HEALTH COMMITTEE

Tuesday 2 March 2004
(*Afternoon*)

Session 2

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HEALTH COMMITTEE

7th Meeting 2004, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

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

*attended

THE FOLLOWING GAVE EVIDENCE:

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

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Graeme Elliot

ASSISTANT CLERK

Hannah Reeve

LOCATION

Committee Room 4

Scottish Parliament

Health Committee

Tuesday 2 March 2004

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:00*]

Subordinate Legislation

National Health Service (Transfer of Property between Health Boards) (Scotland) Regulations 2004 (SSI 2004/15)

National Health Service (Borrowing and Loans from Endowments) (Scotland) Regulations 2004 (SSI 2004/16)

Health Act 1999 (Savings) (Scotland) Order 2004 (SSI 2004/31)

Community Care and Health (Scotland) Act 2002 (Savings) Order 2004 (SSI 2004/34)

National Health Service (General Ophthalmic Services) (Scotland) Amendment Regulations 2004 (SSI 2004/36)

National Health Service (General Dental Services) (Scotland) Amendment Regulations 2004 (SSI 2004/37)

National Health Service (Tribunal) (Scotland) Regulations 2004 (SSI 2004/38)

National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2004 (SSI 2004/39)

National Health Service (General Medical Services Supplementary Lists) (Scotland) Amendment Regulations 2004 (SSI 2004/40)

National Health Service (General Medical Services) (Scotland) Amendment Regulations 2004 (SSI 2004/41)

The Convener (Christine Grahame): I welcome everyone to the seventh meeting of the Health Committee this year. I ask everyone to ensure that their mobile phones and pagers are switched off.

We turn to item 1. I refer members to paper HC/S2/04/7/1, which was circulated to you all. It contains the points that were raised on the instruments before us by the Subordinate Legislation Committee. We are asked to consider 10 instruments that are subject to the negative procedure, as shown on the agenda.

The Subordinate Legislation Committee has commented on Scottish statutory instruments 2004/15, 2004/16 and 2004/38. Once again, there are issues of drafting—you might have thought that the Executive would have got it right by now. However, no comments have been received from members and no motions to annul have been lodged in relation to the 10 instruments. Is it the position that the committee does not wish to make any recommendation on the instruments?

Members *indicated agreement*.

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 2) (Scotland) Order 2004 (SSI 2004/43)

The Convener: Item 2 on the agenda is an instrument that is subject to the affirmative procedure. We are familiar with amnesic shellfish poisoning; I had suspected that we would have a rerun. I welcome Tom McCabe, the Deputy Minister for Health and Community Care, to the meeting. No comments have been received from members in relation to the order. Does anyone wish to say anything?

Mr David Davidson (North East Scotland) (Con): I am sorry, convener—my comments should have been received. I simply wish to put on record the fact that I am against the approval of the order.

The Convener: The Subordinate Legislation Committee has made no comments on the order. No member has expressed the wish to debate the order, so I now ask the minister to move motion S2M-876.

The Deputy Minister for Health and Community Care (Mr Tom McCabe): Thank you convener, and good afternoon.

I move,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 2) (Scotland) Order 2004 (SSI 2004/43) be approved.

The Convener: The question is, that motion S2M-876 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.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 2) (Scotland) Order 2004 (SSI 2004/43) be approved.

Primary Medical Services (Scotland) Act 2004 (Draft Regulations)

National Health Service (Primary Medical Services Performer's Lists) (Scotland) Regulations 2004 (draft)

National Health Service (Section 17C Agreements) (Scotland) Regulations 2004 (draft)

National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004 (draft)

14:04

The Convener: We move on directly to item 3. I refer members to paper HC/S2/04/7/2, which contains three sets of draft regulations—I will not read the titles out—and, again, I thank Tom McCabe, Lorna Clark, bill team leader for the Primary Medical Services (Scotland) Bill, and Jim Patton for attending the meeting. The minister may take us through the regulations as he wishes and I will then open up the meeting to questions from members.

Mr McCabe: I am pleased to be here to try to make good on the commitment that we made to the committee in November, when we said that we would be happy to continue our dialogue on the regulations that flow from the Primary Medical Services (Scotland) Act 2004.

As you rightly said, there are three sets of regulations before us. The first is the list of performers of primary medical services, the second is on general medical services and the third is on section 17C arrangements. The first two sets of regulations are the most recent versions of the regulations that we discussed last year, but the committee has not seen the third set until now.

