HEALTH COMMITTEE

Tuesday 26 October 2004

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by Astron.

CONTENTS

Tuesday 26 October 2004

HEALTH COMMITTEE
23rd Meeting 2004, Session 2

CONVENER

*Roseanna Cunningham (Perth) (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)
Mr Stewart Maxwell (West of Scotland) (SNP)
Mrs Nanette Milne (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Rhona Brankin (The Deputy Minister for Health and Community Care)
Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP)
Carolyn Leckie (Central Scotland) (SSP)
Martin Reid (Food Standards Agency Scotland)

THE FOLLOWING GAVE EVIDENCE:

David Currie (NHS Consultants Association)
Dr Lesley Holdsworth (Allied Health Professions Forum Scotland)
Dr Hew Mathewson (General Dental Council)
Stephen Moore (Allied Health Professions Forum Scotland)
Dr Bill O'Neill (British Medical Association)
Professor Peter Rubin (General Medical Council)
Dr Mairi Scott (Royal College of General Practitioners Scotland)
Marc Seale (Health Professions Council)
Professor Graham Teasdale (Royal College of Physicians and Surgeons of Glasgow)
Ray Watkins (Chief Dental Officer)
Professor Tony Wildsmith (Royal College of Anaesthetists)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 4

Scottish Parliament

Health Committee

Tuesday 26 October 2004

[THE CONVENER *opened the meeting at 14:02*]

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No 4) (Scotland) Order 2004 (SSI 2004/417)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 11) (Scotland) Order 2004 (SSI 2004/418)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (Scotland) Order 2004 (SSI 2004/435)

Food Protection (Emergency Prohibitions) (Diarrhetic Shellfish Poisoning) (East Coast) (No 3) (Scotland) Order 2004 (SSI 2004/436)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 12) (Scotland) Order 2004 (SSI 2004/447)

The Convener (Roseanna Cunningham): I welcome the new Deputy Minister for Health and Community Care to the committee for what I suspect will not be too onerous a task in her first showing. I also welcome Martin Reid from the Food Standards Agency Scotland.

The committee is asked to consider five affirmative instruments on amnesic and diarrhetic shellfish poisoning. The Subordinate Legislation Committee had no comments to make on SSI 2004/417 or SSI 2004/418, which it has considered. This morning, the Subordinate Legislation Committee also considered SSI 2004/435, SSI 2004/436 and SSI 2004/447; similarly, it had no comments to make on those instruments. Accordingly, no points arise on the instruments as far as the Subordinate Legislation Committee is concerned.

Does any member wish to seek clarification on the instruments from the minister and Mr Reid? David Davidson has a question.

Mr David Davidson (North East Scotland) (Con): Thank you, convener. You are remarkably well trained for such a short time in the chair.

I have a simple question for the minister. I am not seeking a full debate, but I would like a response from her in the light of the comments that her senior colleague made on his first visit to the Health Committee. From what he and the representative from the Food Standards Agency said, I got the impression that the ministers had no problem with the Irish system of end-product testing, which is acceptable to the European Union, but the minister went on to say that it simply was not good enough for Scotland. Will you confirm whether I am right in thinking that, at a time of seasonal difficulty in the sector, Irish produce can be taken from the sea, go through end-product testing and be sold in Scotland, but Scottish products cannot? If that is the case, why is the minister not considering more firmly a move to end-product testing so that our industry is not disadvantaged?

The Deputy Minister for Health and Community Care (Rhona Brankin): Thank you very much, convener. I am delighted to be here and look forward to working productively with the committee.

I understand that, at this stage, we are not satisfied that end-product testing that is as accurate as we would like it to be is available. My further understanding is that the discussions about the transposition of the European directive into Scottish regulations, which are already taking place with the industry, will include consideration of end-product testing, so the door on end-product testing is not closed. However, I understand that, at the moment, we in Scotland are not satisfied that we are in a position to carry out end-product testing that will give us satisfactory public safety levels.

Martin Reid (Food Standards Agency Scotland): As far as the situation in Scotland is concerned, new European legislation is about to come through, which will take effect from 2006. We are in negotiations with the industry on the balance between official controls, which the Food Standards Agency carries out, and the requirements for industry to carry out end-product testing. We must ensure that we get a satisfactory balance as regards the protection of public health. There are some difficulties with end-product testing to do with various methods that are available to the industry. Much reliance is placed on the official sampling and monitoring that we carry out. We need to work with the industry on striking the correct balance in the regime. What that proportionate balance should be is part of continuing discussions with the industry.

Mr Davidson: I thank the minister for a much more positive response than that given by the previous incumbent of her post. I welcome any reflection on the Executive's previous position, but I ask the minister to answer my first question. Given that there is a public safety concern—no one disputes that that is what the issue is all about—what moves have you made to deal with the possibility of the Irish product being available when the Scottish product is not? Is it simply the case that the Irish have got their end-product testing in place to a satisfactory European standard? Is that the direction in which you are trying to head?

Rhona Brankin: Before I hand over to the official, I will say that, as a minister, my initial responsibility must always be to ensure that we have adequate regulations in place in Scotland that protect the safety of its people. That must always be my first priority.

Martin Reid: The Food Standards Agency has never commented specifically on the regimes that are operated in other member states. It is for the food and veterinary office of the European Commission to assess the acceptability or otherwise of the various regimes that exist in different member states.

In Scotland, we are conscious of the impact that closures have on the industry. At present, we operate what we call a shucking regime, which means that areas that would be closed if the whole animal tested above the current action levels are allowed to continue to be fished and exploited by the Scottish industry, subject to the implementation of that shucking advice. Although that is a different type of concession to that which is operated in Ireland, it is a concession. The continuation or otherwise of that concession will form part of the discussions that we have with the industry over the coming months as we move towards the implementation of the new regime. There are different ways of approaching the problems of toxins, but we have implemented at least one significant measure to help the industry.

Mr Davidson: I thank the minister and Mr Reid for that and I repeat my offer to meet the ministers to discuss some scientific papers that have been sent to me, which are relevant to their discussions for the future.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The committee considers a large number of such orders and it obviously takes time to consider what is an important issue. However, the committee does not consider the lifting of restriction orders. On average, how long do such restriction orders last?

Martin Reid: That is a very difficult question. Some of the restrictions can be quite short term—they might last two, three or four weeks. Others have lasted for the best part of a year. The toxin levels fluctuate significantly.

Predicting exactly the impact of closures is a difficult business. We know that some areas are more susceptible and we target our sampling on them. We also target our sampling on areas that we know that the industry exploits. Our sampling programme is focused.

In addition, as we did last year, we will this Christmas reassess the programme and examine the closed boxes that we know are active boxes. We will focus our sampling resources on those areas to try to minimise the time for which they are closed. If the levels are still high, we can do little about that, but we can test as frequently as possible in the areas that the industry finds it particularly beneficial to have open.

The Convener: If the information that statutory instruments have been lifted is available, perhaps you could provide it by e-mail or in another fashion.

Martin Reid: We will notify the committee when openings have occurred if that is helpful.

Mike Rumbles: Once testing shows that toxins have reached a safe level, how long does it take to lift an order?

Martin Reid: We must have a minimum of seven days between two samples that are below the action level in order to lift a restriction. That will be changed. The new regulations that come into force in 2006 will cut that to 48 hours, but a question has been raised about ensuring that a boat is out there to pick up a sample, so logistical problems are involved. At the moment, seven days is the minimum. As I said, at Christmas time, when we are trying to be a wee bit more focused and as helpful as we can be to the industry, we will try to minimise the period between samples.

The Convener: I am advised that we are told when statutory instruments are closed—or whatever the official term is for saying that they are no longer in force. Perhaps we have just not had any such instruments recently; I do not know. I do not want to prolong the discussion.

Mr Davidson: I want to say just that the committee receives notice of revocation orders—the official action to lift an order.

The Convener: We have obviously not received such an order since I became convener.

Rhona Brankin: If it helps, we could prepare a short paper for the committee that sets out what has happened on opening and closing in Scottish waters overall and sets out the pattern.

The Convener: That would be useful—thanks very much.

The committee has no further questions. I thank the minister and her official for attending. I have no doubt that we will see you in future.

Rhona Brankin: Regularly, I fear— [*Interruption.*]

The Convener: I am sorry, but before you head off—

Rhona Brankin: I need to move the motions—do not let me go without doing that.

The Convener: I was getting slightly ahead of myself, because I know that we have much to do.

No member wishes to debate the instruments and no member objects to a single question being put on the motions, so I invite the minister to move motions S2M-1809, S2M-1810 and S2M-1871 to S2M-1873.

Motions moved,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No.4) (Scotland) Order 2004 (SSI 2004/417) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.11) (Scotland) Order 2004 (SSI 2004/418) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (Scotland) Order 2004 (SSI 2004/435) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Diarrhetic Shellfish Poisoning) (East Coast) (No.3) (Scotland) Order 2004 (SSI 2004/436) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.12) (Scotland) Order 2004 (SSI 2004/447) be approved.—[*Rhona Brankin*.]

The Convener: The question is, that motions S2M-1809, S2M-1810 and S2M-1871 to S2M-1873 be agreed to. Are we 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

Cunningham, Roseanna (Perth) (SNP)
Robison, Shona (Dundee East) (SNP)

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

Motions agreed to.

The Convener: The deputy minister can go now.

Work Force Planning Inquiry

14:14

The Convener: I ask the first panel of witnesses for our work force planning inquiry to come forward. The panel comprises Professor Tony Wildsmith, who is a Royal College of Anaesthetists council member; Dr Mairi Scott, who is the chair of the Royal College of General Practitioners Scotland; and Professor Graham Teasdale, who is the president of the Royal College of Physicians and Surgeons of Glasgow. We will move on to questions and Jean Turner wants to go first.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): This might not be an easy question to answer, but what are the witnesses' impressions of the work force planning process in Scotland?

The Convener: Do we have a proper work force planning process in Scotland?

Professor Graham Teasdale (Royal College of Physicians and Surgeons of Glasgow): In the past, such a process has been lacking. However, during the past two years there have been many developments and improvements and the foundations of planning for the future look much more secure.

Dr Mairi Scott (Royal College of General Practitioners Scotland): Work force planning for general practice is complex, because we are independent practitioners. That has had an impact on the number of general practitioners who are in the work force and the issue is of concern to us. As Graham Teasdale said, we are beginning to see a way forward, but much remains to be done and we have some catching up to do on GP work force planning.

The Convener: We are having a bit of a problem with the sound, which is not projecting well. Could people speak up a little until we establish what is wrong? At this end of the table we are having difficulty hearing what is being said.

Professor Tony Wildsmith (Royal College of Anaesthetists): I know that I am the deafest person in the room; that is why I am wearing headphones.

My specialty has been in reasonable balance for five or six years—provided that any outside factors have been fed in soon enough. Our perceived current problems relate to the impact of the European working time directive, which has created a need for extra consultant or other career-grade staff that cannot be met in a short time.

Dr Turner: I and many others have always regarded general practice as bearing the burden of changes in the national health service, such as centralisation and the reduction in the number of hospitals. Is Dr Scott worried about how we will fund the numbers of GPs that will be needed to cope with the new contracts and the new work loads that will come the way of GPs?

Dr Scott: Yes, we are worried. There is capacity and capability within general practice and primary care to deal with many of the issues that will arise from service redesign. However, adequate resourcing will be needed, some of which will be about increasing training opportunities in the current and the new programmes. Resourcing considerations will need to take account not just of the number of opportunities for people to take part in the training programme, but of the support that the established GP principals, practitioners and trainers can give and of the structures in NHS Education for Scotland and the colleges for delivering that training. There are opportunities for us to deal with the issues, but we will need considerable resourcing to deliver on them.

Dr Turner: Are you worried about the number of staff that might be available in hospitals as you increase the teaching of young doctors who come along? Are there enough consultants or senior registrar-equivalents in hospitals?

Dr Scott: An important thrust of the new training for general practice is that more training should take place in the general practice setting. I can say confidently that we will have the capacity, particularly if we grow the work force over a couple of years, to deliver that training. However, the emphasis on the hospital component of training continues to concern the Royal College of General Practitioners Scotland, not least because we consider the proportion to be inappropriate. Some training posts deliver excellent generalist training to future GPs, but some do not.

Dr Turner: I address this question to all the witnesses, but it might be interesting to hear from the consultants' perspective. Do you have concerns about the new contracts? I am thinking about the differences between the contracts in Scotland and England. It seemed from the submission that you were worried about the United Kingdom initiatives as opposed to the possible implications of our approach to work force planning being slightly different.

Professor Teasdale: I think that you want me to respond to that, Dr Turner. There are a number of aspects to the new contracts. The first is that how they have been introduced at trust health board level has created tension between the time that people spend providing clinical service and the time that they have for education. Quite naturally, trusts and doctors have tended to give priority to clinical service, but the feedback that we receive is that that is at the expense of commitment to

education. We surveyed our members and about a third of them felt that the new contract arrangements were impeding their involvement in training.

The second aspect is the bigger picture: medical staffing is a worldwide market. The change in England and Wales has been the introduction of foundation hospitals. The extent to which those hospitals will abide by national terms and regulations is causing a lot of concern. I was talking to English colleagues yesterday and the information that they have is that those hospitals will not abide by the national terms and regulations; they will offer premium salaries to attract people.

