

(*Afternoon*)

[THE CONVENER *opened the meeting at 13:37*]

National Health Service Reform (Scotland) Bill: Stage1

The Convener (Christine Grahame): Good afternoon. I welcome committee members and witnesses to the 15th meeting of the Health Committee in the second session of Parliament. I have received no apologies and I remind people to switch off their mobile phones and pagers.

The witnesses who are here to give evidence are sitting in groups of two for ease of reference for the committee. Elaine Tait is chief executive officer and Dr Mike Watson is dean of the Royal College of Physicians of Edinburgh. Dr Bill O'Neill is Scottish secretary and Dr John Garner is chairman of the Scottish council of the British Medical Association. Our witnesses from the Royal College of Nursing Scotland are Pat Dawson, who is head of policy, and Christine Brown, who is board member for Ayrshire and Arran. I thank them for coming today. The committee will ask questions, and it would be helpful if witnesses would indicate when they want to speak; if representatives of other organisations want to add something they should feel free to do so—but that is not obligatory.

I start with an open question. Do witnesses think that the change to the structure of the national health service that is proposed in the bill is necessary or indeed appropriate? How will the change improve service delivery?

Dr John Garner (British Medical Association): Are there buttons that we have to press if we want to speak?

The Convener: No, please just indicate that you want to speak.

Dr Garner: In general, the BMA welcomes the changes and reforms that are proposed in the bill, although we would particularly like there to be greater emphasis on certain areas. The BMA is keen that inter-health board working should be pushed quite hard, as we believe that, although Scotland will continue to have 15 health boards, there is great opportunity in a country of some 5 million people to work across health boards through managed clinical networks to develop services that are appropriate for the populace.

Pat Dawson (Royal College of Nursing): The Royal College of Nursing Scotland supports the reforms in the bill. Some of our concerns are probably operational. We are concerned that nursing, nurse leadership and nurse executives should be in position in the levels underneath the boards, but that is not necessarily a matter for legislation. In general, however, we support the commitments to the integration of services at an NHS board level that will be brought about by the reforms.

Dr Mike Watson (Royal College of Physicians of Edinburgh): We broadly welcome the reforms, which will improve service delivery through better integration. We are slightly concerned that training and education are not given a high profile as they are integral to better service provision. We would like more emphasis to be put on the integrated approach to training and education, and for NHS Education for Scotland to be brought into that equation.

The Convener: I thank you all for your written submissions, which we have before us.

Mr David Davidson (North East Scotland) (Con): What do the three groups of witnesses think of the treatment of service delivery in rural and remote areas? Do they have any views for or against it, or suggestions that we should listen to?

Pat Dawson: Your question is valid, but I hope that the dissolution of trusts and the focus on the health board area, the other reforms such as the establishment of community health partnerships as vehicles for service delivery in remote, rural and island communities, and the linkages between health boards that have been mentioned, will be among the routes to secure improvements and integration of service design and delivery in remote, rural and indeed urban areas throughout Scotland.

Mr Davidson: My question was on the back of the convener's, in that the bill talks in generalities about health boards as if they were all unique models. We have received indications that there will be problems in some areas. There have been comments about inter-board area working, which has obviously been accepted by the college and the BMA. I wondered whether, at this early stage in our discussions, you had any other comments about the roll-out of services in those areas.

Dr Watson: It is important that the need for local flexibility in service delivery is recognised. The arrangements for service delivery in the remote communities have to be significantly different. Although we want to maintain standards of care that can be delivered locally, there are issues to do with the availability of staff that mean that local solutions are required and there has to be flexibility. One hopes that the new health boards will take that into account.

Shona Robison (Dundee East) (SNP): On the abolition of the trusts, first, do you think that the proposed operating divisions in the NHS boards are the right structure? Secondly, do you think that the aim of reducing bureaucracy will be achieved as much as it should be with the removal of the trusts or should the opportunity have been taken to reduce bureaucracy further and ensure that there is a more streamlined management structure?

Dr Bill O'Neill (British Medical Association): If you are asking us whether the BMA would have favoured having fewer health boards, we have probably said in the past that we would. However, that has to be balanced against the risk of introducing major upheaval throughout the service in Scotland. There is clearly no appetite for that.

With the abolition of trusts, there is an opportunity to streamline management. Clearly, the bill is enabling, in the sense that that can happen following enactment. It will be down to the operating divisions and health boards to ensure that it does. We will examine closely what happens to ensure that there is improvement with regard to bureaucratic barriers and the lack of expertise in some areas. For example, we have publicly cited human resources as an example of where there is an opportunity—at health board level, quite apart from collaboration between health boards—to pool expertise to improve arrangements in what will be operating divisions across Scotland.

13:45

Elaine Tait (Royal College of Physicians of Edinburgh): It is important that there is clarity of responsibility within the new health boards. In the old trust structure it was clear who had responsibility for quality of care. It should be made explicit in the bill who has direct responsibility within the health board structure. So long as there is clarity of responsibility and accountability, the operating divisions should be able to function correctly.

We are not just talking about clarity of responsibility for quality of care. As my colleague said, we are also talking about ensuring that health boards, which have the health of their population at their heart, recognise their responsibility to maintain the education and training of all health care professionals, even though conflict sometimes arises between the pressures of service and training. Some clarity of responsibility in the bill might be helpful later, when the operational rules, regulations and structures are determined.

Pat Dawson: We make clear it in paragraph 5 of our submission that our members have said that they are seeking

"a period of stability without further major changes to the way NHS Scotland is structured beyond these proposals".

We are keen that nursing, quality and patients are at the centre of the changes, and that whatever structures of divisions or integrated units are put in place, they recognise the pivotal role of patients, quality and nursing.

Dr Watson: I reiterate that, at ground level, there is concern about the impact of another change in management structure. It is important that that is done relatively seamlessly. In the longer term, there may be a saving on bureaucracy, but it has perhaps not been recognised that there will be a transitional cost.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): You mentioned the obvious opportunities to tackle the bureaucracy in the management system by bringing people together and so on. Below the managerial level, in front-line services, what opportunities will the new structures open up for greater flexibility for clinical staff to deliver services? How will the bill improve the cross-board working that has increasingly become necessary to deliver services?

Dr Garner: By introducing a duty on health boards to work across their boundaries. That will ensure that when they are moving and developing services, they will look at what is happening in the boards around them. There will—hopefully—be a more seamless development of services that takes into account the needs of patients outwith the board area.

When you talk about what happens below the level of management units, you may be moving into the area of community health partnerships, which is another major part of the bill.

The Convener: We are going to move on to that in due course.

Mr McNeil: I am happy to come back to that. Is there not a requirement on boards at the moment to work together for the benefit of patients? If there is, why has that not worked effectively? What will be the effect of the bill making that an imperative? We see boards protecting their budgets. Are you confident that you will receive a realistic and positive outcome as a result of what seems like an increased duty?

Dr Garner: My understanding is that boards have not been under any statutory duty to co-operate. They have obviously been under a moral duty to find out what is happening around them, but stipulating in the bill that boards must work together means that when developing a service they will have to think about, for example, the area to the west or east of them as well as their own patients. They will have to consider the commonality of area instead of concentrating on

their own silo. I hope that such an approach will avoid a situation in which services that are developed in different areas are in competition because they are responsible only for the patients within a particular boundary.

Mr McNeil: Will that in turn encourage a culture within the present trusts and among clinicians in which they can work effectively together? After all, although we can give some good examples of networking and of clinical networks that have been established, we know of bad examples within hospitals where people do not co-operate with those in other disciplines.

Dr O'Neill: Before the document "Partnership for Care" and the draft bill were published, much of the discussion on this matter centred on the issue of removing competition. In Scotland, we seem to be heading towards the removal of competition. I realise that we are including other aspects of performance assessment, but down south they are moving towards a system of competition that we certainly do not favour. It is not in patients' interests to have a system that does not have to take account of patients in other parts of the country or other health board areas, or that allows two trusts to compete with each other even in the same patch over the provision of services to patients. In that sense, the bill's direction of travel has got to be a good one.

The Convener: Pat Dawson has been very patient. I know that she wants to comment on this matter.

Pat Dawson: The acute services review report best described aspirations with regard to working together across health boards. Indeed, one of its first sentences refers to considering the NHS in Scotland without any boundaries. Such a statement recognises that there are critical masses of service provision in small, medium-sized and large areas and indeed in areas beyond Scotland's borders—that is, south of the border. I agree with colleagues who have suggested that, in its requirement to have cross-border working, the bill represents the final aspiration. Whereas the issue previously centred on cross-border finance flows, we will now have a very helpful requirement to carry out cross-border planning.

In response to the second part of Mr McNeil's question, on whether abolishing trusts would help with integration, some of our members who work in integrated child health teams in Glasgow might belong to the acute trust and others might belong to the community trust. Although there might be differences in service models and service delivery, bringing the two aspects together will simplify integration. Things merge more naturally where there is one organisation that has good and meaningful relationships with the areas that it borders or the people to whom it provides service.

Shona Robison: Dr Watson, it is important to return to a comment that you made in response to an earlier question. I think that you said that a transitional cost might be associated with the dissolution of trusts. However, there could be problems in that respect, because the Executive has said that the bill is cost-neutral and that it will have no cost implications. Indeed, it has said that any savings from the reduction in costs will have to be used to improve patient care. Presumably—[*Interruption.*]

The Convener: Shona, I have to interrupt you, because your microphone is pointed away from you. The people in the recording room are semaphoring at me.

Shona Robison: Sorry.

Is one of the bill's major stumbling blocks the fact that it is cost-neutral and the prospect that the savings that the Executive thinks will fund some of its elements might not materialise or that costs might arise that would undermine them?

Dr Watson: The answer depends on what time scale you are talking about. There are potential cost savings in the medium term, but if they are to be achieved, investment will be required in the initial phase of change. Over a longer spread, money should be saved but, unless we prime the management change properly, it will be increasingly difficult to implement the bill effectively, which will mean that savings will not be made. In the past, the tendency has been to underinvest in change, which has meant that the outcome of the change has delivered less than was expected.

Shona Robison: Are you saying that the Executive is wrong to claim that the bill will be cost-neutral?

Dr Watson: No. The issue depends on the time scale over which the Executive is saying that the bill will be cost-neutral. Over a five-year time spread, the bill may well be cost-neutral and money might be ploughed back into patient care, but it will be difficult to implement the bill at zero cost in the first year.

Shona Robison: The Executive says that that will happen, but you think that it may be difficult to achieve. Are you worried that the resources that are required may have to come from within existing budgets?