I will try to provide some background. General medical services and section 17C arrangements—members might be more familiar with the term "personal medical services", which is the old name for section 17C services—are the two main contractual options through which boards can discharge their duty to provide or secure primary medical services. GMS contracts are, as members know, national contracts that are negotiated at UK level and section 17C contracts are local contracts that give health boards and contractors much greater flexibility about what is locally agreed. I stress that the vast majority of contracts in Scotland—around 90 per cent, I think—are GMS contracts. As members looked through the regulations, they might have noticed that the

section 17C regulations are very similar to those for GMS. However, they reflect the greater flexibility that is available through the section 17C option.

Since I last met the committee, a great deal of work has gone into refining and developing the draft regulations. The regulations are very nearly ready and I expect that we will be in a position formally to lay them during the next week, in time for them to come into force on 1 April. In policy terms, the regulations are not very different from the versions that the committee saw three months ago. However, the wording has changed and as a result the ordering of the regulations has changed in some cases. If members have questions, we will do our best to try to answer them.

Janis Hughes (Glasgow Rutherglen) (Lab): I have two questions about schedule 2 to the draft National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004. First, paragraph 2(12), on page 32, says:

"The Health Board must ensure that an assessment panel is appointed by another Health Board as soon as is practicable to consider and determine whether or not to approve the Health Board's proposed decision to refuse a permanent opt out."

I believe that that is true in relation to temporary and permanent opt-outs, whether those pertain to out-of-hours services or to additional services. The assessment panel is mentioned elsewhere in the regulations, too, but how would it be formed? Would it be made up of people from the health board or people who were more independent? How many people would sit on such a panel and what would their status be?

Mr McCabe: The panel would comprise three members: a patient representative; a representative of the profession, who would come through the area medical committee; and either the chief executive or an executive director of the health board that was hosting the panel. I stress that the regulations stipulate that the health board that hosted the panel would not be the health board that had the particular issue.

It would be fair to say that the Scottish General Practitioners Committee has a slight disagreement with us about the composition of the assessment panel. That committee has reservations about the third member of the panel and, I think, takes the view that certain executive directors should not sit in judgment—for want of a better expression—on general practitioners. For instance, an executive director might be director of finance or of nursing. Our view is that the group of people who could be selected to serve on such panels is narrower in scope in Scotland than it is south of the border, so we want there to be as much flexibility as possible about the selection of the third person. It is also important to stress that to allow only executive directors of the type that suited the SGPC to take up the third place on the panel might cast aspersions on the professional objectivity of other executive directors and we would not want to do that.

Janis Hughes: I would like to clarify matters. You mentioned a patient representative and a professional representative, so there would be a professional representative on the assessment panel anyway, irrespective of the status of the director of another health board.

Mr McCabe: Indeed.

Janis Hughes: My second question is on paragraph 6 of schedule 2, on page 37. The issue arose when the committee questioned you previously—I think that I asked you about informing patients about opt-outs. I am still concerned that

"placing a notice in the practice's waiting room; or … including the information in the practice leaflet"

will not inform patients in a suitable manner. Do you have anything to say about that? Will you suggest any further changes to ensure that patients will be in full possession of the facts when general practitioners have been granted permission to opt out?

Mr McCabe: That there are two sets of obligations is important. There are obligations on practices with regard to notification and specific obligations on health boards, as they have a duty to inform patients of any changes. The two examples that are given in the regulations relate to practices, but there are also specific obligations on boards. I cannot remember the exact wording of the regulation, but I suppose that, on first reading it, a person would be entitled to say that it relates to the obligation on health boards, although it is fairly vague and says merely that health boards shall notify patients. However, a further subset of regulations will be developed to add detail to the methods that the health board must apply with respect to that notification.

Janis Hughes: So those regulations still have to come to the committee.

Mr McCabe: If the committee would like us to share them before they are finalised, I would be more than happy to do that. I would probably go a bit further and say that, if members are happy to consider those regulations, they might want to turn their minds to suggestions on how health boards would be required to notify people.

The Convener: Members may ask questions if they are supplementary questions, as I have a list of members who want to ask questions.

Shona Robison (Dundee East) (SNP): Will you clarify who will be responsible for informing

patients about opt-outs? Will the practice or the health board be responsible for letting patients know that contraceptive services, for example, will no longer be provided by the practice?

Mr McCabe: Both will be responsible. The regulations specify the practice's obligations, but a far more specific obligation on the health board sits beside those obligations. As I said, a further subset of regulations will better define the exact obligations on the health board.

Shona Robison: Will those regulations also define the methods that the health board should use to impart information? I would have thought that it would make sense to notify patients in writing that cervical screening services or child immunisation services will no longer be provided by a practice, as people need to know about such things quickly. Will the further subset of regulations specify the process?