Dr Turner: That is an obvious concern because we already have a staffing problem and more people might go south.

Professor Wildsmith: I agree absolutely with that.

The Convener: Does Mike Rumbles wish to ask a question?

Mike Rumbles: I wanted to ask a specific question about the submission.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The second paragraph in Professor Teasdale's submission makes the general point about the need to recruit more people to allow training to take place. How significant is what you say in that paragraph, for example the remarks about off-the-job training and training that takes people off the job? It is my observation that a lot of training takes place on the job. From our point of view, there are many opportunities for that: clinics and peripheral hospitals allow such training to take place. New ways of training, such as through software packages, are not mentioned in your submission. Are we in a box? Is it that we know where we are at present but not where we would like to be? Although your submission identifies the problem, it is a bit short on proposed treatment.

Professor Teasdale: We are not in a box; we are on a very fast-moving runway. The situation is changing more rapidly than anyone in the profession or the Executive expected.

One factor in that change is the reduction in the hours that junior doctors work. That has been quite a development. It means that they are spending realtively less time in hospital during the day and more providing cover at nights and weekends when elective work—training in the major type of work—is not available. I saw a presentation that indicated that, in the new system, some surgical trainees experience of elective operations has been cut by half. The numbers are one consideration, but it is the time available that doctors have to train, as well as the time in the week, that is constraining training.

Some of the service provided is to keep the system going. It is well recognised in reports from the Health Department over many years that Scotland and the UK depend on the activities of junior doctors to support the service. Quite rightly, the view is now accepted that we want people to be cared for by trained people and that, as time goes on, junior doctors should be spending more time on specific training opportunities and less in the old apprenticeship system. The training capacity exists, but it is the amount that can be taken advantage of in present and future arrangements that is a concern. It is inevitable that we are looking at a situation where the input from junior doctors will not be what sustains the service—that will have to come from other sources.

Mr McNeil: I accept that. I speak to consultants in hospitals and I know that as well as junior doctors not being available when they are wanted, consultants are sometimes left with a major clinic while the junior doctor opts to be somewhere else in the hospital. Is it time to examine the new junior doctors' deal, given its impact on patients and services, at least in the short term?

Professor Teasdale: The legislation that has made the biggest impact has been the European working time directive, which came into effect in August and with which I am sure members are familiar. It limits the time that a person can work in 24 hours—a person must have 11 hours rest in 24 hours. One problem was that the original legislation dealt with only two states—working and resting. That created a difficulty because if a doctor is in hospital providing cover and gets a full night's sleep, is that work or rest? Two court judgments have defined that situation as work, which has given rise to many of the intense pressures. Whether the judgments are right or appropriate is a topic that the committee might debate with other colleagues, such as the representatives of the British Medical Association. The issue is being considered. The European Commission has issued a consultation to consider the definitions in the light of the judgments.

Mr McNeil: It may be more appropriate to ask the BMA about that.

Mike Rumbles: I will focus on Dr Scott's written submission, which I found genuinely fascinating, especially the table on the number of GP training posts. I analysed the figures and found that the Royal College of General Practitioners Scotland is saying that in the past 10 years we produced on average 270 doctors a year, while in the 10 years before that we produced on average 318 a year. We produce fewer doctors now than we did 10 years ago and we produced fewer then than we produced 20 years ago.

The submission states that a deficit of about 500 GPs is expected in eight years. The figures also show that there has been a 50 per cent increase in the number of female doctors who are produced—65 per cent are now females. The past record shows that female doctors have a greater incidence of taking time out. The problem about the number of GPs has been exacerbated, but it has not happened just now. Your figures show that the reduction has been sustained and has happened over a lengthy period.

I have two questions. First, given that the Calman report recommends that we should train another 100 doctors a year, how far would that go to solving the projected shortfall of 500 doctors in eight years? My second question is the one on which I would like you to focus. What responsibility does the Royal College of General Practitioners Scotland have for not alerting politicians to the situation in the past 20 years?

Dr Scott: I will answer the second question first. We have been talking about the issue for the past few years. Work force planning for general practitioners is a complicated issue. We did not compile the figures alone, but with NHS Education for Scotland and the Scottish general practitioners committee of the BMA. Because GPs are independent practitioners, it is difficult to count up the number of hours that any one doctor gives to the service. Some GPs will be on a list and may contribute only one session a week as a locum, whereas others are full-time practitioners in a practice who deliver 10 sessions a week. The numbers game is complicated.

The number of training opportunities is at present limited by funding constraints. We have given figures on the present output. If more GPs are to be trained, the Executive would have to fund additional training slots.

Mike Rumbles: How appropriate is the Calman recommendation that 100 more doctors should be trained every year? If the Scottish Executive funds the recommended number of 100 a year, will that solve the problem in the long term?

14:30

Dr Scott: No, that would not solve the problem in the long term, because those extra 100 doctors would not all be general practitioners. That number would be the increase in the number of graduates from medical school, some of whom would go for alternative career pathways.

The figure that we calculated, which brought us to the deficit, also factors in the increasing work load factors in terms of complex, co-morbidity and community-based care. It also factored in out-of-hours work which, as you know, has changed. Many of the practitioners who are involved were GPs who worked during the day, but who are now going to be salaried doctors who work only out of hours, so extra doctors are needed to cover for that. Another issue is, as you said, gender distribution and the tendency towards having more flexible working patterns for male and female GPs.

Mike Rumbles: I wish to pursue this. The committee feels that it is important that we find out what the blockage is in training GPs to meet the needs of Scotland. We are told that there are four applications to become a doctor for each place that is available, so the demand is there in our schools. People want to become doctors. Who is the gatekeeper? Who is not allowing those people through? Is it that the Scottish Executive is not giving the funding? Is it that the universities are not providing the places? Is it that the royal colleges are not pushing the doors open? What is it?

Dr Scott: The simple answer, which is really complicated, is that it is all those things. The journey from becoming a medical student to becoming a GP is a long one. Naturally, during that journey there are opportunities to make career preference choices, which is why I say that increasing the number of graduates by 100 does not mean that 100 more GPs come out the other end.

The other part of the argument is that experience of general practice at undergraduate and postgraduate levels is much more limited than experience of hospital medicine. We know from research that if we allow people to experience general practice at postgraduate level they are more likely to choose a career in general practice than if they do not have that experience. At present, experience of general practice at postgraduate level is extremely limited, which is one of the reasons why, with modernising medical careers, we are pushing hard to have foundation programme experience in general practice, to allow people to try out general practice during that early part of their postgraduate training experience, and then choose general practice as a career path.

Mike Rumbles: I want to focus on what you said. You want more doctors to be trained. Is that right?

Dr Scott: Yes.

Mike Rumbles: So where, from your perspective, is the blockage? I know that you said it is all the things that were mentioned—from which I take it that you as a royal college are taking some responsibility, along with the Executive and the universities—but if you had to put your finger on it, where is the blockage that we are attempting to unblock?

Dr Scott: The current blockage is the number of GP registrar posts. That is a clear block. We have a number, and it is the number we can train. We cannot train any more because of that.

Mike Rumbles: Who changes that?

Dr Scott: The Scottish Executive.

The Convener: Quite a few members want to come in. I will try to get as many in as possible.

Janis Hughes (Glasgow Rutherglen) (Lab): My question was on training.

The Convener: Perhaps we will stay on the current topic for the moment.

Shona Robison (Dundee East) (SNP): I want to go back to something that Professor Teasdale said about the pressures in balancing the time for service delivery with that for training and education. I seek clarification, because in your submission, under urgent actions that are needed, you ask for a

"Central directive to over-ride the local pressures to concentrate on service delivery at the expense of education in order to compensate for the current under-funding."

You appear to be saying that we need more of a focus on service delivery, even if that means a reduction in the time for education, to overcome some of the immediate hurdles. Is that correct?

Professor Teasdale: That is a wish for a wand to be waved and, of course, there is none. I was reflecting the comment that when the new contract was introduced, most doctors identified that they were working 56 hours a week whereas the maximum funding is for 48 hours a week. In deciding what to include in the job plan, service delivery was given priority at trust level. That was understandable because the trusts are charged with service delivery. The inclusion in the job plan time for an individual's own continuing education and training meant that their contribution to education and training others was squeezed. We are going to need more of that because, as you heard from Dr Scott, new training is going to demand more time. From the new plans that are being introduced, all countries expect that doctors will be trained over a smaller number of years from start to finish and over a shorter period of time during the day. It has been calculated that people will have had a third of the experience that they get now, so the time that they are actually in hospital has to be maximised and has to be proper training time, not just time during which they provide a routine service. That training time has to come from somewhere. There has to be time to train doctors and to develop programmes. I can quote quite a number of my colleagues who say that their contributions to education have been threatened by the new arrangements.

Shona Robison: I appreciate what you are saying but the business of health is service delivery. From where the patients are sitting, their priority is to have the services delivered locally. The difficulty that you highlight is that there is no magic wand.

Difficulties with out-of-hours activity were mentioned earlier. I am looking at the submissions from the Royal College of Anaesthetists and the Royal College of Physicians and Surgeons of Glasgow, which contain a couple of suggestions that I would like to run by Professor Teasdale and Professor Wildsmith to see whether they agree with each other.

The Royal College of Anaesthetists suggests that the

"Inclusion of non-Consultant (and even Consultant) career grade staff into the out of hours rota"

might be a solution. However, I noticed that Professor Teasdale's submission says that the barrier to that might be

"that the new Consultant Contract rewards out of hours activity poorly."

What is your response to that? From where we are sitting, the consultant contract seems a good deal and a lot of investment has gone into it. However, we hear that out-of-hours activity is rewarded "poorly" and that that would militate against consultants taking part in such activity. How do we find a way round that?

Professor Teasdale: First, I will pick up on two of your earlier points. The Executive attempted to encourage a balance between work and training but implementation fell to the trusts—there was an attempt to wave a wand, but it was not a magic wand.

You are quite right to say that people want service, but the future of service depends on current training. We will find defining one overall solution elusive. The reality is that the challenges that we are facing in Scotland are much greater than those faced elsewhere because of our historical circumstances where we have almost twice as many hospitals per head of population as do England and Wales. That means that doctors are stretched much more thinly and the sudden limitations imposed on the hours that people can work have hit Scotland much more severely than England and Wales. That is what is creating the pressure.

I suggest that what is needed is for everyone involved to accept the new situation and to work at a much more global solution than just trying to identify one particular factor that will fix it, because there is no such factor.

Shona Robison: But is not there a responsibility on consultants, in recognising that, to be more

flexible in the light of the new contract, particularly in relation to out-of-hours work? The matter seems to come down yet again to finance. Your submission states:

"It is disappointing that the new Consultant Contract rewards out of hours activity poorly."

Are we really saying that the matter comes down to money? Are we saying that if the contract gave better rewards, consultants would do out-of-hours work quite happily and that there would not be some of the problems with out-of-hours cover?

Professor Teasdale: The BMA might want to take up the issue of hours and rates. Consultants put patient care as their priority but if they are working nights and weekends they could be taken out of work time during the week.

Professor Wildsmith: I agree in general with Professor Teasdale. There are different specialty views, which is why there might be some differences between what he has written and what I have written. However, the use of non-consultant or consultant career-grade staff for out-of-hours cover, to which I refer, should be seen in the context of trying to provide an interim solution that keeps a service going until there is a more rational solution that does not necessarily involve so many acute sites being open out of hours. Putting a consultant on a rota out of hours is a relatively expensive and inefficient use of that consultant's time unless the hospital is dealing with acute emergencies out of hours. My submission talks about an interim solution.

Helen Eadie (Dunfermline East) (Lab): I want to pursue Mike Rumbles's line of questioning a little further. I heard the answers, but I am not sure that I was satisfied that the panel answered his questions in full. We understand that there is a point at which people withdraw from the pool to go down the specialism route, but Mike Rumbles made the point that, at the very beginning of the university medical school teaching process, there is a massive pool. We heard about that at our previous meeting. I think that Mike Rumbles said that around five people chase every university place. We have not heard from anyone why the number of places is being limited when there is such a dire shortage throughout Scotland. Why are we not capturing every person in Scotland who wants to train as a clinician?

The European directive obviously applies throughout Europe. We can see from newspaper reports and from elsewhere that there is a surplus of general practitioners and consultants in countries such as Germany. Why are there surpluses in such places while the situation in Scotland is dire?

Professor Wildsmith: There is a limit to how many doctors we can train. In the past 20 years, there has been a huge expansion in the number of medical students in Scotland, but we have reached the stage at which patients occasionally complain about the number of students who queue up to examine them. That is why every medical school is exploring different ways of training people, for example by opening clinical skills units. We cannot expand infinitely to train all the potential recruits, and not all applicants are necessarily suitable. I do not know whether they are all suitable, and they might not be.

On people coming in from Europe, I know for certain that the Germans vastly overtrain in respect of the number of doctors. Like every academic, I get bombarded with requests from German medical students who want to come to the United Kingdom for their clinical training, as it is not provided in Germany. We are therefore working with a rather false situation and it would be much better if we took a much more rational approach. Some of those graduates claim to be trained as specialists. I know that the Department of Health south of the border has looked hard at some graduates who look good on paper, but when you sit down and look at their qualifications, the actuality is rather different.