Dr Watson: There is a risk that the rate of change will be limited by resources and therefore that longer-term savings and reinvestment will be more difficult to achieve.

Mr Davidson: I want to return to the issue of relationships between boards, such as managed clinical networks. The idea implies that money will follow the patient, but boards that are under

pressure, in part through the Arbuthnott formula, might have difficulty in providing care for patients in other areas. Within the new structures—if you accept them—do you want a system in which money follows the patient and in which boards are under a duty of uptake if another board has the capacity to provide a service that they do not provide?

The Convener: Who will answer first? Just go for it—he who dares, wins.

Dr O'Neill: We do not advocate a system in which money specifically follows the patient, although we advocate collaboration in the provision of services. If a health board can potentially provide a specialist service to three health board areas, it would be ridiculous if that board were constrained because of a lack of collaboration between the boards. We do not envisage that collaboration will be on an item-of-service, named-patient basis, although collaborative planning between health boards will be required. It will have to be recognised that, particularly with specialised services, health boards can provide services for populations of patients that are larger than the populations in their areas.

Mr Davidson: I asked the question on the back of your comment that you do not want the NHS board boundaries to change. If we focus on the opportunity for service delivery, more out-of-area payment systems will have to be set up, which will be a paper chase. I ask you to go beyond that stage and say whether money should go from one board to another. Boards may be under a duty to set up services for other boards, but it appears that they will not be under a duty to send patients to other areas, as long as they meet the Government of the day's waiting-time targets.

Dr O'Neill: I do not think that the two are mutually exclusive. A board may provide services for patients with diabetes in a wide area. The planning of that service will require collaboration and perhaps rationalisation of funding. However, the situation may be totally different for another service. That is the system that we advocate, rather than a system that is focused on individual patients travelling in buses in one direction or another.

Dr Watson: My answer is partly in response to Mr McNeil's question. The impact of the working time directive and the consequent need for service rationalisation will result in a lot of intra-health authority reorganisation and in movements across board areas. A formula for resource transfer will be essential because, particularly for rural and remote communities, specialist services will inevitably be provided in other health board areas. For certain services, there might be a single unit for Scotland. A smooth system of transfer of resources will be essential in that situation.

Janis Hughes (Glasgow Rutherglen) (Lab): You have already mentioned community health partnerships, which are obviously an important part of the bill. The specific details of those proposals are still quite sketchy. Are you assured that community health partnerships will lead to an improvement in service delivery?

14:00

Dr Garner: I will start off. I declare my interest—I have a day job as a general practitioner.

The Convener: Yes, your name-plate says "Dr John Garner", although I have difficulty reading it, because of the angle that it is at.

Dr Garner: I am sorry—I will give it a wee twist.

The Convener: My eyesight is also at fault.

Dr Garner: We welcome the principle of community health partnerships, but we must recall that local health care co-operatives—the organisations from which they will evolve—are relatively young; they have been around for only four or five years. A lot of work has been done in LHCCs and the BMA is concerned that the developments that have taken place and the networking, the inter-practice working and the community working that have been achieved should not be lost as a result of the development of CHPs.

For example, we are told that there will be fewer CHPs than LHCCs, so the boundaries may change automatically. That will obviously disrupt current relationships and systems. We are told that CHPs may follow social work boundaries more closely. There is a lot of sense to such coterminosity but, from the point of view of my practice, I would probably have to work in two CHPs, so there are all sorts of areas in which we need to get down to the detail.

We are keen for there to be an evolution from LHCCs to CHPs, to ensure that the gains that we have made—I think that LHCCs have made real gains—are not lost as we go down the road of CHPs. However, we welcome CHPs, because they will mean more public involvement. It is absolutely right that we will be much more inclusive because, at the moment, LHCCs are focused more on doctors than on the broader community of health care professionals and the public.

Janis Hughes: I agree with most of what you have said. Some local GPs have raised with me the fear that, because the community planning process within which it is envisaged that CHPs will work involves a large number of agencies working together but is in effect driven by local authorities, the work of CHPs—from an ex-LHCC point of view—might be subsumed by the community planning process. Do you have any views on that?

Dr Garner: That is very much up to the GPs. We do not want the creation of CHPs to result in GPs disengaging from the process. That fear exists, because GPs will no longer be at the core of things. The BMA obviously wants to encourage GPs to get involved in, and to work with, CHPs, but there is a hurdle to overcome. That is why I am not keen on a revolution from LHCCs to CHPs, but would prefer more of an evolution that builds on the strengths of LHCCs.

Janis Hughes: Would you like any specific measures to be included in the bill that could go towards ensuring that people on the health side—not just GPs but other health professionals who are involved in LHCCs and who will be involved in CHPs—will benefit?

Dr Garner: What is in the bill has a very thin structure—or rather, it does not contain a lot of detail. The detail that emerges from the consultation process that has gone on will need careful examination to determine how matters can be progressed.

The Convener: Do any other members of the panel wish to come in on that?

Christine Brown (Royal College of Nursing): We would like more explicit reference to be made to consulting communities under sections 5 and 6. We would also like explicit reference to be made to staff governance, including staff representation and arrangements for staff consultation. We would like the wording to be a bit stronger and we want reference to be made to professional advisory networks.

Janis Hughes: That is helpful. Thank you.

The Convener: I want to ask a supplementary. Paragraph 2.7.7 of the BMA's submission states:

"Financial support for LHCCs has been variable across Scotland".

You might like to put on the record how they are funded. You proceed to say:

"There should be transparent and equitable arrangements for the funding of CHPs across Scotland."

Do you have anything to say about changes in funding? Those comments seem to be quite significant.

Dr Garner: From our point of view, LHCCs are financially supported by the primary care trusts—the money is devolved down. The extent of devolution from primary care trusts has varied throughout Scotland. That has given some LHCCs opportunities to develop, but others have felt that they have been constrained by the lack of resource that has been devolved to them.

In future, the health board will be the funding body and we would like there to be some guidance to ensure that money flows to the CHPs. Obviously, the CHPs will have to be accountable for how they spend that money. However, it would be nice to have some guidance on how CHPs should be funded and what duties are expected of them—although that will depend on whether they are urban or rural—so that there is no disparity in what the CHPs achieve throughout Scotland.

The Convener: Would that be better done through the regulations or guidance?

Dr John Garner: I think so, yes.

The Convener: The minister will hear what you are saying.

Pat Dawson: We have to think long and hard about the capacity of primary care at the moment. As the committee well knows, there are major changes happening with the implementation of the general medical services contract. We also have ambitions to implement "Agenda for Change" in primary care, especially for our practice nurses. There is also the reform of the structures that support primary care.

Let us not be under any illusions. I cannot see how on earth this is going to be cost-neutral—it will cost money. We know that there has been investment, but the costs will be about more than just pound signs; it is about people. Nurses, doctors and other health professionals are already working day in, day out in primary care, and going the extra mile for patients. Major changes are coming along that will need a huge amount of capacity in human resources, in development, in support for service delivery that starts where GPs stop under their new contracts, and in the packages and the services that nurses will have to deliver to make up the shortfall under that contract. The agenda is so huge that it is simplistic for the RCN to say that there should not be any change other than what is in the bill. The bill is significant.

The Convener: It is the pebble in the pool.

Pat Dawson: Absolutely.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I will deal with public involvement, which is covered in sections 5 and 6. Section 5 will insert a new section 2B(1) into the National Health Service (Scotland) Act 1978, which makes it clear that

"It is the duty of every Health Board and Special Health Board to take action … that persons to whom those services are being or may be provided are involved in, and consulted on—

(a) the planning and development, and

(b) decisions of the Health Board".

Section 6 is about the dissolution of local health councils. Is the abolition of local health councils and their replacement by local advisory councils

coupled to the health boards' duty of public involvement and improvement to the system of public involvement?

Pat Dawson: The RCN in Scotland believes that the committee must ask and decide whether it believes that the new structures will provide and promote independence.

The consultation process for the new public involvement structure had limited research evidence in an area in which we seek to promote evidence-based policy. The current powers and statutory responsibilities of LHCs were not explicitly demonstrated in the consultation, and were only mentioned in the policy memorandum and explanatory notes.

The committee must ask whether the strengths and weaknesses of the current LHC structures will be improved by the new relationships. Each of our organisations has come separately to the conclusion that independence within NHS Quality Improvement Scotland requires a long stretch of the imagination, not for those of us who know the systems and structures, but for the public, and the issue is about the public and their services.

A second question is whether the plethora of systems, advisory structures and so on will deliver a one-stop service for patients and members of the public who seek to be represented or to have their voice heard. I could go on, but I am happy to take questions.

Mike Rumbles: I understand that independence is the key, certainly to local advisory councils fitting into the local and national system, but I am more interested in the duty of public involvement being given to the boards, as I have not heard about that. Surely, any organisation—I include your organisations—must have responsibility for public involvement and that responsibility should not be hived off to somebody else. Surely that is the key element of the bill. I would like you to comment on that matter, as I have not yet heard comments about it.

Pat Dawson: How much better might things be if there was a duty on boards and a duty to have an independent voice to represent the public? Why should the baby be thrown out with the bath water? If everything is to be done internally and there is to be a duty on the NHS to consult, we should consider the consultation processes of 20-odd years ago. In 1976, the health councils had rights and responsibilities vis-à-vis consultation processes. Indeed, the evidence that the local health council collated gave people a voice to speak directly to the secretary of state, who made decisions about whether service closure or redesign would be promoted. In essence, that structure has been changed, but what I have said indicates that, hitherto, our systems have promoted an independent patient voice at the highest level. In the bill, there is no route other than for the NHS itself to say that it has consulted and followed good practice and it either agrees or does not agree with the public. It is difficult to see how an independent external body will be able to challenge the board or be a vehicle for the voice of patients or the public.

Mike Rumbles: I have another question, as the issue is important. Correct me if I am wrong, but I believe that, under the current system, local health councils are appointed by the health boards, so where does independence come in?

Pat Dawson: For many years, the health council movement has sought to reform that situation—I say that as a past director of the Scottish Association of Health Councils. It seems that we have gone for a complete overhaul and have not kept the key components of health councils' success. By virtue of there being one or two areas in which health councils recognised that it was not clever for statute to have the board appoint them, we will no longer have them—the board will be it. The duty will be on the board to do such work, with advice from an independent panel.

Shona Robison: I share your views, but want to progress matters a bit. Obviously, independence is a crucial element, but there are also basic roles and functions that a patient expects at a local level. I am not clear about something and wonder whether you are clear about it. Who will provide the local point of contact for a patient who wants to be guided through the complaints system, for example, or who wants to bring to the attention of the local council—as they currently would—a concern at a local hospital that might lead to a walking-the-ward situation, which has happened unannounced on a number of occasions? Can you think of an alternative organisation that could provide that point of contact or a way of providing it? That element seems to be totally missing from the bill.