Mr McCabe: The regulations are still being drawn up and might well do so. As I said, I would be happy to share them with the committee before they are finalised and to take on board suggestions that members make. The caveat that I would add is that there should always be a test of reasonableness—members would expect me to say that. Obviously, a request to hand deliver a letter to every patient would be unreasonable, but posting a letter to every patient might be judged to be reasonable.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I think that the draft regulations state that the health board must notify changes in writing, although I cannot find where they say that. I went through them without a pencil—

Mr McCabe: The reference is to paragraph 80 of schedule 5 to the draft National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004. That is on page 76.

I do not mean to be flippant, but the difficulty is that "in writing" could be interpreted as meaning a bill poster that was stuck on a lamp post.

Dr Turner: Really? I would not have thought so.

Mr McCabe: It depends on how "in writing" is interpreted. That is where regulations that are properly scrutinised come into their own.

Dr Turner: I had assumed that "in writing" would mean that patients would be notified by a letter.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I may have missed what was said earlier, but I am interested in finding out more about the obligation to inform patients that will be placed on practices that opt out. I feel strongly that, as the practice is the direct link between the patient and the health service, patients should be informed by the practice rather than by a letter from the health board. In my opinion, if a practice has decided that it has a good reason to opt out of the new service, it should be under an obligation to contact patients about that. Perhaps health boards could be involved in informing people over a wider area. Can you give us further information about those obligations, or have they not yet been defined?

Mr McCabe: The obligations on practices that opt out are defined. Such practices must inform patients both by including the information in the practice leaflet and by posting a notice in the practice's premises.

Mr McNeil: Do the practice's obligations end there?

Mr McCabe: Yes, those are the only two obligations on the practice. I understand your argument about the practice's obligations, but I do not entirely agree with you. The contract is between the practice and the health board, so the obligation to make appropriate communications with patients will be placed on the health board that is party to that contract. That is the way that the matter has been thought through.

14:15

Mr McNeil: So the obligations on practices that opt out will be limited to what you have said. Can the issue be revisited so that the obligations on practices that opt out are extended?

Mr McCabe: The regulations have not yet been laid, so we would obviously take on board any view that the committee expressed. However, let me stress that the further subset of regulations that will deal with health boards will be very important. The committee will have an opportunity to influence the direction of travel of those regulations.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I think that all our questions have laboured the same point. In the end, I doubt that it matters to the committee whether the requirement to inform patients is placed in paragraph 80 of schedule 5, which states that

"the Health Board shall notify those patients in writing of the variation",

or in paragraph 6 of schedule 2, which specifies how practices should inform patients. From the patients' perspective, the important thing is that, if their practice opts out—as will sometimes happen—they will receive a letter to inform them of the situation.

If you are saying that the health board will have the role of notifying patients in writing, the "in writing" provision needs to be beefed up so that it is absolutely clear to health boards that that means sending a letter to those patients. That is what patients would expect.

Mr McCabe: I say again that I agree with those points. It is important that the information is communicated to patients clearly and in a manner that they can understand. Patients should not be placed under an obligation to seek out the information. For instance, I think that it would be unacceptable to assume that patients purchased a particular local newspaper and hope that they would notice an advert that appeared on a particular page on a particular day. That would not be enough.

I agree with the points that have been made, but I stress that the draft National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004 place that general obligation on the health board. That obligation will be defined far better in the further subset of regulations that I mentioned. I am happy to share those regulations with the committee before they are laid and I will be happy to take on board any ideas that the committee might have about how we define that obligation.

The Convener: We seem to be talking about three circumstances. First, there are proposed opt-outs, for which a letter or other communication would have to be sent to patients. Secondly, there are opt-outs that have been confirmed, for which another letter would have to be sent out. Is that correct? Paragraph 6(2) of schedule 2 goes on about the requirement on contractors to

"inform the contractor's registered patients of an opt out".

Thirdly, there are temporary opt-outs. Furthermore, practices that opt out could opt in again.

The mechanics will be quite interesting, in terms of people knowing where they are. There may be a temporary circumstance in a practice such that one of the practice members who performs one of the additional services cannot do it for a while, so the practice has to opt out for six months and then opt in again. I am commenting, rather than offering solutions, but it seems that there will need to be a lot of notifications in certain circumstances. Without wishing to pre-empt anyone's questions, I wonder how often practices will seek to opt out of the additional services. Are we talking about a small issue? We need to put it into context.

Mr McCabe: When I met representatives of the British Medical Association on Friday night and asked them what reaction they thought there would be to the changes, they seemed to think that we would encounter such circumstances rarely. They thought that there would be a low level of opting out of providing additional services—obviously, I am not referring here to out-of-hours services.

The Convener: Yes, the point is specifically on the additional services. You are saying that opting out will be a rarity.