14:45

Helen Eadie: Does that not contradict what Dr Scott said? She said that there is the capacity to do the training, but the issue is to do with getting people into the medical schools. Let us say that 2,000 people are chasing 284 places. Why can we not get those 2,000 people into universities and teach them rather than limit the number of places to 284?

Professor Wildsmith: That is because it is necessary to treat training as a continuum. I cannot answer for general practice, but I think that Dr Scott was saying that, from the medical school output, there are applicants for training in general practice but there is not a sufficient number of posts for that postgraduate training.

Helen Eadie: Does that not come across as a restrictive practice? We, as politicians, and the man on the street are asking whether this is about consultants wanting to ensure that, rather than have a sufficient number of consultants available to fill all the posts, there is such a shortage of consultants that they get paid over the odds. The man on the street wonders whether this is about consultants protecting a very lucrative market for themselves.

Professor Teasdale: I have been volunteered to respond—it was ever thus.

I recall that in your conversation with Professor McKillop, who is very much responsible for student numbers, he made the point that many students

make multiple applications, so those five people may have applied to five medical schools. It is not clear that the number of applications exceeds the number of places by anywhere near the factor that you mentioned. That puts that matter into context. The number of student placements could be increased. The recommendation in the Calman report was an initial step, and there will be proposals for more students to go through.

Helen Eadie will not be surprised that I totally reject the concept that consultants have been trying to keep numbers down. There are statements going back a decade from the profession about the need to expand consultant numbers, the need to expand training numbers and the dangers that are faced. That goes for my specialism of neurosurgery. We started raising that issue in 1993 and other specialists have raised the issue over the years through various channels. The BMA and the colleges have made many statements about the situation. Back in 1998, the BMA made a submission to the UK Parliament about the urgent need to expand the consultant work force. I assure the committee that the consultant body is deeply desirous of expansion. The situation is almost the opposite of what Helen Eadie says it is. That is a straightforward point.

Dr Scott: I will pick up on the general practice aspect of training. We are clear that there is capacity to increase training and teaching in general practice. As both my colleagues have said, we are examining ways of allowing medical schools' clinical teaching to take place more often in community settings. The number of occasions on which GPs come on to campus to teach clinical skills and vocational studies, among other things, is increasing all the time. However, we currently deliver 12 per cent of the teaching for 5 per cent of the funding budget. Again, the issue is the need to shift resources in order to increase capacity. I am clear that that can be done.

Mr McNeil: We are back to the boxes again—this is the way in which we have had to deal with the evidence. Each panel looks at their particular interest and sometimes that can be presented as self-interest. Do we genuinely need all those graduates to be trained to consultant level? Do we need all those GPs, given all the talk of teamwork and the increased use of allied health professionals, nurses and so on? Why do we need all those doctors and all those consultants if not to pursue specialisms and subspecialisms, which the panel members have not mentioned today? That matter is of at least equivalent importance to the European working time directive and the hours worked by junior doctors, and it certainly has an impact on which services can be delivered locally in many of our communities. That is all part of the package that we are being presented with.

Dr Scott: On the generalist aspect, what you are talking about is skill mix. GPs clearly work extensively in teams and without the primary care team primary care itself would not function at all. However, there are training issues about developing skill mix—you would expect me to say that—and we should put aside the issue of whether there is adequate personnel in other branches of the profession, such as AHPs and nursing, because there are recruitment problems in those areas as well.

When it comes to skill mix, some training issues are more complicated than they seem at first. Speaking as a generalist, I can give you an example of one of the things that GPs do particularly well. We manage complex co-morbidity, which is increasing given the age of the population and the general expertise and skills of our consultant colleagues in keeping those people alive and functioning in the community for longer. That is one aspect. Risk management and taking clinical risk is something that generalists do very well indeed. GPs manage to sort out undifferentiated illness, which is a complex task—we are extremely good at doing that. That is why we are, if you like, the gateway to referrals to secondary care. We send people into secondary care appropriately, rather than inappropriately, which would clearly be extremely expensive.

If we were to train other people in those tasks—and we go some way towards doing that in the primary care team—there would be issues to do with redefining roles and responsibilities and how that would influence patient care and the patient's journey through secondary care. That would mean shared, co-operative learning among team members and people with different skills, which would also have to be resourced. Although it is an attractive and fairly clear solution to some of the problems, the bottom line is that it is not an easy solution, and in some instances it might not be the solution at all—in fact, it might be the wrong solution.

Mr McNeil: You made the point that you get too little of the training budget. Should we allocate that training budget to other health professionals besides doctors? Is not that a fundamental question?

Dr Scott: I return to my answer that it is about team working, sharing responsibilities and ensuring that skill mixes are appropriate. You simply could not train off one branch of professionals and say, "There, now you've got the skills," and expect that to make the service manageable and the patient journey safe.

Mr McNeil: So it can be done only through the GPs.

Dr Scott: No—it can be done only through the set-up that I am talking about, with the general practice and primary care skill mix. GPs have to be integrally involved in that.

Mr McNeil: Do you control it?

Dr Scott: No. We are involved in it.

The Convener: I believe that Mike Rumbles wanted to comment. Has your question been dealt with in the interim?

Mike Rumbles: I will come back in later with a question for another panel of witnesses.

Janis Hughes: I refer to paragraph 4 in the submission from the Royal College of Anaesthetists, which concerns the shortage of anaesthetists and discussions that have taken place in the past and in some other EU countries about the use of nurses in that role. The submission states:

"British Anaesthesia has long been set against the concept".

Could Professor Wildsmith elaborate on that? I would also welcome his comments on the end of that paragraph, which states:

"There is also much less enthusiasm for the concept among both nurses and anaesthetists in Scotland than in England."

Professor Wildsmith: British anaesthesia as a whole has long supported the principle that anaesthesia should be delivered by properly trained, medically qualified specialists. There is certainly a view that one can, under certain circumstances, use one physician anaesthetist to supervise two other non-medical individuals—from a nursing or some other background—who would do the mechanics of the anaesthesia while the physician stays a little bit in the background. That requires a different way of working in hospitals and operating theatres to the one that we are used to in the UK, and the impact would probably be as great on my surgical colleagues as it would be on anaesthetists, and perhaps even greater, because operating room schedules would have to be arranged very differently. We also feel that our standards are higher, but I cannot quote you any evidence to prove that.

A few years ago, the Scottish Society of Anaesthetic and Recovery Nurses did a little survey of their members and discovered that there was almost zero enthusiasm for the role. One of the reasons for that is that we do not have enough nurses to fulfil a lot of the nursing roles. Countries in which nurse anaesthetists are used often draw on nurses who have already qualified as intensive care nurses, but we have a shortage of intensive care nurses. We are knocking the problem further down the line.

Janis Hughes: Are you are saying that the reason why there is not a great deal of enthusiasm for the extension of the role of nurses into this area is the impact on nurses and the specialisms in which they work rather than a lack of enthusiasm from your profession?

Professor Wildsmith: It is both. For some of the reasons that Professor Teasdale talked about, the pressures are a lot greater south of the border. A number of my colleagues in the south are prepared to review the issue and there are some pilot studies of the training of either nurses or operating department practitioners up to the equivalent roles that are used in Europe. I am on one of our college committees—to some extent as one of the unbelievers—and I recognise that we have to look at the matter, but we must do so cautiously because we might create a problem somewhere else.

Janis Hughes: What does the evidence show from the other EU countries where this has been tried? Has it been successful there?

Professor Wildsmith: Most of them would like to move to our situation, in which anaesthesia is delivered only by physicians.

Janis Hughes: So they are doing it because the need is so great.

Professor Wildsmith: Their needs may be greater, but it is more traditional in those countries—it is just the way in which they have worked in the past.

The Convener: We are running into a slight difficulty with time. I have been trying to have a conversation about how to proceed for the rest of the afternoon. It is evident to me that we could keep on questioning the panel for the same amount of time that we have used already and we would probably still not exhaust our questions. However, we have two other panels. I wonder what the committee's view is: should we continue with this panel for a little longer in the expectation of making up some time later this afternoon or should we consider asking the panel to agree to come back? Of course, the difficulty with my second suggestion is that it would involve consideration of our forward work programme and when we plan to finish the inquiry. I do not want us to spend only 45 minutes with the witnesses when we could clearly spend considerably longer with them. Do members have any views?

Helen Eadie: My questions have been asked to some extent—perhaps not in detail, but the generalities have been covered.

The Convener: The problem is that there are still a lot of other questions; I do not think that everybody else will feel as Helen Eadie does. I am guessing about that, but I have scribbled down a

number of questions that I would like to ask and I wonder whether others are in the same boat.

Mr Davidson: Given that the panels have made the effort to come here today, I wonder whether you would care to have a short suspension and discuss with all the panel members whether they are prepared to extend the afternoon to save making a second journey to come back to the committee.

The Convener: Does anyone else have any feelings on the matter?

Shona Robison: One way forward, although it is not ideal, is for us to put in writing the questions that have not been asked and pursue any burning issues orally for an extra 10 minutes. It would be difficult to extend the afternoon significantly at this stage.

The Convener: I was thinking about the possibility of inviting the panel back for a second session on another day, if members think that that would be appropriate. The only thing is that that will give us some difficulties with our forward work programme; the clerks are probably cursing me as we speak. It seems to me that we run the risk of not drawing out from the panel the full extent of their information. If we invite the panel back, people can hold their horses in respect of questions.

Mike Rumbles: I agree with that.

The Convener: I am just concerned that we are only halfway through the panel. I know that Fergus Ewing is probably attending the meeting in relation to the Belford hospital action group. Fergus, do you have any specific questions for this panel that could be dealt with before we move on? [*Interruption.*] I see that Carolyn Leckie wants to get in, but the point is that I am going to ask the witnesses to come back.

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): If I may, I have three specific questions about work force planning in rural areas.

15:00

The Convener: Well, that is precisely the route that I do not want us to go down. I appreciate that everyone wants to ask such questions, but it will take up another 45 minutes. I apologise to Fergus Ewing, but I think that I should ask whether the witnesses are prepared to come back to the committee at a future date. There is a lot more that needs to be explored.

Professor Teasdale: I am very keen to come back and help the committee as much as I can.

Professor Wildsmith: I am happy to come back before the committee, but I am equally happy to answer most of its questions in writing.

The Convener: It might be helpful to combine the two approaches.

Fergus, your questions might be asked of another panel—

Fergus Ewing: I really wanted to ask this panel three brief specific questions. Indeed, I could put them into one question, if that would help.

The Convener: I will allow it if your question is genuinely very brief and if we can get relatively brief answers from the witnesses. If the witnesses feel they cannot give a brief answer to any part of your question, they can offer a response in writing.

Fergus Ewing: I am extremely grateful, convener.

My question relates to the work of the west Highland health solutions group, which reported on 1 October, and in particular to work force planning in hospitals that serve rural parts of Scotland. Briefly, the three specific questions that emerge from the report, which I hope that the witnesses will have an opportunity to study, are—

The Convener: I said that you could ask a short question, Fergus. It is already very long.

Fergus Ewing: First, have the panel members some sympathy with the recommendation from the group, which is made up of 15 clinicians, that there should be a new category of hospital, namely a rural general hospital?

Secondly, should there be a different approach to recruitment and retention, which would recognise the particular needs—

The Convener: Come on, Fergus. I gave you the leeway to ask a single question and you are putting your three or four anyway.

Fergus Ewing: Finally, accepting the convener's admonition, I wonder whether the witnesses recognise that NHS Quality Improvement Scotland presents particular difficulties for work force planning for a sustainable future for such hospitals.

The Convener: I will not invite the panel to answer those questions, because each of them would require a fairly long answer. If you can provide a written response to Fergus Ewing that could be copied to the rest of us, please do so. We will also notify him of your next attendance at a committee meeting.

I welcome the next panel of witnesses: Dr Bill O'Neill, who is the Scottish secretary of the British Medical Association; Professor Peter Rubin, who is the chair of the education committee of the General Medical Council; and David Currie, who is a consultant neurosurgeon with the NHS Consultants Association.

I remind members that the GMC advised us that its main interest in work force planning relates to its role as a regulatory body in assuring quality systems and setting standards in medical education, so questions that relate to the allocation of resources or to service delivery would fall outside the council's remit. Such questions should be addressed to the other witnesses—they have not indicated that those matters are outside their remit, so they have laid themselves wide open. Mike Rumbles looks keen to begin the questioning.

Mike Rumbles: I would have pursued this point with the first panel of witnesses, but I will do so with this panel, because it relates to a fundamental issue. I address my question particularly to the witness from the BMA. The submission from the Royal College of General Practitioners Scotland says:

"There are currently four applicants for every place at medical school in Scotland, yet 95% of medical students come from social groups 1 and 2."

At the committee's most recent meeting, the head of an undergraduate medical school said that his school receives 2,000 applications for 240 places. There is confusion and I want to nail the matter on the head. Is it correct to say that four people apply for every place in Scotland?

Dr Bill O'Neill (British Medical Association): Professor Rubin is probably better placed to answer that, because the GMC has responsibility for undergraduate education.

Mike Rumbles: That is a good answer.

Professor Peter Rubin (General Medical Council): I am happy to answer the question, not least because I have the facts in front of me. The facts are in the public domain and can be obtained from the Universities and Colleges Admissions Service, through which all students apply to medical school. For the autumn 2003 intake, there were just fewer than 900 applicants for just fewer than 700 places at Scottish medical schools. I hope that I can correct the misapprehension that thousands of highly qualified young people have the door slammed in their faces. That is not the case; there are around 1.2 or 1.3 applicants per place in Scotland.