Pat Dawson: In the past, one of the shortcomings of local health councils was that they did not have a statutory duty to support complainants, although many did—local health councils in Lothian, Glasgow and elsewhere had high standards of complaint support. In the past five to ten years, several other agencies have sought to support individuals in making a complaint. Those agencies are primarily advocacy and other mental health, learning disability and support services. Their involvement is to be much welcomed. Another crucial organisation that has supported complainants is Citizens Advice Scotland.

However, some of the key experts on managing, manoeuvring and negotiating with the health service are health council support, information,

advice and complaints officers. As I understand the new requirements, the NHS board will have to commission someone to provide that service, and the local advisory structures will have a role in monitoring its quality. They will move from being providers to being quality advisers. I suggest to the committee that that is not seamless service provision or a one-stop shop for patients who want to make complaints. There are other reviews of the complaints procedure that had a poor evidence base.

14:15

Mr Davidson: There has been quite a lot of discussion about the role of NHS Quality Improvement Scotland and about which departments and functions it will take over. I recall that that was a hot topic at the General Medical Council conference.

Will the witnesses talk about whether NHS QIS should be seen as a standards-developing body and whether there is a need, as Pat Dawson described, for another patient-focused or user-focused body? Such a body would be an independent organisation and not part of the standards organisation. If I may, I will quote from the Royal College of Physicians of Edinburgh's submission, which says that NHS QIS

"will be acting not only as judge and jury but will have written the 'laws' too".

Is there a need for clarity between standards systems and the representation of individual patients, users and carers?

Dr Watson: I think that there is. We are concerned about NHS QIS's numerous functions. Standard setting is crucial, as is the inspection and monitoring of those standards. To add to those roles identifying and dealing with service failure and dealing with patients involves a blurring of responsibilities. On service failure, identification is important, but there should be a better, separate mechanism for dealing with it. The public perception is that NHS QIS is a single body and the independence that the public would welcome is not there.

Dr O'Neill: We welcomed the fact that several organisations were brought together under the NHS QIS umbrella, because too many organisations were doing too many things and there was overlap. However, as we said in our evidence, the challenge is for a single organisation to fulfil all those functions. There needs to be considerable discussion about how that will be delivered at the end of the day. There is nothing in the bill to prevent us from proceeding in that way, although there are issues about the abolition of local health councils and the creation of a Scottish health council.

We welcome the provision that Mr Rumbles drew attention to. We must instil a culture of public involvement and standards of acceptable performance, and we must make it easier for people to complain when service falls short of an acceptable standard. We must do that right across the service. If we rely simply on existing structures or new structures to do that, we will fail. We must create a health service in which an accepted part of the culture throughout the system is everyone's responsibility to ensure that there is appropriate public involvement. The organisations that exist to deliver particular services must demonstrate to patients, the public and those who deliver the service that they are fulfilling the different functions that they have been given.

Mr Davidson: I think that you are looking at three different issues: first, the duty on service deliverers to involve patients in planning and everything else; secondly, a clear and distinct duty on NHS QIS to evolve standards; and thirdly—a factor that has not yet appeared in the bill—the question of who will deal with the complaints procedures and so on. Is that a fair summary of your remarks?

Dr O'Neill: There are separate consultations, and Pat Dawson has already drawn attention to concerns that we all share about the separate arrangements at present for reviewing the complaints procedure. The Executive has responded and we are concerned about its response, but that is separate from the bill. Whether it would be appropriate to bring that under the remit of the bill is a different question.

Mr Davidson: In simple terms, do you see the bill as encompassing three different functions?

Dr O'Neill: Yes, but I do not see them as being so distinctly different as you have put it. For instance, I would argue that there is a responsibility on practitioners and on organisations to demonstrate to the public that they are delivering care of an acceptable standard. I do not think that we should be waiting for an examination body of some sort to descend on organisations or on individual practitioners. We should not wait until then to demonstrate that service may be falling short of an acceptable standard.

Pat Dawson: I suspect that there is no member of the committee who has not had a postbag full of letters about NHS dentistry. Will anything in the bill support the promotion of patient rights with regard to access to NHS dentistry? Will it promote some of the European charters and declarations, to which our Government is a signatory, on promoting and protecting patients' rights?

The Convener: Duncan McNeil, are you prepared to answer that or do you want to ask a question?

Mr McNeil: I shall comment on that. The present situation is not working and the health boards are not speaking for the communities that they represent and are unknown to many people in their communities. We have identified an issue. I do not believe that the current system of health councils is operating to people's satisfaction. Why else would all the various groups that are concerned with service change and the health service in Scotland be complaining? I am talking about community interests as opposed to specialist interests, which are well represented in the national health service and well represented here today.

Can the responsibility in section 5 on national health service boards to involve the public improve consultation processes? There is also a harder question: how can it bring about more regular involvement by the public and what actions or ideas would improve the current situation and meet the objectives of the bill? What ideas do the witnesses' organisations have for building in individual patient involvement and community involvement to match the involvement of specialist interests, which clearly have an influence and dominate the thinking of the national health service?

Elaine Tait: That is not a question that can be answered fully in the time we have today. The bill gives health boards a responsibility to co-operate across boundaries on a raft of issues. If one also gives them responsibility for consulting the public on service delivery and service planning, the combination of those two responsibilities, if used creatively with an accountability mechanism through the NHS and the Scottish Executive Health Department, should at least provide a platform for people to share good practice, to learn from one another and to be held accountable. I am not sure that, at this stage of specificity in the bill, it is possible to add anything that will take things much further than that.

We all know that it is an extremely difficult task to engender a culture that will allow patient involvement and encourage patient views to be expressed, and to facilitate that in a structure that itself is involved in organisational change and at a time when we have removed representatives from the local offices that were the predecessors of the Scottish health council. However, the bill at least gives statutory responsibility to the health boards to do that, and it also gives them a statutory responsibility to co-operate across organisational boundaries. That may help. I am not sure whether it is feasible for the bill to do anything more than that at this stage, but I would be happy to be contradicted by my colleagues.

Dr O'Neill: Some things can be achieved by their being enshrined in legislation and some are better achieved by other means. If we look back over the past 10 or 20 years, we see that significant patient involvement and responsiveness to patients' needs have come not from legislation but from patients' groups and the voluntary sector. We will have much more public and patient involvement if we give appropriate support to voluntary organisations and other groups that represent patients.

Let us consider the changes that have come about in the treatment of breast cancer over the past 20 years. A group of patients with breast cancer—predominantly pre-menopausal women—said, "Hang on a minute. We want to have a say in the treatment that we are offered and we want to be involved in the decisions that are taken about our care. We want doctors to consult us about the treatment that is available, not just mete it out to us." That attitude, rather than pieces of legislation, brought about changes in patient and public involvement. We welcome section 5, but it will not deliver public involvement and nor will any other aspect of the proposed legislation. We must have other means of doing so.

Mr McNeil: Mike Rumbles issued a challenge to your organisations, whose influence in the health service is secure. Is there a culture in the various organisations that you represent of promoting the community interest—apart from with warm words—so that the community's influence can be anything like as strong as the influence that you have as professionals? How do we bring that about? What ideas have your organisations brought to the process that we might use to encourage further community involvement?

Dr Garner: What has happened—and what the BMA has strongly encouraged—is involvement at the level of the individual. As a profession, doctors and nurses have moved towards involving patients in consultation about their individual care. That is the prime building block from which the process must evolve. Previously, we have tried to encourage people in general practice to get involved in patient participation groups, but such groups were difficult to organise. We hope that, as the culture changes—and it is changing at the front line, as doctors discuss with patients the options for their treatment—we will be able to move forward.

The first step will be to move the process into the community health partnerships, which will have public involvement. On a broader scale, we will be able to consider the services that are being offered in an area and to consult those who are in the CHP and their constituents in the community about how best to deliver those services. I envisage movement from the individual to the local level, then building up from that, in an evolutionary process. That is the way we have to go.

Mr McNeil: Are we talking about the C-word—I mean consultation—which people misunderstand? The people whom I and other members represent come to us and say, "This is not consultation; they are not taking account of our views." Perhaps consultation is the wrong word to use for the type of engagement that we mean. The word gives people an expectation that they have some influence, which, until now, has not been the reality of consultations, which have mainly been about hot issues such as clinical or maternity services reviews. Can we really aspire to true consultation and a partnership in which the community interest can match the specialists' interests, and sometimes might even win the day? Is that too much to hope for?

Dr Watson: Public involvement is crucial, but there is a danger that, in situations such as those that Mr McNeil describes, people might feel patronised and think that they have not been consulted. The difficulty is for the public to have a sufficient knowledge base, so that they can contribute in the way that they would like. Our organisations consider that it is crucial to contribute to public access to the knowledge base. A major concern is how the public can fully understand the issues, so that they have a basis on which to develop their views.

The Convener: We moved on to that topic, but I want to return to local health councils, which will also involve consultation. The submission from the Royal College of Nursing makes strong representations on local health councils. It says:

"There is no analysis given in the explanatory notes, policy memorandum or otherwise on the content of the powers, duties and rights of local health councils …Neither was this analysis part of the consultation, nor was any mention of the current legislation."

You also make a distinction between "involving people" and

"protecting and promoting patient rights".

It is a strong argument. Should we keep local health councils, or whatever we wish to call them? If we do, should they be directly elected and, if the answer to that question is yes, how do we do that? I want to add your views on that to those that have been expressed on consultation generally.

14:30

Pat Dawson: The RCN board and members are not clear that there has been a full exploration of all the potential policy and other outcomes. The consultation did not involve or describe the roles of health councils. Indeed, it used the managerial objectives and not statute to describe what health councils do, although health councils have a statutory duty to represent the interests of the public of the area in which they are established.

If we take the view that the policy and the consultation were inconclusive, we might be drawn to the conclusion that the abolition is pre-emptive. However, there is no doubt that it is entirely appropriate to have a duty on NHS boards to consult.

On consultation, one of the legal views that was given in the case of R v West Sussex health authority states:

"Consultation is the communication of a genuine invitation to give advice and a genuine receipt of the advice … to achieve consultation sufficient information must be supplied by the consulting to the consulted party."

The committee might find that useful in understanding what consultation is about and determining whether consultation deserves a legal definition.

The Convener: I ask you to answer the other two parts of my question. If we keep local health councils for the purposes of consultation or representation, should they be directly elected?