Mr McCabe: That is the indication at the moment.

Mr Davidson: I have a comment on the back of the last discussion. I recently got a letter from the health board informing me that my dentist had given notice to retire. I gather that the letter went to every single one of the NHS patients registered in the practice. The onus was on the health board, not the practice. I throw that in in passing.

Will contracting for additional services be a matter for guidance or will the next set of regulations lay down how health boards will contract for additional services, because as I read it, it is in their power to decide which practices will be able to offer which services, quite apart from the qualifications of the practice. Is that a correct assumption?

Lorna Clark (Scottish Executive Health Department): Any practice that is providing the additional services at the moment will be able to do so when the new contract comes in on 1 April. Health boards will be able to decide who is going to provide an additional service only if the practice that is providing it at the moment opts out. If the practice wants to continue to provide the additional services, it will be within its rights to do so. The health board will not be able to take additional services from practices that want to continue to provide them.

Mr Davidson: That is helpful, thank you. That clarifies a couple of points.

The interpretation of enhanced services on page 7 of the draft National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004 refers to

"specifications set out in a plan".

Whose plan, and what are the rules for the production of such a plan?

Mr McCabe: Give me a second to find that. Did you say page 7?

Mr Davidson: Yes. It is about 10 lines up. It is under "enhanced services".

Mr McCabe: As far as I understand it, that indicates that the practice would have to lay out exactly how it would implement what it intends to do. It has to set out what is almost a business case for what it intends to do.

Mr Davidson: So it is a matter of negotiation between the practice and the health board.

Mr McCabe: The practice would lay out its original intentions, which the health board would consider and on particular aspects of which it might wish to comment or negotiate.

Mr Davidson: On page 11, subparagraph (a) is about the definition of "pharmacist" in the Medicines Act 1968. Subparagraph (c) refers to "a supplier of appliances", but that is a reserved title. There are suppliers of appliances who are not pharmacists, and who do not operate from registered pharmacy premises. Is that a hiccup, or does something somewhere else cover that?

Mr McCabe: I am not aware of that. The officials may be able to help me out.

Jim Patton (Scottish Executive Health department): That is based on the legal advice that we have received from Scottish Executives solicitors. It mirrors what happens south of the border in England and is included in order to keep the definitions parallel with each other.

Mr Davidson: I am happy not to have an answer today, if you would prefer to drop us a note about the matter.

Mr McCabe: I am happy to do that.

Mr Davidson: Further down that page, there is mention of

"a supplementary prescriber, who is either engaged or employed by the contractor or, where the contractor is a partnership, is a partner in that partnership".

We have just had an announcement about the first set of supplementary prescribers who are pharmacists, but none of the ones that I have seen are anything other than self-employed. They are contractors, but on a different basis. Is their situation covered? The Executive is putting money into universities to help to train those people. Would you like to come back to the committee on that issue?

Mr McCabe: I would not mind a wee bit more elaboration on the point.

Mr Davidson: Very simply, the Robert Gordon University school of pharmacy announced in the press last week that the first fully trained and certified supplementary prescribers who are pharmacists are not actually employed by a contractor in the sense that it is a current GP practice, because they are out there in the community. Are such people covered under the regulation? Unless I have misread the regulation, it appears that they are not covered. I am happy if you want to come back to the committee on that technical point.

Mr McCabe: We will come back on that point, which is fairly technical.

Lorna Clark: There is a definition that relates specifically to the regulation. Different definitions may apply to different sets of circumstances. We will write to the committee on that issue.

Mr Davidson: I am trying to head off a situation in which people out there misread the regulations and seek advice. Those people have spent time and some of their money getting themselves into a situation in which they assumed that they would be entitled to practise.

Mr McCabe: We will try to clarify that matter.

Mr Davidson: Fine.

On page 15, regulation 5(4), which is about a third of the way down, states:

"Where a person has been employed as a member of a health care profession any subsequent employment must also be as a member of that profession."

What happens if somebody moves to teaching and then goes back into practice? Will they be covered by that provision, assuming that they are still registered in whatever field they are in?

Mr McCabe: My understanding is that such people will still be covered, as long as they are registered with the relevant professional body.

Mr Davidson: But they do not actually have to be employed in that capacity.

Mr McCabe: Do you mean in the interim period?

Mr Davidson: Yes.

Mr McCabe: No, but when they take up the employment again, it must be in one of those capacities.

Mr Davidson: On page 26, in schedule 1, under the heading "Contraceptive services", paragraph 3(2)(d) mentions "emergency hormonal contraception". Strictly speaking, should that not be "emergency hormonal termination"?

Mr McCabe: No, I do not think so.