As we are on the subject, I will also clarify the issue of who sets the number of medical school places in Scotland. It is undeniably the Scottish Executive that sets the numbers. If the Scottish Executive wishes to increase the number of medical school places by a certain number, things can roll forward, provided that the Scottish Executive Health Department and the Scottish Higher Education Funding Council are willing to pay their shares.

Mike Rumbles: If there are 900 applicants for 700 places, 200 people do not get a place. To the best of your knowledge, are we rejecting 200 people who qualify for a place under the current requirements? Are there people out there whom we could train?

Professor Rubin: I do not think that all 200 applicants would qualify, but a proportion of those applicants would meet the academic and other criteria for getting into medical school.

Mike Rumbles: I am pushing my luck by pursuing the point. If the Scottish Executive were to accept the recommendations in the Calman report that we fund 100 extra places in Scotland, would there be a problem finding qualified people to take up those places?

Professor Rubin: There would not be a problem for two reasons: first, because of the numbers that I outlined; but secondly, because if for example some or all of the Scottish medical schools were to go down the route of graduate entry—members might know that the English medical schools have done so to a large extent and that there are 14 graduate-entry medical schools in England—there would be a new pool of applicants who would be interested in changing career and entering medicine in their 20s, 30s or 40s. There would be no risk that the new places would remain unfilled.

Mike Rumbles: The demand is there.

Professor Rubin: Yes.

Dr O'Neill: I add one point to that, with reference again to Professor Calman's report. There is an issue around Scotland-domiciled students versus students from other parts of the UK or the rest of the world. Scottish students are disadvantaged in gaining entry to medical schools because although they are required to achieve five highers at one sitting, many schools in Scotland do not allow students to take five highers at one sitting. That is the fundamental point in Professor Calman's report that is worth bearing in mind.

Mr Davidson: Shall I ask my questions now? That might be the easiest way.

The Convener: Yes, you can continue on the Calman report now that it has been mentioned.

Mr Davidson: The first question concerns the lack of capacity in the university sector, for which the Executive has been blamed. The second question is about postgraduate training. Over weeks of evidence, rather than just today and at our previous meeting, we have heard that there is not enough time for people to give training within the hospital system and to deliver patient care. Have you any comments on that situation, or any solutions for addressing it? Even if we get graduates into medical schools, where do they go

after that? How do they get trained and how do we retain them?

Dr O'Neill: There is a fundamental issue about numbers. Scotland has always been a net exporter of doctors, so there is an issue about trying to retain the graduates whom we train. There are specific problems in academic medicine across the UK and in Scotland. There are concerns that, as a result of the introduction of top-up fees in England, we could lose medical academics to other parts of the UK. Undergraduate and postgraduate training is not entirely within the remit of medical academics, but they have a key role to play in it.

One would hope that the new consultant contract will ensure sufficient provision within NHS consultants' time for them to contribute to the undergraduate teaching load; Mr Currie may want to comment on that. However, there is a fundamental problem in that the focus in our universities is on research rather than on teaching. Some would argue that a disproportionate amount of medical academics' time is spent on research rather than on teaching.

Mr Davidson: Are you suggesting that we need a new breed of medical school staff who would be teachers rather than researchers?

Dr O'Neill: The only significant new breed of medical academic staff needed is specifically in medical education. Again, that is in Professor Calman's report.

David Currie (NHS Consultants Association): The breed of people who teach medical students is not, by and large, the academics but the clinical staff who work in hospital wards. The problem in postgraduate education is part of a much bigger problem. When a consultant is appointed to a post, that can make it seem that services have been expanded. However, a consultant can be appointed without their having, for example, an operating theatre, an office, a secretary or clinic space. Such services add hugely to the cost of an appointment and they are often neglected because there is no funding for them.

In addition, the teaching of postgraduates in surgery must be done in an operating theatre, and taking trainees through operations is done by reducing by half the number of patients on the operating list. Therefore, the teaching of medical students and postgraduate students has a huge impact on what consultants can do in their clinical time.

Mr Davidson: So if the Executive funds medical schools to take more students, a bottleneck will still occur in NHS clinical training.

David Currie: Yes.

Mr Davidson: The figures from the BMA and some colleges tell us that we are likely to be 1,000 medics down in the next few years, on current requirements—although techniques may change. How do you envisage such a bottleneck being removed? Is that down to the consultant contract? Or do we need to employ more consultants and equip them with the services that you have just described?

David Currie: The association that I represent hopes that the consultant contract will contribute to tackling the problem. Consultants in most fields do not spend all their time working fixed sessions. For example, surgeons are not always in an operating theatre. The majority of surgeons will have three operating sessions a week, in either the morning or the afternoon, and they may also have a couple of clinic sessions; that leaves other time during the day that is not necessarily used for clinical work. That other time may be used for administration; it may be used for seeing relatives; it may be used for teaching. It has been apparent to many of us for a long time that a lot of that time is not spent profitably in teaching. We hope that the consultant contract will nail down that time and ensure that consultants, rather than being elsewhere, are present and teaching, and that they are not leaving the teaching to junior staff.

15:15

Mr Davidson: Is there a magic cure?

David Currie: Hospital general managers now have a tool to tackle the situation, in the form of the contract.

The Convener: Mike, do you want to come back in on Calman?

Mike Rumbles: No.

Janis Hughes: I have a quick question for Dr O'Neill. In your submission, the first paragraph under "Medical students" refers to

"increasing the number of training posts in hospitals and in general practice as well as offering an attractive postgraduate learning experience."

Can you define that? What is unattractive about the current model?

Dr O'Neill: I would be happy to write a 500-word essay and submit it.

Janis Hughes: Perhaps you could be a bit more succinct.

Dr O'Neill: Clearly, we have a problem in retaining graduates in Scotland. We must examine that, and provide consultant opportunities or places in general practice at the end of their training.

The European working time directive and junior doctors' hours were discussed earlier. The regulations came into effect in 1999, and it was only in August this year that it became a requirement that junior doctors should not work in excess of 58 hours per week. The rest of the population has been restricted to 48 hours per week for the past five years. It will take until 2009 to bring down the figure to 48 hours for junior doctors. We have to examine such issues.

We also have to examine the quality of training. Mr McNeil raised the point about service being part of training. That is absolutely valid, but in 2004 we have to move away from the traditional model of training, which is based on sitting with Nelly. We must ensure that training is focused, that the time that junior doctors spend in the training grades is focused on training, and that we shift away from the disproportionate amount of their time that is spent on delivering service, whether during the day or at night. That is how we will rectify the situation.

Janis Hughes: On the working time directive, David Currie's submission refers to the

"urgent need to find a rational response to this legislation".

Can you define "a rational response"? Does it tie in with Dr O'Neill's comments?

David Currie: At the moment, the elephant in the room for medicine in Scotland is the European working time directive. We can talk about solutions of all sorts for our existing manpower problems, but the big problem that is standing in the way and creating the most staggering anomalies is the European working time directive. For example, we have an across-the-board standard for working hours, irrespective of whether one happens to be the dermatologist working in Inverness or the orthopaedic surgeon working in Glasgow, with a hugely different intensity of work. We are not considering the intensity of work; we are applying standard working hours across the board.

I am a neurosurgeon and work in a small department with three colleagues. Three surgeons cannot provide a legal service under the terms of the European working time directive. The apparent solution is to increase the number of staff, but if one increases the number of staff, one dilutes experience and the unit cannot exist. In any case, it is beyond our means to do so

We are talking about closing services to deal with a man-made anomaly. In what is meant to be a patient-centred service, we are turning round and looking in the opposite direction; we are basing absolutely everything not on the patient, but on the doctor's quality of life. I do not know what the solution is. I am batting the problem back to the politicians, because it is a political problem.

The Convener: Are you aware of differential application of the European working time directive within the European Union? Is it not the case that, in some countries outside the EU, similar processes are being introduced anyway, even though they might not be referred to as coming under the European Union working time directive? Is what is happening here wholly anomalous or not?

David Currie: I do not have evidence on that, but the committee might find it very useful to seek such evidence. The word on the street is that a lot of European countries ignore the legislation.

The Convener: Do you have any evidence at all for that?

David Currie: No.

The Convener: You, personally, have no evidence of that.

David Currie: No. We are, however, aware of efforts being made in this country to get round the legislation. The current deal in Lochaber represents one such effort. There is not going to be an increase in the number of consultants, but a deal has been worked out. With a little bit of creativity and co-operation between different units, we can go some way towards meeting the requirements of the working time directive. However, we will not satisfy it altogether without either an amalgamation of services and a stripping of services out of the rest of Scotland or a big expansion in the number of consultants, which I do not believe we can achieve.

The Convener: Does the same situation confront non-EU countries, as far as you are aware?

David Currie: I am afraid that I do not know that.

The Convener: Does anybody on the panel have any information, experience or evidence about what is happening elsewhere?

Dr O'Neill: The one concrete piece of evidence is the number of doctors per 100,000 population. In the United Kingdom, we have disproportionately fewer doctors than in other European countries. There are approximately 250 doctors per 100,000 population in the UK, although the figure is slightly higher in Scotland compared with England and Wales; in most European countries, there are around 330 to 350 doctors per 100,000. In some countries, there are in excess of 400.

Mr McNeil: How many of those doctors are unemployed in Europe?

Dr O'Neill: Some countries have some unemployed doctors, but—

Mr McNeil: What is the point of that?

The Convener: We heard some conflicting evidence earlier this afternoon about the situation in Germany, which suggests that the issue is not straightforward.

Shona Robison: I was struck by how honest David Currie's submission was in its analysis of who benefits from the health service and whether the health service is designed around the needs of doctors rather than patients. It is refreshing to hear that view being expressed in such an up-front way.

You talked about creativity and co-operation. You are right to say that we need to examine the needs of a population of 5 million, much of it located in remote and rural areas, and that we need to consider how we deliver a service as close to people as possible.

We heard earlier that we have far too many smaller hospitals, yet we have also just heard that we do not have enough doctors. I agree that increasing hugely the number of consultants is probably not possible, at least not in the short term. However, surely it would be possible to examine what those consultants do. Is there not an argument that consultants should be prepared to look again at whether their current level of specialisation and subspecialisation is really in the interests of a health service that is trying to serve the needs of 5 million people? Is it not the case that we need more consultants with a broader skill base to serve the needs of rural hospitals, particularly in emergency cover? We heard from anaesthetists earlier—

The Convener: Could you ask a question, please?

Shona Robison: It is a question. Would it be possible to achieve an increase in the number of consultants with a broader skill base? If so, how could we implement that solution within a reasonable time?

David Currie: I will take your last point first. We are making moves to train people specifically for medicine and surgery in remote and rural areas. The first such consultant—a Scottish graduate, trained in Scotland to be a Scottish surgeon on one of our islands—has just started work in Shetland. We should be greatly strengthening and encouraging such initiatives for posts that have mostly been filled by people from abroad and which have very rarely been filled from among our own graduates.

As for redefining what consultants do, I believe that there is scope for changing traditional roles within specialties. With a population the size of Scotland's, we can take highly specialised problems and centralise them. We can appoint somebody to deal with a particularly highly specialised problem in one of our centres.

My concern, and my association's concern, is that that is being taken as a general principle that should be much more widely applied. In other words, it is thought that it stands to reason that people will get a better service if they go to a big centre, but we do not believe that to be the case. It is true up to a point, but for a lot of the generalities in medicine, the patient is far better off having their service near home, and we should argue strongly for that.

Shona Robison: I would like to pursue that, because I think that it is an important issue. If I heard you correctly, I think that you said that the people whom you were talking about were trained outwith Scotland.

David Currie: No, they were trained in Scotland.

Shona Robison: Where were they trained and how did the royal colleges respond to that? We get the feeling that there is a dislike of that model, because we hear that it is safer to have more specialisation because of the number of people involved. However, someone somewhere has clearly turned that around and has faced the other way. Who did it? Where were the people trained?

David Currie: The royal colleges have accepted that as a legitimate specialty and the first graduate has been appointed as a consultant with accreditation in remote and rural surgery. The training was provided in a multi-centre fashion, principally in Glasgow but also in Aberdeen, and it involved visiting the different specialties that that surgeon will be required to know something about.

Shona Robison: Are more people coming behind that surgeon?

David Currie: There are more people coming behind, and I think that you will have the opportunity to speak to Professor Needham, who is the postgraduate dean for the north of Scotland and who has a specific interest in the subject. I believe that she will be speaking to the committee next week.

Shona Robison: That is interesting.

Carolyn Leckie (Central Scotland) (SSP): I want to develop the question of alternatives to the orthodoxy of centralisation. I am always reminded that one of the main drivers for setting up the NHS in the first place was to avoid the sucking in of specialisms into teaching hospitals and the lack of access that resulted from that. The aim was to spread out the specialties and to address inequalities. I sometimes wonder whether we have come full circle, as we are having to make the same arguments again about the balance between centralisation and generalism.

