HEALTH COMMITTEE

Tuesday 22 February 2005

Session 2

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HEALTH COMMITTEE
5th Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*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)

*attended

THE FOLLOWING ALSO ATTENDED:

Rhona Brankin (Deputy Minister for Health and Community Care)

THE FOLLOWING GAVE EVIDENCE:

Martyn Evans (Scottish Consumer Council)
Andrew Lamb (British Dental Association)
Catherine Lush (Highland NHS Board)
Alex MacKinnon (Scottish Pharmaceutical General Council)
Mary Morton (Highland NHS Board)
Chris Naldrett (Scottish Executive Health Department)
Hal Rollason (Optometry Scotland)
James Semple (Scottish Pharmaceutical Federation)
Joyce Shearer (Fife Local Health Council)
Dr Iain Wallace (Greater Glasgow NHS Board)
Dr Hamish Wilson (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 22 February 2005

[THE CONVENER *opened the meeting at 14:16*]

Interests

The Convener (Roseanna Cunningham): We will have a full house for today's meeting; I hope that everyone can be accommodated. While we wait for everyone to take a seat, I invite Nanette Milne, as a new member of the committee, to declare any relevant interests.

Mrs Nanette Milne (North East Scotland) (Con): I have a medical degree from the University of Aberdeen. However, it is some time since I worked in the national health service and I am no longer registered with the General Medical Council.

I am a member of the Aberdeen Medico-Chirurgical Society and a lay member of the University of Aberdeen court—which I mention because the university has a medical school. Finally, I am married to a general practitioner who has formally retired but who still works part time.

Items in Private

14:17

The Convener: Item 2 on our agenda is to decide whether to take items 5 and 6 in private. Item 5 will be an immediate discussion of the evidence that we will hear this afternoon. It will, in effect, be part of our draft stage 1 report on the bill. Item 6 is also a draft report, on our eating disorders inquiry. Do members agree that we should discuss those two items in private?

Members *indicated agreement*.

Subordinate Legislation

Scotland Act 1998 (Modifications of Schedule 5) (No 2) Order 2005 (Draft)

14:18

The Convener: Item 3 is two pieces of subordinate legislation. I welcome the minister—once again—to the committee.

The committee is asked first to consider an affirmative instrument—the draft Scotland Act 1998 (Modifications of Schedule 5) (No 2) Order 2005. The minister is accompanied by her officials Fiona Tyrrell and Joanna Keating.

I can advise committee members that the Subordinate Legislation Committee considered the order and made no comment on it. Does any member wish to seek clarification from the minister or her officials on the order?

Members: No.

The Convener: Does any member wish to debate the order?

Members: No.

Motion moved,

That the Health Committee recommends that the draft Scotland Act 1998 (Modifications of Schedule 5) (No 2) Order 2005 be approved.—[*Rhona Brankin.*]

Motion agreed to.

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 2) (Scotland) Order 2005 (SSI 2005/69)

The Convener: The second Scottish statutory instrument to consider is also an affirmative instrument—SSI 2005/69, on amnesic shellfish poisoning. For this instrument, the minister is accompanied by Sandy MacDougall from the Food Standards Agency, who is slotting into his place as we speak.

The Subordinate Legislation Committee considered this order at its meeting this morning and had no comment to make. Does any member wish to seek clarification from the minister or her official on the order?

Mrs Milne: I do not seek clarification, convener, but I maintain the stand that I took at the committee's previous meeting and I will oppose the order. I hope that I vote the right way this time. [*Laughter.*]

The Convener: Yes—you will be correcting the stand that you took at the previous meeting.

Does any member wish to debate the order?

Members: No.

Motion moved,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 2) (Scotland) Order 2005 (SSI 2005/69) be approved.—[*Rhona Brankin.*]

The Convener: The question is, that motion S2M-2439 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (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

Milne, Mrs Nanette (North East Scotland) (Con)

ABSTENTIONS

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

The Convener: The result of the division is: For 5, Against 1, Abstentions 2.

Motion agreed to.

The Convener: Thank you, minister. That was short and sweet.

I will now suspend the meeting for five minutes only, to allow witnesses who intend to give evidence on the Smoking, Health and Social Care (Scotland) Bill to come to the table.

14:21

Meeting suspended.