Mr Davidson: That is accepted terminology.

Mr McCabe: Yes.

Mr Davidson: Fine. I was just checking.

The word "appropriate" appears regularly throughout the document. I presume that a definition exists for each and every use of the word.

Mr McCabe: I am sure that our learned friends have a legal definition of the word "appropriate".

Mr Davidson: Fine.

Does paragraph 63(6) on page 71 cover holiday and illness cover?

Lorna Clark: It is not about emergency cover or holiday cover; it is about sub-contracting out the services.

Mr McCabe: Yes.

Mr Davidson: I understand. I beg your pardon. I misread it.

Lorna Clark: It is about formal sub-contracting and not holiday cover.

Mr Davidson: You have covered some of the other points that I wanted to raise, minister. Thank you.

My last question relates to paragraph 15(1) of schedule 1 to the draft National Health Service (Section 17C Agreements) (Scotland) Regulations 2004, which is to be found on page 24 of the second draft. I am referring to the first appearance of the comments that appear in square brackets with the prefix "DQ". Thereafter, a series of such comments appear throughout the document. Will you explain them?

Lorna Clark: That is a question of drafting. It shows how much the regulations are still works in progress. What the comments in brackets mean is that either we or our lawyers have noticed points that we need to think a bit more about and return to before we finalise the document.

Mr Davidson: But they will come back to us eventually.

Lorna Clark: Yes, absolutely. That will be done very soon.

14:30

Shona Robison: I will keep my question short. I turn to page 87 of the original draft and to paragraph 104(1) of schedule 5 to the draft National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004. I seek a point of clarification. Subparagraph 104(1) begins:

> "Where the contractor is a company limited by shares, if the Health Board becomes aware that the contractor is carrying on any business which the Health Board considers to be detrimental to the contractor's performance of its obligations under the contract",

and goes on to describe the entitlement of the health board to "give notice" and so forth. Does that refer to a conflict of interest situation? If so, could you give us a couple of examples of what that covers?

Mr McCabe: I do not think that we have a wide definition at the moment. It is a general regulation that aims to protect the best interests of patients. If anyone with whom a health board has contracted is engaged in other activities that in any way whatever—and I think that we want to keep it as wide as that—is judged to be detrimental to the level of service that they are supplying to the board's patients, the regulation gives the board a lever in those circumstances.

The regulation helps to underline our determination that, when a health board contracts with a party to deliver primary medical services, we hope that those services will form their main function. We want to ensure that nothing unnecessarily distracts the party from concentrating on that activity.

Shona Robison: I am trying to think back to the concerns that were raised during the passage of the bill about the involvement of private companies in the provision of primary medical services. I think that the questions about those concerns were answered adequately at the time. We understood at the time that there would be an element of control over the provision of those services. I am trying to think of examples of how things will work in practice. Are you thinking about a company that is providing those services but is also involved in other activities that might be thought to be dubious?

Mr McCabe: Take, for instance, an extreme example of a practice with three doctors and four practice nurses in which we discovered that all three of the doctors were spending 50 per cent of their time providing private services and that the nurses were also involved in an activity of that kind, which meant that the practice found it difficult to live up to its obligations under the contract. If that were the case, the board would have the ability to move in and say, "The service that the practice is providing no longer suits our purpose. It is clear that you are not dedicating enough time to properly service your patients."

Shona Robison: How would that be monitored? How would it come to the attention of the health board in the first place?

Lorna Clark: There is a general monitoring scheme that will oversee what happens between the practice and the health board. There will be an obligation on the health board to ensure that it knows what the practice is doing and that it is aware of the standard of service that is being provided.

That will be done partly through an annual monitoring visit and partly through continuing discussions about how the services are going. The matter could come up through the monitoring process or through patients complaining that they are not getting an appropriate level of service; there are several routes whereby that information can come back to the health board. I imagine that the main route will be through the contract monitoring that will occur between the practice and the health board.

Shona Robison: There is nothing to stop such companies being involved in private work. You are saying that that would become an issue only if it impacted on the company's ability to fulfil the contract. If it was fulfilling the contract, there would be no bar to it being involved in whatever it wanted to be involved in.

Lorna Clark: They are not allowed to undertake

certain activities, particularly those around private practice and treating NHS patients privately. There are lots of rules about what doctors may do privately and what they may do for the NHS—those rules are a separate part of the regulations that we have to sustain. The issue is about making sure that the level of service that a practice provides is not damaged by any other work that it does.

Mr McCabe: Private practice is a good example, but there may be a raft of other examples.

The Convener: I would like to ask you about three areas, all of which concern the draft National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004. First, I have a general question on fees and charges, which are dealt with in schedule 4, on page 41. Have there been any changes to the fees and charges that are levied? Have any fees or charges been added to or removed from the list?