Pat Dawson: The RCN does not have a policy position on that, but if the implication of your question is that independence of membership should be delivered, processes that deliver it are appropriate.

The Convener: Do you have any views on how direct election would be done? My local health council put the proposal to me, and I asked it how we would go about electing local health council members. The argument against their being nominated by the board is a fair point.

Pat Dawson: It is an absolutely valid point. Over many years, the health council movement has sought ways to distance itself from the NHS boards. Indeed, until a few years ago—I do not know about current practice—most health councils managed the process themselves. The selection process and the guidelines that were developed post the Eckford review were all in place, so that, although the board had a formal role, the health councils delivered the nomination and appointment processes.

Shona Robison: Before we leave public involvement, I would be interested to know whether the witnesses think that a good way of instilling or restoring public confidence would be to introduce directly elected seats on the health boards themselves.

Dr Garner: I am not sure whether the BMA has a policy on that. My concern is that the board is too remote for the person who sits in my surgery or who is in Dr Mike Watson's outpatient clinic, even if they have elected someone to it. We need much more local involvement in consultation, rather than involvement at the board level. The people in my practice, the local clinic and the user

groups for the diabetic clinic are those who need to contribute their thoughts about how the service is developed and delivered.

Shona Robison: What do you think about directly elected places on community health partnerships?

Dr Garner: We need to consider how we could achieve that. As we said, the trouble is that we do not know completely how those bodies will function. I have no personal problem with that, but the BMA does not have a policy on the matter.

Dr Watson: I back what John Garner says. Local delivery is important. That returns to the point that what is put in place must work. There is no point in having elected individuals who pay lip service to the consultation process. The process will be effective only if people feel that they or their relatives are directly involved locally.

Mike Rumbles: The purpose of our asking you questions is to obtain further detail about the comments in your written submissions. After hearing Pat Dawson's response to the convener's questions, I admit that I am more confused about the Royal College of Nursing's position. In its submission, the RCN says that it is right to give health boards the responsibility for involving people, but Pat Dawson's response to the convener's questions seemed to undermine the RCN's support. She has not mentioned something else in the RCN written submission, which criticises the policy by saying:

"This policy position fails to recognise the legitimate interests of other representative bodies to be consulted, have/hold/give opinion or work with Boards to involve people."

The Convener: I am sorry to interrupt, but will you tell us where that is in the submission?

Mike Rumbles: That sentence is at the bottom of page 4.

I am confused about the RCN's position.

Pat Dawson: It is not contradictory to agree that any public service should have a duty to consult. The bill creates such a duty. Any statutory organisation that provides a service to the public and involves taxpayers' money should have a duty to consult in line with the requirements in the bill.

Mike Rumbles: Do you confirm your support for the provision that places a duty on health boards to encourage public involvement?

Pat Dawson: The contrary part is whether dissolving health councils is also a requirement. As I said, I see no difficulty with all public bodies that provide services having a duty to consult.

Mike Rumbles: Point III on page 5 of your submission says:

"RCN Scotland has supported the creation of the Scottish Health Council",

yet what you say is contrary to that. Do I misinterpret you?

Pat Dawson: Support for a national organisation is not contradictory. A Scottish health council or whatever it is to be called is needed—we have no difficulty with that. The issue is whether that organisation should be within NHS QIS. Each submission to the committee has referred to that.

In the formal consultation, the question was not asked whether the functions that had been grouped to be performed by the Scottish health council should be part of NHS QIS. That was a statement in the consultation document and not a question for consultation.

Mike Rumbles: Forgive me, but I want to ensure that we get this right, because it is important that the RCN's views are stated clearly and that there are no problems. You say that it is right to have section 5, in as much as it gives the responsibility to health boards. You also say that it is right for the Scottish health council to be established. Is that right?

Pat Dawson: Yes.

Mike Rumbles: What about the abolition of local health councils?

Pat Dawson: We question whether the new structures will provide the same safeguards as local health councils do in statute.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The BMA witnesses suggested that they would like more detail on when the power of intervention would be or should be used. I think that the public would like to know your opinion on that. When the public know about folk lying on trolleys in accident and emergency departments, or not being able to have hip replacements because there are not enough surgeons, or having to wait an inordinate time for cataract surgery because Gartnavel is short by one and a half full-time equivalent staff, they will think that someone should have intervened in some health boards a long time ago.

Dr O'Neill: What do you enshrine in legislation, and what do you deliver by other means? We have a performance assessment framework, we have NHS QIS and we have the power for ministers to intervene. Those three issues should be seen as separate. I may have misinterpreted the question, but Dr Turner seems to suggest that ministers should have powers to intervene much earlier. I am not sure that we would agree with that. We support the idea of the performance assessment framework, we believe in the accountability of health boards and we support the functions of NHS QIS. However, we have

reservations about whether one organisation can deliver all of those functions. It will be up to that organisation to demonstrate to us that it can.

Our only concern about ministerial intervention is over whether it is reasonable to pass costs on to health boards. That has already been investigated by the Finance Committee, which has, I believe, referred to this committee in its report. However, as I say, the three issues that I mentioned should be seen as distinct from one another.

Dr Turner: So, you agree that there should be some intervention but feel that you would not intervene if you found that the staff and patients were dissatisfied. They have been dissatisfied for a considerable time and I am not sure that what we are discussing today will bring about any magical improvement unless structures and management change.

Dr O'Neill: I agree that the provision in the bill for ministerial intervention will not solve the problem of patients waiting on trolleys. However, I do not think that the bill ever could do that. We will have to have a different system for that sort of intervention—a system that is much more responsive to the needs of individual patients when they are waiting in an accident and emergency department, on a ward or wherever. The culture will have to change across the system. We are achieving that to an extent, but we have a long way to go.

Dr Turner: We certainly have. I do not think that the money or the personnel exist. It may be that the Executive could intervene by asking how money is being spent if all the checks are balances are not doing their job. Otherwise we would be saying that the Executive cannot change anything. Do I misunderstand you, or do you think that the Executive cannot do much?

Dr O'Neill: It is not up to me to defend the Executive.

Dr Turner: No, but you said that you had ideas on how the Executive might intervene.

Dr O'Neill: To give a direct answer to the question, I would say that all three organisations agree that we could certainly do with more nurses, more doctors, more staff and more resources in the health service. That is separate from the discussion about the bill, but we would not disagree with Dr Turner on that.

The Convener: For the committee's information, paragraph 39 of the Finance Committee's report on the financial memorandum of the bill states:

"The Committee would, therefore, strongly recommend that the Health Committee seek further clarification from the Minister on the circumstances when the Scottish Executive would bear the cost of intervention as opposed to the Health Board as proposed by the Bill."

It is useful to have that on the record for when the minister comes before us.

Mr Davidson: My question is specifically for the RCN, although it has implications for all professional groups that deliver health care. The RCN's submission recommends that there should be more detail on how staff groups will be consulted when services are being planned in different parts of the health service.

You talk about supporting professional nursing advisory structures in paragraph 6 of your submission. That is a start, but are you talking about that on the basis of bringing something to the table in clinical care that you think only you are in a position to offer? Are you looking for directors of nursing to be involved at board level and so on?

14:45

Pat Dawson: Yes and yes. The issue of the nurse executives on NHS boards was made clear by the minister, who required all NHS boards to include such a post. We are currently seeking clarification about two NHS boards that do not have nurse executives. There seems to be a strong evidence base that supports the view that clinical leadership in services—from nurses, doctors and others—can promote patient quality of care.

Our concern in paragraph 6, which comes under the heading "Dissolution of NHS Trusts", was that an unintended consequence of the legislation would be our having NHS boards with a nurse executive and no other senior nursing or clinical input into the operational divisional structures that supported that. We have also been emphatic that we would like to see nurse leadership recognised on those new CHP boards, as my board member Christine Brown said.

Mr Davidson: Does that apply to other clinical areas as well?

Pat Dawson: We are developing partnership throughout the NHS in a supportive and positive way; for example, through development of the partnership information network guidelines. The RCN in Scotland is pleased that the minister has recommended amendment of staff governance in the form of one of the powers to intervene. We know that that is being consulted on at the moment and we wait to see how that consultation unfolds.

All of us here today have vested interests in ensuring that partnership working across all of our professional groups works as positively and effectively as possible.

Mr Davidson: Is it fair to say that you are happy that there will be nursing input at board level, but that you have concerns about the operational divisional level?

Pat Dawson: Yes.

Mr Davidson: I have not come across that before. Non-executive directors of trusts seem to be vanishing, but I was not aware that there would not be some form of management group that included all the potential professional input that exists. Do you suggest that that does not appear in the bill as you would like it to appear?

Pat Dawson: It might be that we are hearing emerging soundings from our members in senior positions to the effect that they are concerned about whether there will be sufficient and robust nursing leadership at the level below the board. We are keen to see whether that is the position of legislation, although I feel that that is another matter; limiting ourselves to the bill was mentioned earlier. We will certainly consider the matter because we have to promote and protect clinical leadership at all levels in the health service.

Mr Davidson: Can I widen that to the other two groups? I think that they might also have input to make.

Dr Garner: From the BMA point of view, along with our colleagues in nursing, we want to ensure that there is medical leadership in the operational divisions—it is essential. I do not know whether that leadership would take exactly the same form, whether it would come from a unit medical director or a divisional medical director, but there would have to be someone there who has the administrative and strategic responsibility to implement the medical advice on how a particular division, hospital or unit is run. I agree entirely with Pat Dawson.

Dr Watson: We are concerned that there were structures in place in the trusts as they stood before that have not been duplicated in the established health boards. I agree that it is early days and that the matter should not be enshrined in legislation, but we are concerned that clinical leadership will not be fully represented, as we feel it should be. The medical director sits on the board, but there are concerns that the full value of professional leadership will not be felt.

Janis Hughes: I have a question on the minister's proposals on clinical governance. Following an earlier committee meeting, the minister pledged to lodge an amendment at stage 2 that will place a duty on health boards and special health boards to ensure that they have systems in place for monitoring and improving the governance of NHS employees. Do you have any comments on the suitability of the proposed amendment? Will it go far enough?

Dr O'Neill: A separate consultation on the proposed amendment on staff governance is under way and will finish, I think, on 4 February 2004. We are supportive of the principle that will be enshrined, which was suggested by the human resources forum of the Scottish partnership forum.

Janis Hughes: So you think that the proposed amendment goes far enough.

Dr O'Neill: We are still consulting our members on that. Superficially, we are happy with the proposal, although some minor changes may be required. We are happy that the minister has accepted the principle and is prepared to include it in the bill.