14:24

On resuming—

Smoking, Health and Social Care (Scotland) Bill: Stage 1

The Convener: I thank everyone for coming along. I think that the witnesses realise that the committee is doing something a little different today in that we are having a round table discussion rather than our usual approach of having panels of witnesses slot in and out for questioning by members. This is the first time that the committee has tried such an approach and we are a little uncertain about how it will work. We hope that it works well and that everyone will join in the spirit of the approach, which is about engendering livelier cross-participation than can happen when members simply question witnesses.

The witnesses were sent a note that introduces the process with the papers for the meeting and I hope that they have had an opportunity to read the note and get their heads round the new way of working. The committee papers included background briefings from the Scottish Parliament information centre on parts 2 and 3 of the bill, along with submissions from a number of the witnesses—the committee has received other submissions, too.

I will ask the Executive officials to outline briefly—they must be really brief, because we are quite pressed for time—the main provisions of the parts of the bill with which we are dealing. I will then go through those parts of the bill section by section and invite people to comment. That will not preclude cross-discussion and at some point during the discussion on each section committee members will want to ask questions. We will try to get through the work as well as we can. It will not be necessary for every witness or committee member to comment on every section that we discuss; some sections might be completely uncontroversial, so people should comment only if there is something that they want to contribute. I invite the officials to refresh members' memories about parts 2 and 3 of the bill and then I will start the process and see how we get on.

Dr Hamish Wilson (Scottish Executive Health Department): I will be as brief as I can be. Three main areas are covered by part 2. First, the implementation of the partnership agreement pledge to introduce free dental and eye checks for all before 2007 is covered by sections 9 and 10. The provisions also allow for more comprehensive oral health assessments and eye examinations than current legislation permits. The second main area is dental services and in that context the

main provisions relate to the dental charging regime and the opportunity that we have to separate the dental charge from how dentists are paid, which will allow us to make the charging system more flexible and transparent. Section 12 extends the arrangements for the provision of general dental services to include bodies corporate—currently, arrangements can be made only with individual dentists. Section 13 allows health boards to provide assistance, including financial assistance and support to persons who provide general dental services and section 14 allows health boards to make arrangements with general dental practitioners to enter into what we call co-management schemes in relation to functions that are complementary to the work of hospital departments.

The final sections of part 2 deal with the listing of dental and ophthalmic contractors. Currently only those whom we describe as "principals" are included on health boards' lists, but in future it is intended to include in lists for dental and ophthalmic services people who assist with the provision of those services—so the bill extends the provisions for listing. That is a clinical governance issue for health boards. Those are the main provisions of part 2.

The Convener: Will you also describe part 3?

14:30

Dr Wilson: Part 3 relates to community pharmacy services in Scotland. In general, the provisions are intended to underpin the implementation of a new community pharmacy contract, which is currently under discussion with the profession in Scotland. Section 18 introduces a duty on health boards to plan and then provide or secure the pharmaceutical care services that are required for their areas. Section 19 describes the contractual arrangements under which pharmaceutical care services will be provided or secured. Section 20 strengthens the clinical governance arrangements in the community pharmacy sector, as I described in relation to dental and ophthalmic services, by extending the listing arrangements to encompass everyone who performs pharmaceutical care services. Section 21 empowers health boards to provide assistance and support to those who provide pharmaceutical care services. Finally, paragraphs 11 and 12 of schedule 2 provide powers to transfer resources for pharmaceutical care services to health boards' unified budgets.

The Convener: Thank you. We will start by considering sections 9 and 10, which deal with free dental and eye checks. I invite the patients' representatives to comment: they are Martyn Evans, from the Scottish Consumer Council; and Joyce Shearer, from Fife local health council.

Martyn Evans (Scottish Consumer Council): Should I be brief?

The Convener: Very brief.

Martyn Evans: We welcome the proposals, which will reduce the initial barrier to treatment for people. However, we have concerns about how the proposals can be implemented, which is not the direct concern of the committee. We would like there to be a greater emphasis on the use of professions complementary to dentistry in delivering the policy. In the context of the evidence of the Audit Commission, we are not convinced that six-monthly dental checks are universally necessary. We are concerned that aspects of the current process of dental checks, for example additional work such as scaling and polishing, which are not part of the dental check but form a significant part of a dentist's income, should be clearly defined, so that users know what they will pay for and what will be free in future.

Joyce Shearer (Fife Local Health Council): In a nutshell, I will focus on four key areas. First, access must be based on need rather than the ability to pay—

The Convener: Could you ensure that you speak directly into the microphone? If you do not do so people will have difficulty hearing you.