I have a specific question for the BMA and for Professor Rubin. It refers back to the question that Fergus Ewing asked and it concerns the

concept—which was debated in the 1920s and 1930s, before the inception of the NHS—of combined GPs and surgeons and, in rural areas particularly, of combined GPs and generalists. It is suggested that such professionals would be able to provide cover and that that would perhaps address some of the recruitment problems in GP training, as hospital specialisms are seen as having more kudos. Will you comment on that?

Various submissions have made reference to approaches being made to the Executive about projected trends and about the effect of the working time directive and of the imbalance between student intake and what is needed for the service. Will you develop that point a wee bit more and describe in detail what those approaches were and what the responses were?

It is evident from the trend that is shown in the table in the RCGP Scotland submission that the number of female recruits to GP practice was increasing around 1988-89 although the numbers coming into GP training were decreasing. When was it understood that that trend was developing? What calculations were made about the impact of that trend, what representations were made to Government and what reactions did you get?

Everywhere I go when there is a consultation, health boards say that there are nurses, paramedics and other professionals who can all play different roles. However, other witnesses have pointed out that those personnel are also in short supply and that you cannot knit them. It will be a long time before nurses, for example, will be able to take on some of those extended roles.

Will you comment on instances in which nurses have attempted to take on extended roles, such as the emergency nurse practitioners in accident and emergency units? How many of those nurses are not able to perform that role because they have not got their remuneration, given that health boards are not funding the vacancies that they are advertising?

I have a more visionary question. A lot of nurses and midwives are more than capable of being doctors. What co-operation is there among those who provide medical training, nurse training and midwifery training to find ways of supporting those nurses? There would obviously have to be recruitment to replace them.

15:30

The Convener: Carolyn, come on.

Carolyn Leckie: Sorry. What co-operation is there to support nurses into medical training and would you support such a move? That is it.

The Convener: This witness panel has only 10 more minutes. If issues have been raised to which you think it would be better to respond in writing, please do so. If there are issues that you think we can deal with relatively quickly this afternoon, you can do so too.

Dr O'Neill: I will deal briefly with the midwifery issue. As an undergraduate I was terrified of midwives, rather than taught with them. I am sure that Carolyn Leckie will remember those days.

More than 90 per cent of patient care is provided outside hospitals. I do not think that anybody is suggesting that the solution for Kirkwall will be the same as the solution for the centre of Edinburgh. We must have different solutions for different parts of Scotland.

Increasingly, GPs have special interests, although whether those interests extend to extensive surgery is a different question. GPs do minor surgery; whether they should be doing major abdominal surgery is a totally different question, on which I am sure Mr Currie will want to comment. There is provision in the new GP contract for GPs to have special interests; that is a growing feature of general practice.

On the gender issue, there is no doubt that the world has been a bit slow to respond. When I was an undergraduate in Dublin in the 1970s, more than 50 per cent of those in my year were women. In the medical schools in Scotland the shift came later, although in other parts of the UK it was in evidence in the 1970s. There is no doubt that the whole world—not just the profession, civil servants or politicians—was very slow to react appropriately, which is part of the difficulty that we now have.

The Convener: Does any other panel member wish to respond on any of Carolyn Leckie's points?

David Currie: I agree that general practice specialisation has a great deal to offer us. A lot of what has traditionally been kept jealously as hospital specialty work is now being done—increasingly in the form of clinical networks—by general practitioners and hospital colleagues. Nurse practitioners are an important brick in the construction of some kind of out-of-hours service in hospitals, given the reduction in junior staff hours and the coming reduction in the number of consultants. Nurse practitioners are coming in in a patchy fashion, but they have a huge amount to offer in keeping specialties where they are.

You might have the opportunity to speak to Professor Needham. We had isolated structures for postgraduate medicine, nursing and professions allied to medicine, but they have all been gathered together into regional training. We now have the equivalent of postgraduate deans—I have forgotten the precise term for them—whose responsibility is to consider common training and

pull together training for the different professions as far as possible so that they have common training to some extent.

Mr McNeil: Why does an expert on the elbow have higher status than a generalist who can deliver the services that a community would want? Why are people being given a choice between excellent service and no service at all in their locality?

Professor Rubin: I will have a go at that question. One factor that encourages medical students to follow a certain path is the role models that they have. I will give a parochial anecdote. My medical school at the University of Nottingham was established in the late 1960s primarily to improve the woeful quality of primary care in the east midlands. A major approach to doing that was to ensure that primary care was a big part of the undergraduate curriculum and that from an early stage—week 1 of year 1—medical students were exposed to enthusiasts in primary care.

For many years, the General Medical Council has required medical schools to have 75 per cent of the curriculum as core—every doctor must be able to do those things—and 25 per cent as options. Some issues that are faced in Scotland, such as those that relate to rural areas, could be dealt with in the options bit of the curriculum. It would be useful to enable students to work in rural areas with enthusiasts to see that such areas are not the back of beyond, or the end of the world—or that you can see it from there—and to say, "Hey, this is exciting and fun and you do much more than you would do as an elbow specialist in Glasgow or Edinburgh." There are many ways to encourage people from a young age to take such a route.

I will quickly pick up Carolyn Leckie's point about interprofessional learning, which the GMC encourages strongly. We expect all medical schools to give us examples of interprofessional learning. All medical schools are trying to do that and many have been trying to do that for many years. Paradoxically, that has become more difficult as the years have passed, because the numbers of people—I return to that—who are training in medicine, midwifery and nursing have gone up and up. Meaningful interprofessional training, as distinct from sticking people in a big room and teaching them together, is a challenge, but it can be achieved at the undergraduate and postgraduate levels.

Mr Davidson: I will follow up Duncan McNeil's point. Does England provide lessons to learn from foundation training? England does not seem to have the same difficulties in converting undergraduates and graduates into GPs.

Dr O'Neill: I am not entirely sure whether I understand the question. Are you talking about the new foundation programmes and modernising medical careers?

Mr Davidson: Yes.

Dr O'Neill: They come into effect next year. The committee will take evidence from NHS Education for Scotland next week or the week after, so perhaps the question would be best put to it. We are considering systems to ensure that people have access to most sectors of medicine during the foundation programme, which will last for two years immediately post graduation—that is expanded from the current one year. I am not sure whether I have answered the question.

Mr Davidson: I asked the question because I wanted to know what the groups that the witnesses represent think of foundation training and because the answers that you have given suggest that the resources are not available to provide the programme in Scotland. Is that the case?

Dr O'Neill: Significant progress has been made on examining the details of the two-year foundation programme. Recently, a commitment was made to include the opportunity for teaching in general practice in the programme. Modernising medical careers goes beyond the two-year foundation programme to specialist training and offers great opportunities. Significant challenges will be presented and much detail must be worked out, but the solutions to many difficulties that we now face across the NHS rest with modernising medical careers. I have seen nothing that suggests that Scotland is worse off than other parts of the United Kingdom.

Mr Davidson: Do your colleagues agree?

David Currie: I agree.

The Convener: Do you agree in the light of the evidence from the Royal College of Physicians and Surgeons of Glasgow? It has stated categorically:

"The immediate priority is to avoid the harm that may follow the implementation of Modernising Medical Careers … The risks to staffing … include: … The current loss … of around 300 doctors per year after their PRHO post will start to happen immediately post graduation"

and

"Doctors choose Foundation Training in England",

to which David Davidson referred. Do you disagree with that organisation?

Dr O'Neill: I do not disagree that challenges will arise, but we can overcome them. The will and commitment are present to sort out the difficulties that will arise from the changes throughout the range of postgraduate training.

The Convener: You would not have used the terms that I quoted.

Dr O'Neill: I would have used different phrasing.

The Convener: Nobody else wants to comment on the harm that the Glasgow royal college says is likely to be created.

We have reached the end of the time for the panel. I am conscious that members want other questions to be answered and we reserve the right to send you written requests for further information, if that is required.

I suspend the meeting for five minutes. It is extremely hot in here and everybody could do with a breath of air, if nothing else.

15:40

Meeting suspended.

15:46

On resuming—

The Convener: I welcome the third panel of witnesses: Dr Holdsworth from the Chartered Society of Physiotherapy Scotland and Stephen Moore from the Society of Chiropodists and Podiatrists, both representing the Allied Health Professions Forum Scotland; and Marc Seale, the chief executive and registrar of the Health Professions Council.

I will ask a general question to kick us off. In evidence some weeks ago, the outgoing Minister for Health and Community Care said that, in his view, work force planning had begun only recently in Scotland. Do you share his view and, if that is the case, when do you date the planning as having started?

Dr Lesley Holdsworth (Allied Health Professions Forum Scotland): We share the view of the previous Minister for Health and Community Care. Although I speak on behalf of the physiotherapy profession, I know that many of our concerns are shared by the numerous disciplines that make up the Allied Health Professions Forum. The advent of work force planning for our professions has been very recent. I am aware that an advertisement has been placed for a work force planning officer in the Scottish Executive to lead on that agenda; we believe that that measure is long overdue.

Stephen Moore (Allied Health Professions Forum Scotland): I echo that and add that, as soon as the work force planning officer is in post, we will need to put in place systems that provide robust information for the health service to make judgments on work force planning. That information has not been available in the past, so we need to look critically at what information will be helpful and how we will get it, so that we can have it as quickly as possible.

Marc Seale (Health Professions Council): I have no knowledge of what has been happening, but the Health Professions Council has an enormous amount of information about health professionals, for example on geographical breakdown and age, for anybody who is undertaking work force planning.

The Convener: Members want to ask a number of questions so I will try to ensure that we get through as much as possible in the short time that we have.

Mr Davidson: My first question is for Mr Seale. The Health Professions Council website claims that it is a

"UK-wide regulatory body responsible for setting and maintaining standards of professional training, performance and conduct"

for the various professions that it regulates. What is its role in professional training? What influence does it have on how training is changed and delivered? How does it monitor delivery?

Marc Seale: We approve about 350 programmes throughout the UK, predominantly at universities, although training for paramedics is not undertaken within the university system, for example. We influence the quality of the individuals who complete courses in several ways. One is by setting what are called the standards of proficiency, which lay out what we expect a new registrant to be able to undertake in their profession. Secondly, we publish standards of education and training, which, in essence, are the standards that universities must reach to ensure that the individuals who complete courses meet our standards of proficiency. Thirdly, we run tribunals on fitness to practise. If a registrant does not meet the appropriate standards, we can act either to remove them from the register or to have them retrained.

We have a huge influence on how graduates are trained through the standards that we produce through public consultation and close working with the professional bodies.

Mr Davidson: Do you have as much influence and control over nursing courses as the GMC has over medical training?

Marc Seale: It is difficult for me to comment on other regulators. There are nine regulators of health professionals in the UK, each of which works under substantially different legislation. While I have a reasonable understanding of what the HPC does, I cannot comment on other regulators' work on educational standards.

Mr Davidson: Do you have influence over recruitment and retention for the various professions?

Marc Seale: We do not have a direct influence, but because health care is an international market, one of our roles is to ensure that international applicants who come to the UK meet our standards of proficiency. For example, if a Scottish hospital recruited a Spanish radiographer, we would ensure that that individual met the required standards.

Janis Hughes: I am sure that the panel knows that we have a particular interest in education and training. What collaboration takes place between your organisations, the higher education institutions and NHS Scotland on education and training for your professions?

Dr Holdsworth: Stephen Moore and I would struggle to give a comprehensive answer to that question because we are not from the education sector—we are NHS employees. You might get a better answer from another source. There is a view in the service that education is extremely disjointed, which leads to problems, such as the matching of supply and demand, particularly because, we feel, we are different from doctors and nurses. We have different professionals within our organisation, but what we have in common is the fact that we are usefully placed to meet many of today's challenges and many of the challenges that will hit quickly—in five or 10 years—as a result of demographic changes. Whether we do so will be determined by how much we increase capacity and the number of allied health professionals out there. We are unique in that we qualify as first-point-of-contact practitioners, unlike members of many of the other professions. Technically, we can go straight out the door from training and start dealing with patients in all sorts of settings.

We have a lot of evidence that the allied health professions are working successfully in extended roles, undertaking tasks that doctors previously undertook. At present, we do not have a shortage of people who are willing to carry out those roles and we have the beginnings of an education and competency framework to support the extension of our role. However, very soon—in five to 10 years—we will have a problem with filling posts. We could expand considerably further and more laterally if the work force was greater.

Janis Hughes: I appreciate that you are not involved specifically in education, but are you saying that, although we have a shortage of physiotherapists, for example, there is no strategic thinking or vision in the NHS and the education sector about how many people we need to train in the next 10, 15 or 20 years?

Dr Holdsworth: I am not aware of any forum where that is formally debated. That comes back to the issue that very little work has been done on establishing what the demand is. Modelling and projections for the future need to be done.

Stephen Moore: It is about developing the skills to predict what the future demand on the service will be. Over recent years, there has been a knee-jerk response to various professional developments in the health service. We must be more scientific and establish more evidence about what is required. The relationship with NHS Education for Scotland is a fairly new one, so to an extent it is necessary to watch this space.

I am aware that some universities have concerns about funding streams. In particular, there seems to be a difference between the funding of some English and Welsh universities and the funding of Scottish ones. I am not an expert on that, but educationists tell me that there is a significant shortfall. Although Scottish universities would have the capacity to expand the number of students, funding is an issue.

Janis Hughes: Might not it be in the remit of the Allied Health Professions Forum Scotland to do projections to establish what the future need will be?

Stephen Moore: I would certainly hope that, along with other agencies, we would be far more involved in that process.