Lorna Clark: My understanding is that the list represents a continuation of the current circumstances.

The Convener: Secondly, on the removal of patients from lists at the request of the contractor, paragraph 20(2) of schedule 5, on page 48, refers to cases where, in the contractor's reasonable opinion:

(a) the circumstances of the removal are such that it is not appropriate for a more specific reason to be given".

In other circumstances, more specific reasons are appropriate. Also, if

(b) there has been an irrevocable breakdown in the relationship between the patient and the contractor",

the contractor may simply give that breakdown as the reason for removal.

I understand that the record will be kept by the practice in such cases, and that the board will have access to that record. Will the board be in a position to ask for more specification if the contractor says simply that it is not appropriate for specific reasons to be given and that there has been an irrevocable breakdown? Could the board ask for more detail, perhaps in circumstances in which a pattern develops?

Mr McCabe: Yes, very much so.

The Convener: Thirdly, I have a general question on the complaints procedure, which is covered in Part 6 of schedule 5 to the regulations, on page 77. I do not want to prolong this, but perhaps you will explain to me briefly what difference the regulations make to the current complaints procedure. I understand that complaints procedures throughout the NHS are under review—how does this fit in?

Mr McCabe: The document refers to complaints that are specifically on primary medical services. You are right to say that there is a general thrust to achieve a far more transparent and accessible system for patients to lodge a complaint against a range of activities in the national health service, and there is a continuing programme to try to develop that.

The Convener: I understand that, but I asked you where the regulations fit in. When will the general complaints procedure be in the public domain? The other part of my question asked how the regulations vary from the existing complaints procedure.

Mr McCabe: As far as I know, they do not vary very greatly at all.

The Convener: It has been put to me by practitioners that the involvement of the Scottish public services ombudsman is new—is that the case?

Mr McCabe: No.

The Convener: It is not.

Mr McCabe: I could almost certainly say no.

The Convener: So the procedure is exactly the same as previously—you have just standardised it. That is all that I had to ask.

Mike Rumbles: On the convener's point about the removal of patients from lists at the request of the contractor, paragraph 20 of schedule 5 to the regulations states that

"Subject to paragraph 21, a contractor which has reasonable grounds for wishing a patient to be removed from its list"

must notify those grounds to the patient except where

"in the reasonable opinion of the contractor … it is not appropriate for a more specific reason to be given".

To me, that seems strange. As with other MSPs, many people write to me with complaints about that practice. In the 21st century, is it reasonable for a contractor to remove somebody from its list and not tell them why? To me, that is unreasonable. Will the minister comment on that?

Mr McCabe: The caveat always applies that the situation depends on the circumstances. In general, that situation would be unreasonable, but some circumstances might invoke that approach. Health boards are obliged to monitor the way in which and the frequency with which a practice removes people from its list. If a practice felt that circumstances occurred regularly in which it could not give a fuller explanation, a health board would be able to express its opinion, as part of its contract with a practice, that the practice was putting an extraneous interpretation on the regulations.

Mike Rumbles: I accept that entirely. A health board could pick up a pattern. However, I am taking the individual patient's point of view. The event happens to them just once. It is hardly any benefit to an individual patient if a health board picks up a pattern. That might help other people later, but it would not help that patient. In the 21st century, should an individual patient know the grounds for their removal from a contractor's list? The regulations refer to the

"reasonable opinion of the contractor".

The contractor does not have to give an explanation. That is wrong. I do not understand the reason for that provision.

Mr McCabe: In a range of circumstances, a practice might believe that an explanation was not in the patient's best interests, for instance.

Mike Rumbles: I cannot believe that a practice should not tell the patient that.

Mr McCabe: The patient also has recourse to the complaints procedure through the health board. If the patient was unhappy that the practice did not go into detail about the reasons why they were removed from the list, that patient could complain to the health board and the circumstances would then be examined. I understand that no situation exists in which a health board could compel a practice to give those reasons, but if a health board upheld a complaint, a practice would have to think twice before engaging in that activity again. It would have to ensure that it could justify invoking that reason.

Mike Rumbles: I return to the point that that is fine and will sort things out in the long term for everybody, but the individual patient who may feel aggrieved has no redress and receives no benefit.

Mr McCabe: If a patient complained about a practice's reluctance to specify reasons and the complaint was upheld, the patient would at least know that the practice was wrong to behave in that manner. However, I do not know whether anything could be done to compel a practice to reveal the reasons. I could be wrong about that and I am certainly prepared to examine the matter.

Mike Rumbles: That would be helpful.