Helen Eadie (Dunfermline East) (Lab): The minister has also pledged to lodge an amendment that will encourage health boards to promote equal opportunities when carrying out their statutory functions. What do you feel about that and how do you envisage that the duty might be undertaken?

The Convener: I do not know why I keep turning to you, Miss Dawson.

Pat Dawson: I am the fount of all knowledge.

Dr O'Neill: Doctors have always deferred to nurses.

Pat Dawson: They get their best advice from us.

The Convener: That statement will be used in evidence against you, Dr O'Neill.

Dr O'Neill: We are not aware of the proposed amendment to which Helen Eadie referred.

Helen Eadie: The minister has stated that he will lodge such an amendment. In fact, Parliament has pledged that, in producing legislation, we will be mindful of its implications for equality of opportunity. The Health Committee is anxious to understand how you envisage health boards' being able to encourage health professionals to deliver on equal opportunities.

Dr O'Neill: Perhaps on the back of the proposed amendment on staff governance, there will be a requirement on health boards to meet the staff governance standard on equal opportunities, which was published in 2002. We expect all employers in the NHS in Scotland to accept the range of partnership information network guidelines that are being produced by the human resources forum.

Dr Watson: Will the proposed amendment be about equal opportunities for staff development?

Helen Eadie: It will apply across the range of services and to employees within the health service.

Dr Watson: Equal opportunities issues have a key role in staff development. As I said, education and training are not highlighted as specific responsibilities, but it is well recognised that the opportunities for staff development are

significantly different among different staff groups. We are in favour of a multi-professional approach to staff development that applies across the board and that gives people opportunities, although that will require resourcing. Overall in the NHS, staff development is under-resourced. I hope that NHS Education for Scotland will be able to help, but the boards also have a function.

The Convener: Time is pressing, so if the witnesses have nothing to add, I thank them for their evidence, which was most helpful.

Subordinate Legislation

14:53

The Convener: Items 2 and 3 on the agenda are on subordinate legislation, on which we will receive a short presentation from the minister. We will have a break after we have dealt with the subordinate legislation.

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 11) (Scotland) Order 2003 (SSI 2003/561)

The Convener: I ask the committee to consider SSI 2003/561 on amnesic shellfish poisoning, which is subject to the affirmative procedure. I welcome Tom McCabe, the Deputy Minister for Health and Community Care, and Chester Wood, from the Food Standards Agency Scotland. No comments have been received from members in relation—[*Interruption.*] I beg your pardon. A comment has been received from one member in relation to the instrument. The Subordinate Legislation Committee has no comment to make. Do you wish to make your comment now, David?

Mr Davidson: I will do so briefly, convener. I cannot support the instrument, but I ask the minister to meet me to discuss evidence that came from a research company at the weekend.

The Convener: That is very intriguing—it is an invitation you could not resist.

The Deputy Minister for Health and Community Care (Mr Tom McCabe): Absolutely—I will do it after Christmas, convener. [*Laughter.*]

The Convener: Given that, do members wish to debate the instrument?

Members *indicated disagreement.*

The Convener: In that case, I ask the minister to move motion S2M-670, in his name, on the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 11) (Scotland) Order 2003 (SSI 2003/561).

Mr McCabe: SSI 2003/561 is an emergency order to ban harvesting of king scallops off the west coast of Scotland, because amnesic shellfish poisoning has been found at a level above the safety level set by Europe.

I move,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 11) (Scotland) Order 2003 (SSI 2003/561) be approved.—[Mr Tom McCabe]

The Convener: The question is, that motion S2M-670 be agreed to. Are we all agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Davidson, Mr David (North East Scotland) (Con)

ABSTENTIONS

Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

The Convener: The result of the division is: For 6, Against 1, Abstentions 2.

Motion agreed to.

National Health Service Superannuation Scheme (Scotland) Amendment (No 3) Regulations 2003 (SSI 2003/517)

Specified Sugar Products (Scotland) Regulations 2003 (SSI 2003/527)

The Convener: We are to consider two instruments that are subject to the negative procedure. They are SSI 2003/517 and SSI 2003/527. The Subordinate Legislation Committee has no comment on either instrument, and no comments have been received from members. No motions to annul have been lodged, and it is suggested that the committee make no recommendation in relation to the instruments. Is that agreed?

Members *indicated agreement*.

14:58

Meeting suspended.

15:06

On resuming—

Primary Medical Services (Scotland) Bill: Stage 2

The Convener: I reconvene the meeting. I will take members' guidance, but I think that I should share some information, in particular for the benefit of new members of Parliament—I welcome Carolyn Leckie, who is here to speak to her amendments. I will take a moment to go over stage 2 procedure, although I know that many members present are old hands—I hope that Duncan McNeil will bear with me. This explanation is for the benefit of people who are moving amendments and who might find the procedure difficult.

Amendments have been grouped to facilitate debate. However, the order in which the amendments will be moved and called is dictated by the marshalled list. All amendments will be called in turn from the marshalled list and will be disposed of in that order. The committee cannot move backwards in the marshalled list. There will be one debate on each group of amendments. I will call the first amendment in each group, and the member who is to do so should speak to and move that amendment. I will then call other speakers, including those who are to speak to all other amendments in the group. However, those members should not move their amendments at that stage: I will call members to move amendments at the appropriate times. If other members wish to speak, they should indicate that in the usual way. The minister will be called to speak to each group.

I will, following debate, clarify whether the member who moved the amendment wishes to press it. If the member does not wish to press the amendment, he or she may seek the committee's agreement to withdraw it. If the first amendment is not withdrawn, I will put the question on that first amendment in the group. If any member disagrees to the amendment, we will proceed to a division by a show of hands. It is important that members keep their hands raised until the clerk has fully recorded the votes. Only members of the Health Committee may vote. Any member not wishing to move an amendment should say simply "Not moved" when that amendment is called. I will give guidance if there is confusion—provided that I do not get confused.

The committee is required to decide whether to agree to each section or schedule of the bill. As members will recall, we go through each section one after the other and sign them off. I do not propose to delay any division to enable members who are not present to return to the meeting—this is the one and only stage 2 meeting for the bill.

Section 1—Health Boards' duties: provision of primary medical services

The Convener: Moving swiftly on, I call amendment 1, in the name of the minister, which is grouped with amendments 4, 5, 6, 7 and 24.

Mr McCabe: I will speak to amendments 1, 4 to 7 and 24. This group—

The Convener: I ask the minister to move amendment 1.

Mr McCabe: Okay, I will move amendment 1.

The Convener: You can speak to all the other amendments in the group.

Mr McCabe: I was waiting for your next instruction.

The Convener: I am sorry. You are required to move only the first amendment. I presume that you wish to move it.

Mr McCabe: Yes—I think that that would be a good idea.

This group of amendments deals with health boards' general powers and duties over primary medical services. I will summarise the main points of each amendment.

Amendment 1 is about a health board's power to provide services to patients for whom another health board has the duty to provide those services.

Amendment 4 clarifies the fact that ministers' power to prescribe the information that is published by health boards should cover all aspects of primary medical services.

Amendment 5 clarifies the intention that health boards should co-operate in relation to the full range of functions that are connected with every aspect of provision of primary medical services.

Amendment 6 provides for situations in which primary medical services can be provided to patients and includes provision for a health board to contract with a practice outside its area, and to send a patient to receive services outside Scotland if that is deemed to be in the patient's best interests.

Amendment 7 clarifies that such provisions will relate to any order that may be made, rather than to one specific order.

Amendment 24 is consequential on amendment 1.

I move amendment 1.

The Convener: I refer members to the letter that we received from the minister and I thank the minister for it. It is not numbered among today's papers because it came in too late. The letter is dated 1 December 2003 and explains some of the amendments, which members might find useful.

Amendment 1 agreed to.

The Convener: Amendment 2, in the name of Carolyn Leckie, is grouped with amendments 3 and 8.

Carolyn Leckie (Central Scotland) (SSP): All the amendments in the group seek to ensure that the bill provides no opportunities to contract with private, for-profit medical establishments. As it stands, the bill does not preclude a private organisation, such as a pharmacy, from expanding the services that it provides. That is happening at present. Boots the chemist is moving into primary services, and even BUPA could be contracted to health boards.

All the amendments in the group seek to ensure that there is no contracting with a private, for-profit provider. Although the Executive's statements on the guidance that it will issue to health boards give some assurance, outwith legislation, about contracts with private providers, I am a bit puzzled as to why, against a background of negotiations on the general agreement on trade in services, that has been omitted from the bill.

I move amendment 2.

Mike Rumbles: I oppose the amendments in the group on the ground that they challenge current practice. Private health care providers already provide care in the national health service. For example, GPs in limited liability companies already provide services and Carolyn Leckie's amendments would wreck that provision. Therefore, I have no hesitation whatever in suggesting that the committee reject amendments 2, 3 and 8.

Mr Davidson: I also wish to speak against the amendments, although not quite along the same lines as Mike Rumbles did, despite my having some sympathy with his views. I got the impression that the aim of the bill is to improve the desirability of working in certain aspects of health care in Scotland. It therefore strikes me as rather odd to set up additional barriers to stop people working in health care. If anything, the amendments would close down the national health service as we know it. All health care is governed by legislation as to suitability and qualification, and the same procedures are followed for the education and accreditation of those who work in the health service, regardless of which sector they work in. Many of the people who end up in private health care, such as general practitioners, invest in and work in the health service, and there has never been a question as to whether they put their patients first.

Ms Leckie will be able to answer my questions when she winds up. Is it her purpose to nationalise all aspects of health care? If so, how does she envisage that being affordable, accessible or desirable? How will the transition be handled? Is she not of the view that perhaps the health service should be paid for from the public purse, as it is now, but not necessarily delivered through the public sector, because that has led to inefficiency in many cases?

15:15

Shona Robison: Whereas I would always take the opportunity to restrict private profiteering from the health service and oppose the use of private finance initiatives and so on, I agree with Mike Rumbles's view of this group of amendments. The fundamental problem with the amendments is that they would undermine the role not only of general practitioners as independent contractors but of community pharmacies, which would fall foul of the proposal on the ground that they are privately owned concerns. However, community pharmacies are an essential part of health service delivery at the moment and will be given an enhanced role in the delivery of many aspects of illness prevention in local communities. The amendments would target them, even if that is not the intention.

It is worth pointing out to Carolyn Leckie that, in its briefing on her amendments, the BMA points out that the proposal would not restrict commercial companies' ability to provide health care, as it relates only to privately owned companies and not to limited liability companies. That shows that the amendments are fundamentally flawed.