Marc Seale: As a regulator, we have an influence on what happens, although we do not have direct control. That relates to the concept of standards of proficiency. Within the UK, what a particular professional can do is not defined and is not written down. We control registrants through use of the title, so if a physiotherapist wants to practise in the UK, they have to be on our register.

The role of the regulator is to ensure that the scope of practice and our standards of proficiency are flexible so that we do not restrict what registrants or health care professionals do. For example, a physiotherapist might want to extend their scope of practice in the accident and emergency department to work with the department in triaging individuals who come in. It is not the role of the regulator to set barriers to prevent physiotherapists from extending their scope of practice. The standards of education that the universities provide must reflect the standards of proficiency, but we, as the regulator, do not put up barriers to prevent individuals from undertaking new tasks.

The process of extending professionals' scope of practice is accelerating for two reasons. One is that technology is changing, so a task that was undertaken by a certain individual 15 years ago can now be undertaken by other individuals.

Secondly, in pharmacology, involvement in how drugs are used can also be extended to the allied health professions. It is important that the regulator does not act as a barrier to such movement within the health care system.

Helen Eadie: Among the submissions that we have received is one from the Chartered Society of Physiotherapy Scotland. The submission questions the ambition of the Scottish Executive to increase the number of allied health professionals by 1,500. The Scottish Executive currently has control, or some influence, over the number of places in medicine. What is your view on the Scottish Executive having more control over the number of places on undergraduate courses in the allied health professions?

Dr Holdsworth: I think that you are referring to the fact that, although we very much welcomed the statement in the Scottish Executive partnership agreement that there would be 1,500 more AHPs, it is not clear whether there will be 50 more physiotherapists and 1,000 more of something else—what is the split? There are nine different professions, and one could argue that the demand on some of the professions is greater than that on others. There does not seem to have been any dialogue with the professions about what the split will look like or how the provision of 1,500 places will impact on our ability to provide services. That is the query in our submission. There does not seem to have been any discussion about developing the roles and about how the 1,500 places will be provided. I do not know whether Stephen Moore wants to add anything.

Stephen Moore: Dr Holdsworth has covered the matter well. We support the Scottish Executive having more input on funding and on the total number of places, but that must happen in partnership with health boards, professional bodies and the universities.

We need to do robust work on the needs of the different professions—how many people they need and what their roles should be—because many positive extended-scope roles are emerging that could have a real impact on the health service. We would like such areas to be developed and for some of the additional 1,500 AHPs to be placed in those areas. However, I wonder whether the figure of 1,500 was arrived at scientifically or was plucked out of the air. We might need more than 1,500 extra AHPs. We need to start the process now if we are to train people to the right standard for the future.

16:00

Helen Eadie: The question that flashes across my mind is whether work has been done to compare historical provision with future needs or whether planning has been ad hoc and random. Perhaps the witnesses cannot answer that today, but it would be helpful if they could write to the committee with additional material.

Dr Holdsworth: We will be happy to do so, if that is possible. However, I think that you have got the gist of the issue: there is no historical basis and no evidence base for the determination of the numbers. We acknowledge that we need a significant piece of work that can model into the future to enable us to plan ahead. We cannot plan just on the basis of historical data because, as we all recognise, health services are changing and everybody's career is being modernised. We can pick up some of the key roles that are associated with those changes, but we need to model into the future.

Mr Davidson: If I heard him correctly, Mr Seale said that the Health Professions Council regulates entry to a profession for someone using a restricted title, but does not interfere if that person takes on other activities. What happens to public safety and accreditation in such situations? Who is ultimately responsible for the employment of someone who takes on a role that the council has apparently not registered them to take on?

Marc Seale: The principle is professional self-regulation. Every professional, when they decide to treat a patient, in effect asks themselves, "Am I competent to carry out this treatment or should I refer the patient to an individual who is competent to do so?" Before a professional takes on a new task and extends their scope of practice, they must decide what training and experience are required to enable them to take on the extended role. We set the threshold requirements for the individual to come on to the register, but if someone wants to develop into a particular area of practice, it is for them to ensure that, before they do so, they are competent because they have been trained or have built up the relevant experience.

Our approach is different from that of regulators in other parts of the world. For example, the French model defines in legislation what a physiotherapist can do. The problem with that model is that, first, the medical profession tends to influence heavily what the other health professionals do in the health care delivery system and, secondly, it is restrictive, because primary legislation must be changed every time professionals want to change their scope of practice.

Mr Davidson: When you responded to my earlier questions, you talked about the council's influence on training courses. Why do you give up at that point, given that you already do part of the job?

Marc Seale: It is not a question of giving up. Health professionals undertake a range of tasks and we do not know what tasks might develop in five, 10 or 15 years' time. Also, one professional might go down one route and another professional might go down another. The HPC's role, which is driven by legislation, is to set threshold standards for individuals to come on to the register. Beyond that, it is for the professional to decide which direction to take, on the principle of self-regulation.

There are different approaches. In effect, the GMC and the royal colleges have a register that is divided into different standards of post-registration proficiency. We have not gone down that route.

Mr Davidson: Do the other two panel members have views from their professional perspectives?

Dr Holdsworth: Physiotherapy is possibly one of the AHPs that has extended its role the most. That has tended to be driven by the people who are keenest in their specialty, and has happened predominantly in orthopaedics and in musculo-skeletal clinical areas. Individuals have been very much at the cutting edge and have tended to form their own networks and specialist interest groups, in a way to legitimise their roles under the auspices of the Chartered Society of Physiotherapy. There is an opportunity for people working with extended scope in all clinical areas to work with their professional body to establish a framework that is perhaps not regulated formally.

Mr Davidson: Does your organisation want that to go to formal accreditation?

Dr Holdsworth: I cannot talk on behalf of my professional body because I am not allowed to do so.

Stephen Moore: We broadly support the approach taken by the regulator that it is down to the individual clinical profession to demonstrate its competency and to prove that in a recognised format, so that the public and the regulator can be confident that a person has the appropriate skills or experience. Taking that approach will also mean, I hope, greater collaboration between the professions, because people are not being put into fixed silos to work.

I will give you a nice Scottish example of professional bodies working collaboratively to develop new roles. The Society of Chiropodists and Podiatrists, the Royal College of Surgeons and the Royal College of Physicians and Surgeons of Glasgow now have an agreed programme to train podiatric surgeons in Scotland. Although the system in England and Wales has had podiatric surgeons for many years, it is fair to say that there has always been tension between some of the professional bodies. Scotland has taken a different approach and there has been collaboration between the professional bodies.

The first cohort of students to go through the programme has just started. The course was over-subscribed and 20 students are taking the MSc that will lead to a qualification in podiatric surgery, which will be recognised by the universities, the Society of Chiropodists and Podiatrists and the royal colleges.

Marc Seale: Am I allowed to make a couple of extra comments?

The Convener: Yes, of course you are.

Marc Seale: It is also important to mention that we expect that, as a profession develops, a new profession will start to emerge. At that point, there would have to be new standards of proficiency and individuals would have to be educated differently. It is like an amoeba; the developing profession would split off at the point when it becomes a new profession and we would regulate it separately.

The other component is continuing professional development, which we are currently consulting on. We expect that by July 2005 we will be introducing a CPD scheme under which all registrants will have to demonstrate that they meet the CPD standards for whatever their scope of practice is. Once they are on the register, they will have to certify to the regulator that they meet a new standard every two years, because that is how the profession will develop.

Dr Turner: When a doctor is delivering services and is trying to cover the work load because the work force is not there, they have to think about public confidence and competence, which is sometimes difficult. People can be given many jobs to do and doctors might wonder how confident they can be that people out there have the competence to know when they should pass something on to someone else.

In years gone by, physiotherapy tended to be for more acute conditions. As Dr Holdsworth said, we are entering an age in which people are living longer, there are more chronic conditions such as osteoarthritis and more physiotherapists are needed to help the rheumatologists and orthopaedic surgeons. We are told that there are 10,000 people on the waiting list in Glasgow and that people would like to have two special clinics, so that physiotherapists could help out.

From what I have read and in my experience, we never had slack in any department and if someone goes off because they are pregnant—

The Convener: Question, Jean.

Dr Turner: I am trying to explain that we are trying to get the organisations to focus on the work force. I am not getting information from them that gives me confidence that there are competent people ready to replace the people that go into

specialist posts. There are not enough podiatrists or chiropodists out there, for example.

How do we get there as quickly as possible? We seem to be going round the problem. Yes, the problem is being considered, but from what we have been told, I understand that there are not enough places in the colleges. Who would the witnesses like to get hold of to deal with that? How could the information go as quickly as possible from the sharp end to the health boards and the Executive? Is it a question of communication?

Dr Holdsworth: I would love to have the complete answers. I agree with you on many of the issues that you have raised.

The situation is that 12 applications are received for each place on university physiotherapy courses. We heard earlier about the issue with medical places, but such is the demand for physiotherapy courses that people often need higher qualifications for physiotherapy than for medicine. That is an anomaly.

You hit the nail on the head. Given the demand for places, it appears that schoolchildren and others have an interest in pursuing careers in physiotherapy or other AHPs, but our education system does not have the capacity to process enough people.

At the clinical and service-delivery end, during the 1990s, there was an 80 per cent increase in the number of physiotherapists who work in community and primary care settings. Traditionally, physiotherapists were very acute focused, but that is not the case now. That reflects the changing profile of how health care services are delivered. Today, physiotherapists are predominantly most effective in terms of numbers when they work in community and primary care settings, where they can impact considerably on the burden of chronic disease management and on orthopaedics, which is the subject of one in four general practitioner consultations. Allusion was made to the fact that some 10,000 people are sitting on waiting lists. Research from England suggests that, where physiotherapists work with primary care teams—which may or may not have medical input—some 87 per cent of patients can be dealt with without their ever going near a hospital.

We have quite a dichotomy. There is a good argument for extending those teams and allied health professions who work predominantly in community and primary care settings and we have the interest from young people who want to pursue those careers. However, there seems to be a bottleneck in the middle, where there is a problem with getting people through the system. I do not have all the answers to that, but somebody needs to consider the issue.

Dr Turner: Should the Executive be addressing the issue by providing more money?

Dr Holdsworth: There is obviously a capacity issue within the higher education community. I presume that the number of people who can be trained is not unlimited, but I know for a fact that two Scottish universities that do not currently provide physiotherapy education are desperate to run programmes. Having done a lot of work on the viability of such a proposal, they feel that it is certainly feasible. People like me who are based in the NHS are perplexed by why such issues are allowed to drag on for years instead of being solved. It takes 10 years to get a good physiotherapist, podiatrist or other AHP, yet the current situation seems to continue every year.

Dr Turner: I have one more question. Let us assume that there are suitably qualified people out there. Do you think that posts are advertised quickly enough when they become vacant?

Dr Holdsworth: No; we have a problem. At the moment, 5 per cent of posts are frozen.

Stephen Moore: There is an anomaly in that delays are built into the system for replacing staff. The fact that they are not replaced in the short term places further burdens and pressures on the system. It takes a minimum of three months to replace staff, but often it takes longer than that. Periodically, health boards freeze posts to make short-term financial gains to adjust their financial position. Although that may be understandable and acceptable, such deliberate freezing of posts is a bit at odds with the Executive's view that more AHPs should work in the service to improve patient care. Unfortunately, there are examples of posts being lost within the various allied health professions both in Scotland and across the United Kingdom. I do not have hard evidence for this, but my perception is that that is due to short-term financial management rather than the strategic thinking that the committee is looking for.

16:15

Marc Seale: It is important to say that there is no guarantee that allied health professionals will remain in Scotland just because they are produced in Scotland. There is an international market. Individuals can move within the four home countries, within Europe and internationally. Demand will not necessarily be met simply by considering the supply of health care professionals.

Scotland has another problem, for which I do not have a solution. I am not aware of any health care economy in which the supply of health professionals has met the demand for them. Things are always out of sync. Either too many health professionals come out of the system—that

happens in Germany, for example—or there are situations such as that in New Zealand, which is in a much worse position than Scotland. New Zealand trains individuals, but they cannot be retained there. I am not aware of any country that has ever achieved a reasonable match between the supply and demand of health care professionals.

Stephen Moore: Another element is the use of assistants and staff to support the allied health professions. We have discussed the role of allied health professions to support medicine in delivering better services. There are many good examples of that, but there are also examples of using assistants to support the allied health professions. We must invest in and develop that area. Regulators should ensure that there is confidence that people who are in assistant posts have the skills and abilities to undertake the tasks that they are asked to undertake.

Dr Turner: Do you agree that it would have saved money if we had looked into the matter earlier in order to keep people mobile and able to walk about? There might not then have been as many people in hospital beds as a result of a lack of foresight.

Dr Holdsworth: There is an overall public health issue, which extends beyond health into the responsibilities of local authorities and so on. The public health message is owned by many people in the public sector.

Mike Rumbles: I declare an interest. My wife is in practice in Aberdeenshire and is a member of the Society of Chiropodists and Podiatrists.

The Society of Chiropodists and Podiatrists states in its submission:

"Clinical diaries are often booked three months in advance."