The Convener: What the minister just said conflicts with what he has told me. On page 49, paragraph 20(7) of schedule 5 says:

"The contractor shall keep a written record of removals under this paragraph … and shall make this record available to the Health Board on request."

That record would not have specific reasons. The minister told me that an NHS board could say that it wanted to know specific reasons.

Mr McCabe: A health board can do that.

The Convener: That provision applies without a complaint from a patient.

Mr McCabe: A health board can ask a practice for the reasons, but it would not be at liberty to disclose that information.

The Convener: I understand.

Paragraph 20 also says that patients cannot be removed from a list for several classes of reasons, two of which are disability and medical condition. For the record, I want to know that that also relates to mental disability or a mental medical condition, not just a physical one. Sometimes we get mail that refers to people with certain mental difficulties and disabilities that bring them into conflict with their practitioners.

Lorna Clark: That would certainly be true. The only circumstance in which a practice could refuse to treat a patient for a particular condition is if they were being treated through an enhanced service and the health board had contracted with someone other than that practice to provide that service. That would then only be for that particular treatment.

The Convener: The reason has to be a medical one; that was my point.

Lorna Clark: Yes.

14:45

Mike Rumbles: I did not make the link with paragraph 20(7). If a patient is removed from the list and wants to know why, and the contractor does not tell that person, that person can make a complaint to the health board. Under paragraph 20(7) of schedule 5, the health board can obtain the reasons for the patient's removal and the health board would be able to give the individual the reason for their removal. If that is the case, then I am satisfied.

Mr McCabe: Are you asking if the health board could tell the individual?

Mike Rumbles: Yes. If that is the case then I am happy.

Mr McCabe: As far as I know, that is not the case.

Mike Rumbles: So the contractor and the health board will know the reasons for removing an individual patient, but the individual patient will not.

Mr McCabe: Yes.

Mike Rumbles: That is wrong. That cannot be right.

Mr McCabe: The health board and the contractor would have to have specific reasons for not imparting that information, and they are defined in paragraph 20(4), where the contractor

believes that the information would

"be harmful to the physical or mental health of the patient;"

or it would

"put at risk the safety of the persons specified in sub-paragraph (5)".

There is a range of other reasons in the legislation. For example, those "persons specified" could be members of the contractor's staff.

The Convener: With respect, minister, that appears to refer only to subparagraph (3) and not subparagraph (2).

Mr McCabe: I am reading from subparagraph (4).

The Convener: Subparagraph (4) says

"The circumstances referred to in sub-paragraph (3)".

It does not include subparagraph (2), unless I am misreading it. Subparagraph (3) relates to giving a patient notice of removal from a list.

Mr McCabe: Yes, it does.

The Convener: Subparagraph (4) does not relate to subparagraph (2).

Mr McCabe: I think that you might be right, convener.

Mike Rumbles: Could the minister look at the regulations again?

The Convener: The problem is that the regulations have to be laid. There are obviously concerns, and clarification is needed about the operation of paragraph 20 of schedule 5. In his evidence, the minister made it plain that there are no third-party rights under the contract, so no third party, or patient, has a right to information. Am I correct in summarising that there are concerns that human rights might be being sidestepped just a little?

I appreciate that there can be circumstances when it would not be appropriate for people with certain serious mental conditions to be told. It might be destabilising for them, or there might be a medical reason for not telling them. However, if it is not a medical decision, I wonder why the details cannot be given to the patient.

Mr McNeil: The reasons are outlined at the beginning of the procedure. People are warned at that point that they might be removed from the contractor's register and they are given reasons for that.

Lorna Clark: Unless there are particular grounds for not giving those reasons.

Mr McCabe: In the majority of cases, the patient will have had prior warning. There might be specific circumstances when that is not appropriate.

The Convener: It will be the hard cases that test that.

Mr McCabe: I understand the difficulty. We are trying to be transparent and create a climate within the health service where people have access to as much information as possible. I am happy to take that issue away and perhaps think about a further method of appeal when a patient has been refused the reasons to ensure that there is a second view of the reasons and that a test of reasonableness is applied. That may give people comfort that the decision of the practice is not final and that another look could be taken at the matter.

The Convener: I think that we are content to move on.

Mike Rumbles: I am very happy with that response.

The Convener: We are content to move on. Helen Eadie has been waiting patiently to comment.

Helen Eadie (Dunfermline East) (Lab): That is exactly the point that I was going to raise with the minister: we have a flow of dispute resolution that does not end up with an appeal situation. However, the minister has said that he will consider the issue, so I am happy with that.

Mr Davidson: I have a general question about paragraph 12 of schedule 5 to the draft National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004, on the

"Duty of co-operation in relation to additional, enhanced and out of hours services".