I am not quite clear what Carolyn Leckie is trying to achieve. All of us, with the exception of David Davidson, want to restrict the ability of the private sector to expand in the national health service—

Mr Davidson: Will the member take an intervention?

The Convener: I am afraid that interventions are not allowed.

Shona Robison: We have to realise that the current set-up of the NHS, with its many elements and the relationships that it has with community pharmacies and so on, is complex and that this bill is not the place to try to amend that situation.

Helen Eadie: I will oppose Carolyn Leckie's amendments, from the perspective that the existing set-up is correct, provided that there is always state funding when contracting with any agency, whether it be a private concern, a GP or whoever. We see similar approaches across Europe. For example, Sweden contracted with Germany to undertake a range of operations that were paid for by the state in the interests of providing services to individuals. That step was critical with regard to making progress on waiting lists.

Further, the amendments would physically harm many complementary or alternative therapists, at a time when their support for GPs and other primary care services is growing. I would not like the use of reflexologists, osteopaths, chiropractors, aromatherapists and so on to be restricted. They play a growing and vital role in the health service.

Dr Turner: I did not get a chance to consider further the detail of Carolyn Leckie's reasons for lodging her amendments but I think that we must take care when introducing private companies into the health service. Back in the 1970s, a company called Aircall used to conduct out-of–hours calls on behalf of doctors. It was keen on making a profit at the expense both of the doctors who worked for the company and of the patients.

It was nice to have an alternative—sometimes, one needs an alternative. In my case, I worked with another company that provided a doctor-run service, so there was an alternative. It was difficult to get GEMS going when it started up, and when I opted out of it, I had the alternative of going to another company that provided a different service. We need to be able to choose services and we should not be held to ransom by any of the companies that may be waiting on the sidelines to come in. I have spoken to patients, doctors, nurses and other members of staff who are worried that BUPA and other companies may well come in and fill the gaps that appear.

I will not vote for Carolyn Leckie's amendments, because I probably do not know enough about the detail, but I am thinking about my experience of situations in which private companies have helped doctors out. They were not the most expensive option and they actually delivered a better service for the patient. We must weigh up each individual case.

The Convener: For the record, could you tell us what GEMS is?

Dr Turner: GEMS stands for the Glasgow Emergency Medical Service (General Practice) Ltd. It was run by doctors and set up by the Government and the local health authorities.

The Convener: David Davidson, would you like the right to reply?

Mr Davidson: Thank you, convener. I would like to respond to a comment made by Shona Robison, who more or less accused me of giving an ideological response that all things must be private. That is utter nonsense. However, if the quality of care can be delivered in a cost-effective manner so that the public purse gets value for money, we should not close our eyes to that.

I echo what Dr Turner has just said. Many years ago, when I was a young pharmacist, I operated the out-of-hours service for the northern half of Kent in conjunction with a private limited company owned by two GPs. There was no public provision for that service whatsoever; it was simply provided on a fee basis to the GPs involved. I do not want us to get into an ideological discussion of whether the only good job is done by the public sector or by the private sector. The bill is about putting the patient at the centre and ensuring that we take every opportunity to provide high-quality, cost-effective health care to the appropriate standards set by the Parliament.

Mr McCabe: As members have recognised, amendments 2, 3 and 8 seek to prevent health boards from contracting with private health care providers to provide primary medical services. We believe that the proposal is unnecessary and that it would prevent health boards from making decisions—utilising maximum flexibility—in the best interests of a patient. We believe that the quality and availability of care are important, not the nature of the provider.

We expect that GP practices will continue to provide the vast majority of care, just as they have done for the past 55 years. The bill is about improving the position of GPs and patients and about sustaining general practice, not replacing it with private companies. Under the new arrangements, existing practices will have the right to continue to provide both essential and additional services. A practice that provides those services on 31 March will not see them taken away on 1 April and given to Boots the chemist or anyone else.

Carolyn Leckie referred specifically to large companies such as Boots, and I can assure the committee that large organisations such as Boots and Tesco will simply not be able to hold a GMS contract, by virtue of the conditions in the bill that stipulate specifically the type of people who would qualify to hold such contracts. Such organisations would not fall within the range of those that would qualify.

I would like to comment specifically on amendment 3. I fail to understand why it would be more acceptable for private providers to be involved in the provision of primary services at certain times of the day than it would be at other times. That does not flow with any kind of logic. I therefore urge the committee to reject amendments 2, 3 and 8.

Carolyn Leckie: The contributions have merely confirmed my fears about one of the insidious purposes of the bill. I shall start with Mr McCabe's contribution. By asserting that quality and availability are the most important aspects and by talking about the "vast majority", he is obviously not ruling out the expansion of private provision of general medical services. He gave assurances about Boots but, as I understand it, the bill refers to any company being eligible to be a contractor as long as one GP is a shareholder. I am sure that Boots and BUPA could arrange that, if they have not already done so.

That takes me on to some of the spurious points that were made in opposition to my amendments. We must remember to see the amendments in the context of the bill and to bear it in mind that they amend specific phrases in the bill. The definitions of company and so on are already laid out in the bill. Amendment 8 is about any company

"whose primary purpose is the provision of medical services on a for profit basis."

Some of the concerns that have been raised are therefore red herrings.

Yes, the SSP's political position is for full public ownership of the NHS, including GP services. Members know that we lodged an amendment seeking that GPs should be salaried. That amendment is not included in this group of amendments, which seeks to address specifically the fear that the bill will allow the expansion of private, for-profit provision of general medical services.

There may be members of the committee who share those concerns, such as Shona Robison or other members of the SNP for example. If my amendments are unacceptable to them, I look forward to discussing amendments that they have lodged to ensure that there is no expansion of private provision of general medical services. Nothing has been said that addresses those concerns. I have to throw the question back to Mr Davidson, for example, who acknowledged in the stage 1 debate that he saw opportunities for the expansion of businesses in the provision of general medical services. He agreed that the bill will allow that to happen. Therefore, there is agreement that a threat exists, although Mr Davidson says that that threat is really an opportunity. I find it to be of concern that although there might be two committee members who acknowledge the possibility that the bill will allow contracting with a private, for-profit provider, I am the only person present who wants to prevent that from happening—I hope that we do not all live to rue the day. I will press my amendment.

The Convener: The question is, that amendment 2 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

AGAINST

Davidson, Mr David (North East Scotland) (Con)
Eadie, Helen (Dunfermline East) (Lab)

Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 0, Against 9, Abstentions 0.

Amendment 2 disagreed to.

Amendment 3 moved—[Carolyn Leckie].

The Convener: The question is, that amendment 3 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

AGAINST

Davidson, Mr David (North East Scotland) (Con)
Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 0, Against 9, Abstentions 0.

Amendment 3 disagreed to.

Amendments 4 to 7 moved—[Tom McCabe]—and agreed to.

Amendment 8 moved—[Carolyn Leckie].

The Convener: The question is, that amendment 8 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

AGAINST

Davidson, Mr David (North East Scotland) (Con)
Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 0, Against 9, Abstentions 0.

Amendment 8 disagreed to.

The Convener: Amendment 49, in the name of Dr Jean Turner, is in a group on its own.

15:30

Dr Turner: I lodged amendment 49 because I found that many general practitioners, patients and nurses were concerned about what will happen when general practitioners decide either to stay as they are at present or to become salaried and about who will opt out of out-of-hours provision.

My practice covered the period from 7:30 pm to 8:30 am, but that might not be the same in every case—I do not know what times will be decided on. I will give members an idea of what general practitioners do at the moment: they provide cover for their patients 24 hours a day. The family doctor service is probably the most effective medical sieve. Practically all patients are seen and diagnosed there, and the family doctor decides which way they should go—whether they should be treated by the GP, whether they should move forward through the system or whether they should go to the emergency service.

At present, if general practitioners have to be away from their practices due to ill health, holidays, maternity leave, postgraduate education, another job or bereavement, it is their responsibility to replace themselves with locums if their partners cannot or will not provide cover. I assume that, if doctors decide to become salaried and opt out of providing all the cover during the day as well as in the evening, that is where the health boards will come into play. No doctor can provide cover when they are suddenly incapacitated, for example by illness, and, at present, if the situation in a practice was really bad, the health board would step in. Over the years, locums have become scarce and expensive for practices. They are a cost to practices, as they are usually paid for out of practice income.

At present, not all general practitioners do their own out-of-hours cover. In some cases, such as in small practices, the hours between 7 in the morning and 6 at night are covered, which often means that the practice covers the on-call provision from 7 in the morning until 6 at night as well as all its clinics and other work. Such practices therefore often use deputising services, but, despite that, they often work into the evening. They cannot possibly do all their own work, so they need deputising services.

In large towns, which have the choice of a deputising service, GPs who wish to do the out-of-hours service make money. There are a few such GPs, and they are able to make a great deal of money. Not every doctor in Glasgow does that. If every GP decided to do out-of-hours work, providing that service would be a small cost to the practice, but because of work loads, it is almost impossible for them to do that work.

The bill will mean that the health board will be responsible if the GP is unable to be present in their practice to cover work within the practice. Looking back over the years, I can remember,

when I was in a single-handed practice, having to make 20 phone calls to get five people together to cover my work for a week when I was struck down with a flu-type illness. Likewise, when my mother had a heart attack and was dying up north, I could not get a locum, but six practices managed to cobble together cover to allow me to get away.

Perhaps members can see where I am coming from. If a practice has a doctor who is still contracted to the health board and another who is salaried, there may be an inequality in covering the hours during the day, never mind the hours in the evening. At present, doctors can work during the day and go on to work all evening. I hope that, for their and the patients' benefit, their ability to work all the hours that come their way will eventually be restricted. At present, they can do 13 hours in a practice and then work all night, and I have known doctors who have driven themselves off the motorway because they were tired or who have come into work in the morning and lain down on their patient couch to recover. That is wrong, and I would like the bill to contain a provision that prevents one doctor in a practice, who might still be contracted, from doing all the work within the practice, or other doctors from being able to continue working all the hours that they can to make extra sums of money, because that leaves patients poorly covered.

With serious situations such as the Ibrox disaster, everybody comes together and works extra hours. In the past, good will has cemented the work that has been done. However, under the European Community working time directive, some doctors will be restricted in the hours that they work, which means that, because many doctors might opt out of being salaried, extra hours might not be covered during the day. Further, because many doctors might opt out of out-of-hours work, there might not be enough people to cover those duties. If members listened to BBC radio this morning, they might have heard about the result of a poll of 3,000 doctors, according to which eight out of 10 doctors wish to opt out of work through the night. That is of concern to patients.