Certainly, according to my constituents to whom I have spoken and the evidence from Grampian, there seems to be a restricted rationing system. It seems that only the elderly and those who are really in trouble can be seen by chiropodists and podiatrists. That certainly seems to happen in north-east Scotland, but is that situation prevalent throughout the country? If so, does the Society of Chiropodists and Podiatrists have any idea how many of the 1,500 extra allied health professionals—quite a substantial figure, as has been said—would be chiropodists and podiatrists? If there is such a problem, how many podiatrists should there be to help to solve it? How many should be trained, given that we have just discussed the numbers of consultants and general practitioners? I know that there are nine elements to the allied professions, but I am simply focusing on the one that I know best. It would be helpful if you would address those issues.

Stephen Moore: At the risk of upsetting my colleagues in the allied health professions, we would like all 1,500 to be podiatrists.

There are significant strains on the system and you are right to say that services are increasingly being restricted. There is good evidence from south of the border of how the point can be reached at which it becomes difficult for patients to access services so that they are forced to seek services from the private sector. Perhaps that is acceptable in some circumstances if patients can afford services, but it is unacceptable if they cannot afford them or do not have access to them.

Unfortunately, there is evidence that Scotland is following that path and that services are becoming increasingly restricted. One challenge that we face is that the Scottish Executive does not have a view about the make-up of or access to podiatry services. As a result, individual health authorities have to determine their service needs according to their funding resources, which is leading to disparities between services. That situation is becoming increasingly obvious.

The fact is that there is a capacity issue and more podiatrists are needed in the system. However, I must be honest and say that I do not have any scientific evidence that highlights that number exactly. The society would like to undertake that study with the Scottish Executive, as that would allow us to predict service needs more accurately. We need the Scottish Executive and the Parliament to offer a clear description of the service that they are looking for, which I argue would centre on comprehensive access to advice and, if appropriate, treatment for people with foot or lower-limb problems.

Mike Rumbles: Your submission contains the following throwaway line:

"Clinical diaries are often booked three months in advance."

At first glance, that might seem okay. After all, people have to wait five months for other professional services. However, is it not the case that many of the elderly people who see an NHS chiropodist have to wait three months before their next appointment? That is too long. You are in an ever-decreasing circle, as it were. What do we need to do to address the shortfall?

Although we have been provided with UK statistics, I wonder whether the society can provide statistics on the number of chiropodists and podiatrists in Scotland. Indeed, the same request for Scottish statistics would apply to the other allied health professions. We simply do not have that basic information to hand.

The Convener: If that information is available, we would all appreciate it if you could submit it in

writing. I think that Shona Robison wanted to ask about the more general aspects of the matter.

Shona Robison: My question is on the same issue, but focuses on how we provide allied health professionals in rural areas where, after all, there are particular challenges. For example, we heard earlier about centralisation. Can you suggest any solutions that would ensure an equal provision of allied health professionals across Scotland?

Dr Holdsworth: I quite agree with the thrust of that question. With the increase of AHPs in some primary care and community settings, we are beginning to address some of those issues in certain areas, although perhaps not yet in very remote or rural areas.

In the past, we might not have engaged with higher education institutions or brought undergraduates into remote and rural areas. As a result, their only clinical experiences have taken place within half an hour's travel from the centre of Edinburgh, Glasgow or Aberdeen and they have not been as exposed as those in general practice are to working in remote and rural settings. However, under one initiative, physiotherapists from one of the education providers have been working with NHS Western Isles and health boards in other very remote and rural areas to provide rotations of staff. Stephen Moore will be able to give greater detail about that and other initiatives, which have in fact resulted in a reversal. Even though those people had not had experience of such areas, they have now chosen to live there.

We must try to incorporate such elements in each of the options for higher education institutions to ensure that undergraduates receive a more diverse clinical experience and to encourage many other urban centres that do not have a problem in attracting newly qualified staff to include more semi-urban and rural areas in their rotations. That approach has been proven to work.

Stephen Moore: Given that my day job is head of podiatry for NHS Western Isles, I already work in a remote, rural location.

The situation is not dissimilar to the problems that have been encountered in medicine. There is a bit of an image problem: working in remote or rural areas can be seen as a cul-de-sac in one's career. What we have going for us, and what we need to market a bit more, is the scope of practice. We need practitioners with good experience who can undertake a broad spectrum of practice. We want some specialists, particularly in extended roles, but they will be supported by experienced general practitioners. That gives people a broad and enjoyable range of work.

We have issues about attracting people via the student pathway. It is fair to say that, for some professions, training mostly takes place in the central belt. In my health board, we have more podiatry students from Huddersfield in England than from the Scottish universities. I would like more students to be trained in remote and rural Scotland because we have something to offer them that they do not see in some of the larger teaching hospitals.

The other issue is CPD and the retention of skills. We need to be much more imaginative about how we do that—for example, the remote and rural areas resource initiative, which is funded by the Scottish Executive, funded a project to support web-based CPD for podiatrists to demonstrate that such technology can be used to provide CPD to any profession that works in rural Scotland. The project was successful; a large amount of the teaching material was designed and developed in Melbourne in Australia and beamed over the internet. There are ways in which we can keep people working in rural Scotland, but we have to gear up systems to support them to do so.

Mr Davidson: Two helpful comments have been made, but I wanted to ask a question on the Executive's 2002 document "Building on Success - Future Directions for the Allied Health Professions in Scotland". Has that strategy been the trigger for your 2005 start point for your accredited CPD? Have the promises or commitments that were made in that document been delivered?

Marc Seale: The decision to bring in the CPD in July 2005 was driven by the extensive consultation process that we undertook when we were in shadow form. In essence, there were so many views and concerns about CPD that we decided to leave it for a year after our register opened. That is the reason—it was driven by the HPC legislation. Beyond that, I cannot comment.

Mr Davidson: Can the other witnesses comment on that?

Dr Holdsworth: The "Building on Success" strategy was developed by Scottish AHPs for Scottish AHPs. I am not sure that it would have had a major influence on the decision because we are registered with our UK bodies and with the HPC, which is the UK regulatory body. However, the decision would have been informed by the strategy.

Mr Davidson: It would be helpful if we could have a written answer on the roll-out of the Scottish Executive document.

The Convener: Okay, if the witnesses are happy about that.

That exhausts our questions for the panel. As you will have gathered from the requests for written evidence, it is unlikely that today's session has entirely exhausted our contact with you in relation to the inquiry, but we hope to be able to do

the rest of the work with written questions and answers. Thank you for coming along this afternoon.

Proposed Dentists Act (Amendment) Order 2004

16:29

The Convener: I welcome Ray Watkins, who is the chief dental officer, and Dr Hew Mathewson, who is the president of the General Dental Council. I will ask you each to speak for no more than two or three minutes in respect of the proposed Dentists act (amendment) order 2004. I ask you, in your comments, to flag up the specific issues that you think are important and relevant for the committee to think about in the longer term.

Dr Hew Mathewson (General Dental Council): I start by referring the committee to its own background paper for this item.

The Convener: Yes—that is the paper that was circulated by the committee. You may refer to whatever you like.

Dr Mathewson: As paragraph 7 of your paper outlines, the proposed order is basically about the next stage of the modernisation of our procedures. I will take you through some of the bullet points in that paragraph.

The first one is important. It is about the

"reform of the GDC's fitness to practise powers".

At the moment, we have a definition of serious professional misconduct. That would change; the issue would simply be about whether or not a registrant was fit to practise. That would give us a much better range of powers of disposal with regard to imposing conditions and so on. There is a proposal in the order that, if someone is erased from the register, that should be for a minimum of five years. We do not think that that is constructive—I would be happy to expand on that later.

The next two bullet points under paragraph 7 are self-explanatory. The fourth bullet point is about co-operation among the four countries of the United Kingdom. We already co-operate in that way, but the proposed order formalises that. The fifth bullet point perhaps deserves a little explanation. Currently, only those businesses that were listed or registered in the 1950s can carry on the business of dentistry. There are about 20 of them. The proposal to remove certain restrictions on dental bodies corporate would allow anyone to set up a business to carry on the business of dentistry. We welcome that, but we believe that, if that happens, a majority of directors should be registrants of the General Dental Council. That would be in the interest of the protection of patients.

The next bullet point contains a small typographical error. It refers to

"complaints about NHS dental service",

but it should say "complaints about non-NHS dental services". That alters the meaning significantly. There is currently no mechanism for patients who receive private treatment to complain and we want to create one. We want to have a system that provides plans for that.

The second-last bullet point is key. We want to change the way in which we register existing dental hygienists and therapists so as to make their registration the same as that of dentists. At the same time, we want to register other members of dental teams who are not currently registered, including dental nurses and technicians. We further wish to create new categories of dental workers, such as orthodontic therapists. The last bullet point is self-explanatory.

Ray Watkins (Chief Dental Officer): The starting point is the Dentists Act 1984. There are some problems with the fact that we are dealing with a rather out-of-date act. Hew Mathewson has already highlighted many of the issues and I will not repeat the points that he has made.

Before the consultation on the proposed order, we tried, on behalf of ministers, to highlight the fact that there are different structures and organisations in Scotland, not least the Scottish Parliament. The education systems are different in Scotland, which could impact on some of the issues with which we are concerned. Dental services are emerging as having different structures; we have started to move away from structures that apply in other parts of the UK.

We have produced draft national standards for dental services in Scotland. Those standards will include a role for the Scottish Commission for the Regulation of Care in private dental services. That is one set of standards in Scotland and we are completing the consultation on that. I do not know whether members have seen the consultation document, but I have it here with me. It highlights from a patient's perspective the standards that they should receive. Those are joint NHS and non-NHS standards.

I will highlight some of the difficulties that we encounter in relation to NHS and non-NHS standards. They come down to some fairly straightforward things. When someone gets treatment at their dentist's, they might have eight of their fillings on the NHS and two of them privately. Deciding how to control that and to deal with complaints becomes complex if we use such divisions. Therefore, we have tried to create a co-operative framework in which we work closely with organisations throughout Scotland and with the General Dental Council. We co-operate on producing standards and regulatory frameworks. We seek a co-operative view rather than a competitive one.

I do not want to say much more other than that, through the order, the Executive's main aim is to find ways of strengthening the partnership between the GDC, all NHS organisations, the Scottish Parliament and the Scottish Executive.

The Convener: I have an initial question and Mike Rumbles will probably want to come in after me. As I understand it, the care commission will soon assume responsibility for standards in private dental services in Scotland and part of that will probably include complaints investigation and inspections. Is that correct?

Ray Watkins: Yes.

The Convener: How will that sit alongside what the GDC wants to do?

Ray Watkins: We will have to work together and we will do so. That is the point. It is a matter of us getting together. We create the regulations and then get all the bodies working together. There could be appropriate areas in which the care commission and others could work together—for example, complaints, which is a complex area.

The Convener: Is there potential for confusion if two bodies deal with the same area?

Ray Watkins: We would work together to prevent that and to ensure that we all have clear remits. There is already confusion in the system because, as I said, most patients do not know what sort of services they have had. At the first contact with patients who have a complaint, we find that they tend not to be sure whether they had private or NHS treatment—for example, they often do not know whether a filling was done privately or through the NHS.

We need to develop among the organisations a clear system for patients so that they have one access point. If a complaint is not resolved as it goes up through the system, other organisations can then come into play. Designing the system is a matter of us sitting down with colleagues such as Hew Mathewson. That is what we are supposed to do. There is potential for confusion, but it should be resolved by appropriate discussions between the organisations that are involved.

Mike Rumbles: Correct me if I am wrong, but seven of the consultation paper's eight proposals for the GDC—which are listed in the bullet points in paragraph 7 of our briefing paper—are about reserved, Westminster matters. The second-last bullet point in paragraph 7 refers to a proposal that is within our competence, which is the

"introduction of comparable regulation of PCDs"—

professions complementary to dentistry—

"in line with regulation of dentists and removal of restrictive lists"

for

"dental hygienists and dental therapists".

Is the point of the order to free up working practices within the dental profession and dental practices in Scotland?

Dr Mathewson: We believe that that would be a consequence of the order. However, the point, first, is to regulate all members of a dental team with whom a patient comes into contact. Currently, when a patient goes to a dental practice, many of the people with whom they come into contact are not registered or have no quality standards from the education process. We want to regulate that situation. The consequence of ensuring that everyone is on the same register is that we will remove barriers in terms of prescriptive lists of what people can do. We intend to free that up and we hope that that will allow more flexible working.

Mike Rumbles: Ray Watkins talked about people not knowing whether their treatment was private or NHS. Someone with a complaint about an NHS dental service must go through the NHS and, eventually, if it is a matter of professional misconduct or whatever, the complaint will go to the relevant professional organisation. Are you saying that the care commission would be the point of call for such complaints?

Ray Watkins: We have not taken a final view on that. When we first considered the issue, we were aware that the GDC was starting to look at the non-NHS side. However, the GDC has a role for the whole UK and there were gaps in that. At the time, no legislation was due in England on private dental care. Therefore, we advised ministers of our opinion that we should ensure that we have a clear system. We knew that the GDC was coming through with something, but we thought that we needed something in Scotland. Therefore, we have given the care commission a role in dealing with complaints. As the convener said, that could be confusing, but we did it to ensure that we had regulation coming out at the end. We need to sit down among ourselves and discuss it. However, if the order goes through, we will have the strength of regulation to ensure reasonable regulation of the private system and a clear complaints system.