If the situation is that a practice has opted out of providing an out-of-hours service and there is a duty of co-operation, how will another practice—an out-of-hours co-operative or whatever—be given access to a patient's records? Is that implied within the duty? Most members will have had cases where difficulties have arisen because a locum or emergency turnout facility has not been able to access a patient's records.

Jim Patton: In those circumstances we are talking about what is reasonably practicable for the contractor who has opted out to do to provide the records. We would not expect a contractor to get out of his bed at 12 o'clock at night to open up his surgery to access the patient's medical records when he has devolved his responsibility. Therefore, I presume that the records would be available during the normal working day and through the computer system that NHS doctors and GPs use. The key phrase is what it is reasonably practicable for the GP who has to co-operate to provide within core hours.

Mr Davidson: I will not be the only member who

has had several cases of something going wrong because a provider of an out-of-hours service could not access prior medical records. They were trying to deal with a current situation and they did not realise that there was another problem.

When I operated an out-of-hours service in conjunction with an out-of-hours service supplier when I was in practice down south, there was a facility where, by arrangement, out-of-hours services had access to patients' surgeries—in other words they had a key and had been trained in how to get in and get records—if they felt that that was required—without disturbing those who had opted out, if I can put it that way. Is such a duty of co-operation implied within the regulations?

Some serious issues have been coming up and a lot of them will end up in litigation if we are not careful. Where is the practical application of the duty? We do not yet have a national database system—I think that people are working on that but we do not have it yet—that would enable an accredited deliverer of an out-of-hours service to access records by electronic means. Until such a system is in place, will there be a duty of co-operation on the practice to set up an arrangement for access to patient records that is approved by the health board?

A voluntary system is currently in operation that means that when someone has a series of conditions doctors voluntarily lodge those with out-of-hours services, but it is not totally inclusive. If we are going to go down this route, will that be part of the system?

Mr McCabe: It is difficult for us to predict every clause that would be contained within a contract for additional or enhanced services. It would not be unreasonable if a clause were inserted that states that it is very much an exception, because it would be an exception when access was required to the records in the out-of-hours period. It would not be unreasonable for there to be a clause in a contract that coped with such rare exceptions, but I stress that it is difficult for me to make predictions about that. We will certainly issue guidance on the matter and we can bear that point in mind when we draw it up.

The Convener: Unless there are further questions, the only point that I can add—[*Interruption.*]

Sorry—Jean Turner wants to comment. The clerk and I had not noticed that she wanted to speak.

Dr Turner: I refer to schedule 2:

"opt outs of additional and out of hours services".

Paragraph 1(7) states:

"Where a contractor has given two previous temporary opt out notices within the period of 3 years ending with the date of the services of the latest opt out notice (whether or not the same additional service is concerned), the latest opt out notice shall be treated as a permanent opt out notice (even if the opt out notice says that the contractor wishes to opt out temporarily)."

I got the impression that doctors could change their mind about opting in and out. It would appear that if they opt out temporarily twice in quick succession they might have difficulty changing their status. How difficult would it be for the doctors to change their mind?

Mr McCabe: That paragraph is designed to provide flexibility in dealing with situations that are thrown up. There might be a range of reasons why a practice decides to opt out temporarily. If a practice is opting out regularly—we have defined regularly as three times within three years—a decision would have to be made one way or the other.

Dr Turner: So it would be decision time for the practice.

Lorna Clark: We are trying to provide continuity of service for the patient. A practice can opt out twice within three years, but we would treat the third opt out as a permanent opt out.

Dr Turner: So the practice would need to have a jolly good reason for having changed the way that it worked?

Lorna Clark: Yes.

Dr Turner: That is fine.

The Convener: I have made sure that Jean Turner does not have any more points.

I was interested in what the minister said about the lists and the possibility of an appeals procedure. It is my understanding that the regulations have to be signed off by 9 March and laid on 10 March. I do not want to put you on the spot, but does that mean that the committee would know in advance of those dates whether you were proceeding with inserting in the regulations provision for an appeals procedure or whether that would require to be delayed?

Mr McCabe: We certainly want to avoid any delay, because the regulations come into force on 1 April. Depending on the hours that my colleagues Lorna Clark and Jim Patton—and their colleagues—are prepared to work between now and 10 March, we might have a resolution. I can only assure you that we will do our best to achieve a resolution and communicate it to you before the deadline.

The Convener: Alternatively, you could tell us the reasons for a resolution not being reached, so that the committee would know in advance.

Mr McCabe: We will certainly strive to do that.

The Convener: Thank you. As there are no other questions, I close the evidence session and the meeting.

Meeting closed at 14:57.

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