I may well not quite understand the proposed options. If we want to retain doctors, we have to provide them with choices—that is great. However, if in providing doctors with a choice, they are still restricted to working excessive hours, nothing will have changed from the present situation. Some doctors may work excessive hours because of loyalty to their patients and others will do so because they want to make more money.

I am not surprised that the BMA is not exactly on my side. The bill will work only if lots of different professionals work together. I worked closely with nurses and paramedic services—I could not have worked without them—but it looks as if we may well replace doctors with nurses. We must guard against that because the two are not synonymous.

I move amendment 49.

Janis Hughes: I am not clear about the wording of amendment 49, which would put a duty on health boards to provide out-of-hours services 24 hours a day. My understanding of the definition of out-of-hours service is that the core hours are from 6.30 pm to 8 am on weekdays, weekends, bank holidays and public holidays. Perhaps Jean Turner will expand on that issue in her summing up and say why it is necessary to provide such services 24 hours a day. I do not understand that point.

I am concerned about the amendment because it would restrict the provision of out-of-hours services to general practitioners. My understanding is that such services are provided by a primary care provider of some description, who may well be a nurse or a practitioner other than a general practitioner. The service involves the Scottish Ambulance Service, NHS 24 and other agencies that provide care in the primary care sector. I am not sure how Jean Turner thinks that the service would work if it were provided only by general practitioners. I am sure that, particularly in rural areas, such a system would be totally impossible and unworkable.

The amendment states that the restrictions that it would impose will not

"apply in the case of a major medical emergency."

Jean Turner mentioned the Ibrox disaster, but the wording of the amendment is loose. I would like a more precise definition of a major medical emergency. Who would decide whether an incident was a major medical emergency?

Mike Rumbles: I am sorry to say this to Jean Turner, but I do not think that the amendment is exactly well thought out. There is a real danger in continually relying on your personal experience or the anecdotal evidence that the committee receives week after week—

The Convener: I think that it would be fair to move on—

Mike Rumbles: Excuse me?

The Convener: I am asking you to speak to the substance of the amendment and not to get into personal issues.

Mike Rumbles: Convener, I am speaking to the amendment—I am giving my reasons why I cannot support amendment 49.

The Convener: Well, we shall see.

Mike Rumbles: I do not support amendment 49 because it is not exactly well thought out.

The Convener: I accept that.

Mike Rumbles: The amendment is typical of what Jean Turner has brought to our discussions on the bill. For example, in her contribution just now, she gave us the benefit of her personal experience. However, that is not a sound enough basis on which we can be asked to change the law. Relying on such anecdotal evidence is not helpful and we cannot possibly agree to the amendment in its present state.

It is important to outline why we cannot agree to amendment 49. Jean Turner referred to BMA Scotland's evidence and said—I wrote down the quotation—"The BMA is not exactly on my side". I can see that; indeed, the feeling is much stronger than that. In its introduction to the briefing note that we all received, the BMA says that it

"strongly urges members of the health committee to reject"—

the amendment—

"in the name of Dr Jean Turner MSP."

The briefing goes on to say:

"The amendment, as written, is fundamentally flawed … Under the new GP contract, the practice has responsibility for 24 hour patient care unless they choose to opt out of responsibility for out of hours care."

Janis Hughes has just made that point. The BMA says that such care is not available for 24 hours a day, because it

"falls within the hours of 6.30pm to 8am on weekends, weekdays and Bank Holidays and public holidays."

The detail contained in amendment 49 is completely unnecessary and delving into it would not be worth while. The BMA also points out:

"As self-employed contractors GPs are not required to comply with the European Working Time Directive. Nevertheless, under GMC guidelines they do have an obligation to ensure that they are fit to practice. If not, they run the risk of facing disciplinary action."

I do not like the idea of accepting as a fact that our GPs are reckless and that they run the risk of damaging people's lives because of the way in which they work. If GPs suspect that other GPs are taking such risks, they can use the disciplinary procedure that is in place. That is the proper course of action. We should not try to change the law in such detail and—I am trying to choose my words carefully—in such an unfocused way.

Mr Davidson: I have some sympathy with the principles behind amendment 49. Mr Rumbles mentioned patient safety. I suspect that the patient safety aspects of the bill will be subject to guidance from the Executive when it comes to issue conditions of practice and advice to the health boards that will ultimately hold the contracts. Using the guidance from the minister and the Executive team, health boards will decide on a national basis how to deal with aspects of patient safety other than through complying with the European working time directive. For example, people in certain areas of accident and emergency, regardless of their age, will be unfit to practise after going through 13 hours of a huge emergency session. We must consider the matter on that basis. However, I understand Jean Turner's position on that issue. I am also concerned about rural and remote practices that might not receive health board support.

The bill does not deal with some details of the duty on health boards, capacity levels and so on. Much of that will be dealt with in regulations and guidance. I accept today as I did last week the minister's assurances that such regulations and guidance will be issued.

My biggest problem with amendment 49 is its wording. For example, it contains a very poor definition of

"adequate level of out of hours care".

I suspect that that matter will not appear in the bill. If Dr Turner is recommending that the bill should cover it, she should provide much greater and enveloping guidance that is based on evidence from best practice.

For those reasons, and not because of the principle of what Dr Turner is trying to achieve, I feel that I cannot support amendment 49. It was lodged at short notice, admittedly, but the legislation will last for many years and there should be adequate negotiation and discussion over matters such as the one that is the subject of the amendment. We do not know, but such negotiations may be on-going between the health boards and the various professional groups that, as far as the public are concerned, will be involved in delivering the legislation.

15:45

Helen Eadie: I, too, will oppose amendment 49, for the reasons that Janis Hughes and Mike Rumbles have touched on. I emphasise David Davidson's point about the implications for the more remote areas of Scotland. As we saw when we considered the draft regulations last week, the out-of-hours period lasts for 13 and a half hours. The amendment would mean that GPs could not work for more than 13 hours, which must include one hour's rest. That would require a minimum of two GPs in a rural area to cover a single night shift. We all know that, in the more remote areas, the likelihood of having a disturbed night is small. Health providers in those areas might find the obligation difficult to meet. The amendment has significant implications, which is why I find it difficult to support it.

Mr McNeil: I am in the same position, in that I cannot support the amendment. I pursued some of the questioning at the committee. I was searching for guidelines that protected the patients, although it may have been misconstrued that the concern was the benefit of the doctor. It was interesting to note at that point that the professional organisations had no guidelines in place, despite their argument that shorter working hours are for the benefit of the patient. That has not been demonstrated clearly—there is an issue there, which the amendment allows us to explore again. The general benefit of reducing GPs' hours is evident in the bill. GPs can opt out of out-of-hours care, so their objectives are being successfully met, but we should still perhaps consider the impact on patients.

Mr McCabe: I shall take the opportunity to explain why, after careful consideration, we have decided that the amendment should be rejected. The amendment raises an important issue and I can well understand why members would want to probe the matter to reassure themselves that there will be an adequate continuity of service. Ensuring that services for patients are of a high quality, regardless of the time of day, is a principle that we would all support. The bill places health boards under a duty to provide or secure the provision of primary medical services in their areas irrespective of the time of day or night. There is no dispute that everyone in Scotland should have access to a quality service when they need care in the out-of-hours period, but we do not think that the amendment is the way in which to achieve that.

As part of any pre-contract discussion, we would fully expect that the health boards would discuss with the provider whether they have sufficient resources to fulfil their contractual obligations. We expect that such discussions would include whether there were enough well-rested staff to cover periods on duty safely, whenever those periods might be.

On the specifics of out-of-hours cover, in order to ensure that patients can access high-quality services during the out-of-hours period, even where the local GP practice has transferred its responsibility to provide cover, health boards will be able to secure the provision of services only from alternative accredited providers, which must meet nationally defined standards. Those standards will require providers to ensure that the quality of care that they provide is not compromised by staff being tired. We think that monitoring and updating those standards will do more to protect patients than placing inflexible restraints in the bill would.

As members have properly pointed out, the amendment would mean that only GPs would provide out-of-hours cover. Many parts of Scotland already receive excellent out-of-hours care from specially trained staff, especially nurses in NHS 24. During the stage 1 debate, Mr Chisholm referred to an example in Buckie, which showed that a range of allied health professionals are involved in the provision of out-of-hours care. The amendment would put a stop to all that. We need to consider more innovative ways of providing services, particularly in remote and rural areas.

I will deal with two points that were made by Dr Turner. It is important to stress that practices, not individuals within them, opt out. The contract holder—the entire practice—would have to opt out; it is not down to one individual to make that decision. Reference was made to the BBC report on a poll. There is an important distinction to be made. GPs may express a desire to opt out of the responsibility to provide out-of-hours cover, but the same GPs, having relieved themselves of that responsibility in their practice, may still want to involve themselves in the provision of out-of-hours cover in a different way. Rather than being responsible for providing cover 24 hours a day, seven days a week, GPs may decide that they wish to take part in out-of-hours cover once a fortnight. That would be their decision. There is therefore a big difference between a practice's decision to opt out and an individual GP's decision to hook back into providing cover through another route.

Dr Turner: I take on board everything that has been said. I am new to this game and we produced the amendment in a hurry—as is probably obvious. The phrase "out of hours" usually concerns the hours from the evening to the early morning. In general practice, however, every doctor knows that they have a 24-hour responsibility, which is a huge burden to live with on a daily basis. I have been reassured by some of the things that the minister has said. I might wish to withdraw the amendment and come back to this important subject at a later stage. The hours that, for example, airline pilots work are restricted. We all know that people's performance decreases with tiredness, which can be as bad as drinking alcohol—tired drivers can cause accidents.

I am aware that not all GPs provide out-of-hours services. I have visited NHS 24 and I must say that I was absolutely impressed by its headquarters. When money is put into a system and people are working together in good teams, they feel confident, they enjoy their work and they perform extremely well. Although NHS 24 has difficulties and teething problems, it has come on in leaps and bounds. I might return to the problem—it is a real problem—and see what crops up. Many doctors are worried about the level of cover, especially if everybody becomes salaried, as is their choice.

Amendment 49, by agreement, withdrawn.

Section 1, as amended, agreed to.

Section 2—Provision of primary medical services: section 17C arrangements

The Convener: Amendment 9, in the name of the minister, is grouped with amendments 21 to 23.

Mr McCabe: I will speak to amendments 9, 21 and 22, but I would like to hear Carolyn Leckie's views on amendment 23 before I offer any comments on it.

The Convener: That is a bit difficult, as she is not present. I ask you to speak to your amendments to start with and to move amendment 9. We will deal with Ms Leckie's amendment 23 later in proceedings.

Mr McCabe: I will leave that to you, convener.