Dr Mathewson: It is 17 years since I first sat, as a Scottish practitioner, on a panel that was trying to devise a complaints system for private practice. We never managed it. The GDC took the view that, although it was not a natural thing for us to devise a complaints system, we wanted to do so. We looked around to see whether somebody else would take it on, but no one would. Therefore, we have done it. However, we are not hung up about running it. We have planned meetings with officials in Scotland to discuss how our complaints system would operate here and how it would interrelate with other systems.

Were there a satisfactory system in Scotland, we would not be territorial and would give up our system here. The only confusion for patients would be that the system in Scotland would be different from that in England, but that situation is hardly new. We have no great desire to run a complaints system, but we feel that there is a need that must be met and that the sooner that it is met, the better.

Mr Davidson: I recently had a meeting with the British Dental Association Scotland. My wife, by the way, used to sit on the GDC, so I understand where you are coming from on some aspects. However, I do not understand what happens if a dentist is reported to whatever body it happens to be and is found to be professionally negligent. You said earlier that you were not happy about there being a minimum suspension period of five years. I presume that there is no scale of charges and that someone would be found either guilty or not guilty, regardless of the alleged negligence. What body judges a dentist's professional ability to continue as a registered dentist? In addition, what variable powers do you want? What remedies do you seek? That would seem to be a day-to-day procedural issue that has nothing to do with the care commission.

Dr Mathewson: An independent appointments panel undertook a national recruitment exercise to get a panel of 35 people that consists of 15 dentists, 15 lay people and 5 PCDs. They make up our fitness-to-practise panel and they are very much at arm's length from our council. After being trained, they were gradually introduced to the work with the existing panel and they have now taken over from it. Those people are independent of us, but they are answerable to us. There is continual assessment and appraisal of what they do.

Our sanctions for dentists range from doing nothing or expressing disapproval, to suspending them or striking them off the register. We want to be able to suspend them but insist that they must do A, B and C before they get back on the register. We could also give them conditions for continuing to practise—for example, insisting that they will not work alone or unsupervised, enter into certain types of work, or do cosmetic dentistry of a certain kind or implants. We also think that it may sometimes be necessary to erase someone from the register, because disapproval must be shown in a strong way.

Throughout society generally there is the idea that people should be rehabilitated. If someone were erased for five years, it would be difficult to get them back into the profession satisfactorily.

Therefore, we think that there is a case for having a much shorter minimum period of erasure of, say, two years or whatever—certainly a shorter period than five years. We think that panels would be reluctant to use the erasure sanction if they felt that somebody could ultimately be rehabilitated. We cannot read the minds of independent panels, but our fear is that they would not erase some dentists when it would perhaps be better if they did so.

Mr Davidson: In simple terms, how many people get struck off in Scotland per year?

Dr Mathewson: I would not say that Scotland has a particularly bad record in that area. I would guess that, on average, one or two Scots are struck off most years, but not every year.

Mr Davidson: So it makes sense to follow the regulatory routes of other professions—for example, the pharmaceutical profession or privy councillors—but you will not have a huge impact on the loss of dental professionals. Your approach will have a greater impact on performance.

Dr Mathewson: One aspect is a continuing process of getting to grips with people before they become involved in fitness-to-practise proceedings—when they have not become that bad and they are simply poorly performing. We have a blueprint for a poorly performing dentist system so that we get to grips with health professionals in dentistry who are doing badly before they get into trouble. We think that we will make a difference with that. We also think that we will make a difference when people are not so bad that they are erased and they are simply allowed to carry on. They should carry on with remedial measures and we want to be able to impose such measures.

16:45

Mr Davidson: Will you achieve what you seek to do?

Dr Mathewson: If we obtain the powers, they will work well. We already have a model. In health-related cases, when people have mental illness, addiction or other health problems, we have the power to set conditions, which works well. The council's health committee works in camera, so people are not aware of that, but setting conditions works well and is often the way forward.

The Convener: I call Shona Robison.

Shona Robison: My point has been covered.

Dr Turner: I was astonished to read about

"a new requirement that dentists have indemnity insurance before registration."

Have I read that correctly? I would have thought that that was compulsory, as in medicine.

Dr Mathewson: At the moment, having indemnity cover is an ethical obligation on all doctors and dentists. Since 1999, the Department of Health has had the legal power to impose that, but that has not happened. The suggestion is that we rather than the department will exercise the power. A minority of people do not have indemnity cover because they have stopped paying for it or whatever. Having such cover is an ethical requirement and the change would make it a statutory requirement.

Dr Turner: So you would strike off a dentist who was not signed up.

Dr Mathewson: We already do that, but the change would give us the power to have better scrutiny.

Dr Turner: Do you have an up-to-date number? Is the figure small?

Dr Mathewson: I am sorry; I do not have the number of people who do not have indemnity insurance. The problem is that the organisations that provide insurance indemnity regard their information as commercially sensitive, so they do not tell us how many people are involved. In broad terms, the vast majority of the profession have indemnity insurance, but I cannot give a precise number, although I would love to have one.

The Convener: Does that mean that no independent way to check exists?

Dr Mathewson: Not that I am aware of. The information can be checked only individually.

Dr Turner: That scares me.

Dr Mathewson: In effect, we want to check the information individually.

The Convener: The situation is astonishing.

Dr Turner: I do not understand it.

Kate Maclean (Dundee West) (Lab): I suspect that everybody will check that tomorrow.

The fifth bullet point under paragraph 7 refers to the

"removal of certain restriction on dental bodies corporate".

I presume that that means that anybody will be able to establish a dental practice, but you said that a board must have a majority of registrants. Is that a simple majority or has a percentage been set? Will that requirement apply only on establishment or will it continue and be monitored closely, because it is a public safety concern?

Dr Mathewson: The consultation paper proposes that anyone should be able to establish a dental practice or business that carries on dentistry and that is it. We think that not only on establishment, but always, a majority of directors should be registrants of our council, although they

would not necessarily be dentists. That would mean that the majority understood patients' interests and that we could hold people to account if things were not done properly. That is important.

Kate Maclean: Is that a simple majority?

Dr Mathewson: We envisage a simple majority.

Mr Davidson: I happen to be a pharmacist. The likes of Boots have a pharmacy superintendent who takes that responsibility and is up to his eyeballs with the Royal Pharmaceutical Society of Great Britain and everybody else if Boots does anything wrong. He certainly does not represent a majority of the Boots board or any sub-company that Boots might own to operate in dentistry. Are you trying to get away from that situation so that people have a contract with the NHS?

Dr Mathewson: Boots Dentalcare, which will wind up shortly as members know, is a body corporate—Boots bought one. The majority of its directors are and must be dentists.

Mr Davidson: The parent company owns the shares.

Dr Mathewson: The parent company is entirely different.

Mr Davidson: I understand the point.

Dr Mathewson: It is the directors who are responsible for the operation who are important and that situation should continue.

Helen Eadie: A thought has just occurred to me. Are the grants and financial support from the Scottish Executive to dentists throughout Scotland accompanied by a checking mechanism to ensure compliance with the various controlled aspects that you have talked about, or is Scottish Executive finance just handed out in any case?

Dr Mathewson: As president of the General Dental Council I cannot answer that question but, as an NHS practitioner in Edinburgh, I can give you an answer. We are subject to practice inspections—the same inspections take place throughout Scotland. Part of the inspection involves checking that each dentist in the practice—I cannot speak for community clinics—has a practising certificate from the council, an indemnity certificate or insurance from an appropriate organisation and satisfactory documentation for pressure vessels and X-ray machines, for example. The chief dental officer introduced strict and thorough monitoring in Scotland some years ago—rather piecemeal monitoring was already in place, but the system is now very substantial.

Ray Watkins: The ad hoc practice inspection that Hew Mathewson described is part of our progress during the past five or six years. The performance assessment framework for health boards includes a requirement to inspect all dental practices in their areas in a three-year period. Practice inspections have been brought up to a standard—we are considering raising the standard—and we check indemnity, pressure-vessel insurance and so on. We are not over-confident, but we have introduced reasonable standards and we are in the middle of reviewing them to ascertain whether they can be raised. The process exists and I reassure members that 100 per cent of practitioners who work in Scotland have had to show their indemnity insurance and other matters during practice inspections.

There is sometimes an issue—I am just being honest—because the fact that we have a three-year inspection system means that people can fall through the system. There are always aspects that need to be tidied up and secured and sieves through which people can fall. Unfortunately, each time we develop a sieve, someone thinks of a different way to get through it.

Helen Eadie: Can you reassure us that the Scottish Executive gives no grant money to practices that have not undergone that kind of check? The Executive has handed out significant moneys to the dentistry profession during the past few years.

Dr Mathewson: A dentist must be in practice to have a grant; they cannot start a practice without having all that stuff in place. They are then subject to on-going inspections. There are even tougher inspections in relation to matters such as vocational training practices—a lot of inspection takes place.

At any time, an indemnity organisation might exclude someone from its membership, for obvious reasons. It would be incumbent on such a person to find insurance at Lloyd's or approach another organisation and perhaps pay a loaded premium, but despite receiving notice, the individual might not do that for a week or a fortnight, or they might not do it at all. They might be ill and simply neglect to open all their mail. The matter is rarely simple and often complicated. Someone who is ill might get into trouble—that is inevitably a difficult situation.

Ray Watkins: We ensure that anyone who receives a grant complies with certain reasonable standards. One grant stipulates that they must have passed the practice inspection scheme before receiving the money, but many grants are linked to such standards.

The Convener: I thank the witnesses for attending the meeting. The consultation on the order is open until 30 October, so the committee must decide whether it wants to write a letter—I think that that is all that we can do at this stage. It seems to me that the only issue that arises out of

the evidence that we heard is the striking-off period.

Shona Robison: Perhaps we should also flag up the issue to do with directors, which is important.

The Convener: Do you mean that you agree with the evidence that we heard that a majority of directors should be registrants?

Shona Robison: That makes sense.

The Convener: Does anyone want to comment on the striking-off issue?

Mr Davidson: It is very practical.

The Convener: What do you mean? It is proposed that the period of erasure from the register should be five years, but the witnesses suggested a slightly different approach.

Mr Davidson: I am suggesting that we support the view that we heard in evidence.

The Convener: Do members have a view on that?

Mike Rumbles: I have a question about the process. Only one of the bullet points is for us in a legislative sense—which is not to say that we cannot comment on the others. What is the process?

The Convener: We are talking about a consultation that is being administered by the Department of Health south of the border in concert with the Scottish Executive. It is a UK-wide consultation.

Mike Rumbles: If we are going to change the law and it is our responsibility, will a Sewel motion come before the Parliament?

The Convener: No. An order will come before us, because some of this relates purely to devolved matters—some is reserved and some is devolved.

Mike Rumbles: It will come to us.

The Convener: Yes. It will come to the Scottish Parliament. The point that I made at the beginning was that when the order comes to us it will not be amendable. At that point, there will not be an opportunity to have any input about what is said. This is an opportunity for us to have formal input in the consultation process if we wish. Do you have a view on that?

Mike Rumbles: I would like to support the specific bullet point about the regulation of professions allied to dental practice, because that is fundamental and will allow us to do many different things.

The Convener: What about the striking-off issue? I know that it is difficult, because we do not have much time to go into it in detail.

Dr Turner: I agree with the witnesses. If there is any hope of retaining an expensively acquired skill that is required in the community, we want to be able to do so.

The Convener: We will draft a letter and circulate it. If people feel strongly about any bit of it, they can comment. We will get it faxed off by 30 October.

Mr McNeil: My only problem with our commenting on that is that we have not heard the other side of the story.

The Convener: I appreciate that. The difficulty is that the consultation process was discovered late in the day. I am concerned that too often we discover things after the process has been gone through. I was concerned that in this case we would not have any opportunity to have any input once the order came before the Parliament. We will circulate the letter as soon as possible.

Subordinate Legislation

Miscellaneous Food Additives Amendment (Scotland) Regulations 2004 (SSI 2004/413)

Feeding Stuffs (Sampling and Analysis) Amendment (Scotland) Regulations 2004 (SSI 2004/414)

16:56

The Convener: Item 4 is subordinate legislation. The committee has been asked to consider two negative instruments. The Subordinate Legislation Committee has no comment to make on the Miscellaneous Food Additives Amendment (Scotland) Regulations 2004. Comments on the Feeding Stuffs (Sampling and Analysis) Amendment (Scotland) Regulations 2004 are reproduced in the paper that was circulated. Does anyone have any questions or comments? The Subordinate Legislation Committee made the point that the Feeding Stuffs (Sampling and Analysis) Amendment (Scotland) Regulations 2004 should have been implemented by 1 July 2004. An explanation has been given for the late implementation. Is anyone particularly concerned?

Members: No.

The Convener: Right. I close the meeting a minute ahead of schedule and thank everyone for their forbearance this afternoon; the meeting was long and the room was extremely hot. I will raise that issue, because it is not acceptable. Next week's meeting does not look as if it will be quite as long.

Meeting closed at 16:59.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Thursday 4 November 2004

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Astron Print Room, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament and annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committes will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at the Astron Print Room.

Published in Edinburgh by Astron and available from:

Blackwell's Bookshop
53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders
business.edinburgh@blackwell.co.uk

Subscriptions & Standing Orders
business.edinburgh@blackwell.co.uk

RNID Typetalk calls welcome on
18001 0131 348 5412
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by Astron