This group of amendments relates to section 17C arrangements for primary medical services. Amendment 9 is a clarifying amendment; it makes it clear that other services that may be provided under a section 17C arrangement for primary medical services are not limited to services that may be provided under part I of the National Health Service (Scotland) Act 1978. The amendment removes a limitation that does not apply to other services that may be provided under a GMS contract.

Amendment 21 makes it clear that the power to require, through regulations, that payments under section 17C arrangements be made in accordance with directions of the Scottish ministers relates only to primary medical services.

Amendment 22 clarifies that the Scottish ministers may use the power in section 17E of the 1978 act to make regulations that set out the process for resolution of disputes over the terms of a proposed section 17C arrangement for primary medical services. The bill already provides for regulations to set out such a process for GMS contracts. Again, the amendment is necessary to ensure that there is parity between what can be done in respect of such disputes, whether they arise over a proposed section 17C arrangement or a GMS contract. In other words, the same protection will apply, no matter which route a practice decides to adopt.

I move amendment 9.

The Convener: Do you wish to speak to amendment 23?

Mr McCabe: Not at the moment.

The Convener: As Carolyn Leckie is not present, it is open to other members to move amendment 23. Does anyone wish to move it? [*Interruption.*] I beg your pardon, I have the wrong instructions. Amendment 23 will not be moved at the moment.

Amendment 9 agreed to.

The Convener: Amendment 10, in the name of the minister, is grouped with amendments 11 to 20, 25 to 29, 50, 31, 32, 40 and 48.

Mr McCabe: The 20 amendments in the group all relate to the providers and contractors for section 17C arrangements and GMS contracts. Together, the amendments clarify our original policy intention and ensure that the bill reflects it. The amendments ensure that the categories of eligible persons with whom a health board may enter into a section 17C arrangement or GMS contract are accurate and complete and that the terminology is clear to the reader. They also ensure that the equivalents of those persons under the relevant English, Welsh and Northern Irish legislation are eligible.

I move amendment 10.

The Convener: As no other member wishes to speak, I assume that the minister will waive his right to wind up. [*Interruption.*] I beg your pardon, David.

Mr Davidson: It is not for me to suggest that you need an optician, convener.

The Convener: I am wearing glasses—that is even more of an insult.

Mr Davidson: Rather than talk about the principle of the amendments, I seek clarification on the details of two of them. First, I wonder why amendment 14 will introduce the word "may" into section 2, at page 2, line 29—I say that for the official report staff.

Secondly, the final lines in amendment 18 state:

"NHS foundation trust, NHS trust and Primary Care Trust have the same meanings".

Why is that the case, given that trusts will no longer exist in Scotland in the near future? Is the provision temporary and intended to provide some kind of regulatory framework? I await the minister's answer.

Mr McCabe: To take the second point first, that terminology is used because those bodies exist in other parts of the United Kingdom. As members know, it has been decided to abolish trusts in Scotland but, because the bill is a United Kingdom bill, it contains terminology that relates to existing situations in other parts of the UK.

Could you clarify your inquiry on amendment 14? I cannot seem to find the wording to which you referred.

The Convener: In the meantime, minister, could I just clarify something? You said that this is a UK bill, but it is a Scottish bill.

Mr McCabe: It was negotiated on a UK-wide basis and it is necessary to incorporate terms that are used right across the United Kingdom.

16:00

Mr Davidson: I understand what the minister has said. With regard to amendment 14, my concern was about the following wording:

"In relation to an agreement … under which … services are provided which is entered into with a partnership, regulations may make provision as to the effect … of a change".

What is the Executive's purpose in using that specific wording?

Mr McCabe: The wording means that we have every intention of making regulations. I will have to come back to you on the use of the word "may", but I assure you that we will make those regulations.

The Convener: Perhaps the word "shall" should be used, then.

Mr Davidson: Does that mean that there will be another amendment to replace amendment 14? In procedural terms, we have to deal with the amendment as it is stated today and the vote today will be based on the submitted document.

Mr McCabe: The amendment refers to a permissive power. The section allows us to have the power to make such regulations. That is why the phraseology is as it is. The position is analogous to the one in relation to the GMS contract, so they both line up.

Mr Davidson: I can accept that.

Amendment 10 agreed to.

Amendments 11 to 22 moved—[Mr Tom McCabe]—and agreed to.

The Convener: Amendment 23 is in the name of Carolyn Leckie. As she is not present, it is open to a member of the committee to move the amendment. Does any member wish to move it?

Mr Davidson: If it is not moved today, does it immediately drop out of the proceedings?

The Convener: It does.

Amendment 23 not moved.

Section 2, as amended, agreed to.

Section 3 agreed to.

Section 4—Provision of primary medical services: general medical services contracts

Amendments 24 to 29, 50, 31 and 32 moved—[Mr Tom McCabe]—and agreed to.

The Convener: Amendment 33, in the name of the minister, is grouped with amendments 34 to 38.

Mr McCabe: The amendments in this group cover a small number of changes to the provisions governing GMS contracts. Amendments 33 and 34 will ensure consistency between section 17C arrangements and GMS contracts. By widening the wording about what any patient choice regulations might contain, amendment 33 ensures that the wording relating to GMS practices is similar to that relating to section 17C practices for primary medical services. That is in keeping with our commitment to protect the rights of patients whatever contractual option their local GP wants to pursue.

Without amendment 34, the wording about what regulations concerning the termination of a GMS provider's responsibility to a patient might cover would be narrower than for those covering the same situation for a section 17C provider. The amendment ensures that the position will be the same for both.

Amendments 35 to 38 are designed to clarify the bill. The first is a simple amendment, which will add a clarifying "and". The other amendments in the group, by ensuring that the correct singular and plural wording is used, clarify the provisions setting out our intention that single-handed GPs, as well as companies and practices involving a larger number of people, will be able to become health service bodies.

I move amendment 33.

Amendment 33 agreed to.

Amendments 34 to 38 moved—[Mr Tom McCabe]—and agreed to.

Section 4, as amended, agreed to.

Section 5—Persons performing primary medical services

The Convener: Amendment 39, in the name of the minister, is grouped with amendments 41 and 43 to 47.

Mr McCabe: This group of amendments covers changes to the section of the bill that deals with listing people who perform primary medical services.

Amendments 39 and 41 clarify the intention to provide by regulation that a performer must have his or her name included on the list for each health board that has the duty to make provision for the services that they are performing. For GPs who

require to be listed in more than one area, administrative arrangements will be put in place to allow all the relevant checks on a person's fitness to be carried out by a lead board, with other boards accepting the GP on to their lists without further checks in a fast-track process. However, the overall principle is clear: to work in any health board area, a GP must first apply to get their name on that health board's list. The fact that an application to one health board has been accepted does not mean that the name is automatically included on all other lists.

Amendments 43 and 44 will remove unnecessary references to the NHS tribunal. There is no need to refer to the NHS tribunal in the bill, as separate powers under the National Health Service (Scotland) Act 1978 relate to reference to a tribunal. Proposed new section 17P(3)(h) of the 1978 act clarifies that regulations may provide for payments to be made by NHS boards to persons suspended from primary medical performers lists to protect their livelihood in the meantime. Amendment 45 removes a reference to persons appointed by ministers, as it is not intended that anyone other than ministers will determine the amount of such payments.

Amendment 46 is a technical amendment to clarify that the word "references" refers to references to the NHS tribunal. Amendment 47 amends section 29(6) of the 1978 act to include those persons on the new primary medical services performers lists in an essential definition of persons who can be referred to the discipline tribunal.

I move amendment 39.

Mr Davidson: The National Health Service Reform (Scotland) Bill, which the committee is currently scrutinising, places a duty on a health board to provide—albeit by agreement—services to patients who are not resident in that health board area. According to the Minister for Health and Community Care, a number of those services will be delivered through current primary care practices. What provision will be made in the Primary Medical Services (Scotland) Bill to ensure that that eventuality is covered?

For example, a GP who carries out a particular procedure will be included on the approved list for his health board. However, because of proximity to a boundary with another health board area, the health boards involved might agree to provide that service in the other health board area. Will the regulations establish a proper procedure to ensure that the people in the other health board area who might receive the service can be secure in the knowledge that the GP is registered and scrutinised—not just for that one purpose but for all purposes that might arise from the arrangement—in both health board areas?

Mr McCabe: I tried to say earlier that, as far as delivery of primary medical services is concerned, the GP must be registered in every health board area in which they perform those services. Ensuring that a lead board makes all the relevant checks will prevent the other health boards from having to reinvent the wheel. However, the health board in each area where the GP in question performs must ensure that it has the relevant information and is satisfied that that person is on the other board's list. If that is the case, that person can be added to the health board's list. In other words, a person who performs in a particular area must be listed with the health board in that area. Does that answer your question?

Mr Davidson: Yes, I think that I definitely received an answer.

I want to clarify some of the fine print to ensure that we do not aggravate the BMA or anyone else because they have to renegotiate a particular point. I think that the minister said that if, for example, a patient in one health board area went by agreement to receive treatment from a GP in another health board area, that GP would be registered with and scrutinised by that health board. That is fine. However, if that GP delivers the treatment in a practice in the patient's health board area, will the bill ensure that he will also have to be registered and on the list in the patient's health board area?

Mr McCabe: If a health board has a duty to provide a primary medical service, any person who provides such a service must be on that health board's list.

The Convener: Thank you very much, minister. I take it that you have just wound up on that group of amendments.

Mr McCabe: Yes.

Amendment 39 agreed to.

Amendments 40 and 41 moved—[Mr Tom McCabe]—and agreed to.

The Convener: Amendment 42, in the name of the minister, is in a group on its own.

Mr McCabe: Amendment 42 relates to the standards for individual performers and makes it clear that regulations may cover the standard to which primary medical services must be delivered by individual doctors. That will allow us to ensure that appropriate action may be taken when such services are not delivered to an acceptable level. The vast majority of GPs provide excellent services to their patients, but it is important for the safety of patients that the few who fail can be dealt with appropriately.

The amendment also clarifies our intention to use the regulations to continue to require doctors

to make declarations and give undertakings in relation to inclusion in lists and to require them to give certain consents.

I move amendment 42.

Amendment 42 agreed to.

Amendments 43 to 47 moved—[Mr Tom McCabe]—and agreed to.

Section 5, as amended, agreed to.

Section 6 agreed to.

Section 7—Ancillary provision

Amendment 48 moved—[Mr Tom McCabe]—and agreed to.

Section 7, as amended, agreed to.

Section 8 agreed to.

Schedule agreed to.

Section 9 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill. I thank the minister and committee members.

Meeting closed at 16:13.

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