Joyce Shearer: Secondly, and linked to access, accommodation, by which I mean the places in which checks are carried out, must be fit for purpose. Thirdly, patients are very much concerned with accountability and whether robust standards and procedures are in place in relation to assessment and treatment. Finally, in relation to credibility, the regulation of the professions is foremost. The professionals who carry out the examinations must be registered and have recognised qualifications.

The Convener: I invite comments from the witnesses from the professional bodies: the British Dental Association and Optometry Scotland.

Andrew Lamb (British Dental Association): On free dental checks, in our response to the consultation, "Modernising NHS Dental Services in Scotland", we supported the principle of a properly funded oral health assessment as part of basic oral health care. We are pleased that the bill uses the words "oral health assessment". It is important that we understand exactly what will be delivered as part of the pledge and that we fully define "oral health assessment". It is also important that patients have access to a dentist who can deliver the assessment.

We also have concerns about funding. The properly funded health assessment will require more than just a quick look at a patient's oral tissue; it will require an assessment of the

individual patient's needs, and the ability to talk through with the patient their particular problems and to focus on a preventive approach. The time that is required to allow dentists to take such an approach is not available in the current system. One of the reasons why dentists are moving into the private sector is so that they can deliver a preventive approach. Dentists need time to be able to do that. We are concerned that, given the continuing problems of access to dentistry, the bill might raise expectations in patients' minds that cannot be delivered.

It is important that the oral health assessment is not considered in isolation from the general overall principles of "Modernising NHS Dental Services in Scotland". Without a ministerial response to that, we are talking about the oral health assessment and free dental checks in a detailed policy vacuum. It is a bit unfortunate that we are in that position, because the oral health assessment cannot be taken in isolation and must be part of the overall package.

Three questions arise. What does the oral health assessment consist of? How will it be delivered by the workforce? How will it be funded?

The Convener: No members have questions on those specific issues, so we will go to Mr Rollason of Optometry Scotland.

Hal Rollason (Optometry Scotland): I thank the committee for the opportunity to address it. As chairman of Optometry Scotland, I state that we broadly support the bill. Press coverage last week, which might not have been entirely positive, highlighted our concerns. We understand that the terms "sight test" and "eye examination" are used in the bill to describe the same entity, but that must be clarified in the bill or to the committee to ensure that the proposed health gain becomes a reality.

An urgent need exists for a new contract that focuses on health issues rather than just the provision of spectacles. Funding and resources are another issue. However, we have a positive message about improving health care by enhancing the scope of optometric practice. We aim to deliver a world-class service by providing not just the general ophthalmic services sight test that is available at present, but a more relevant and appropriate eye examination, whose availability will subsequently be widened to all. That will produce considerable health gains to the nation by introducing improvements in the eye care that is available to the public; the earlier detection of more eye disorders; better preventive eye care, which leads to a reduction in visual impairment; and a meaningful step towards the long-term goal of eliminating avoidable blindness.

Those measures will provide immediate access to a health professional who can assess, diagnose and treat or refer as required, and that service will be available in every community in an easily accessible and convenient environment, which will ensure equality of eye care throughout the country. Such measures will also achieve a significant reduction in inappropriate referrals to hospital eye departments. The combination of enhanced community-based care and the reduction of inappropriate referrals to out-patient departments will have a considerable impact on the time that people wait for hospital appointments. The measures will also reduce hospital waiting lists and waiting times. They will produce substantial savings in real terms for secondary care by helping to ensure that only people who need to be in hospital eye departments are sent there and by reducing the number of wasted out-patient appointments. They will also help to eliminate most of the 5 per cent of GP appointments that eye-related issues take up.

I work in the east end of Glasgow, in an area that has major health problems, according to every report that is published. The people in the east end become quite upset when they read such reports. I admit that I have a passionate and personal interest in improving health care in my area. Procedures that can provide health benefits somewhere such as Shettleston can work throughout the country.

The Convener: Health boards are also represented. From Greater Glasgow NHS Board we have Dr Iain Wallace and Highland NHS Board is represented by Catherine Lush. I ask them to make opening remarks.

Dr Iain Wallace (Greater Glasgow NHS Board): Greater Glasgow NHS Board supports the principle behind the proposals. It is difficult to gauge the unmet need and therefore the demand that will result from the bill and to know how we will deliver the service by the due date in places with access difficulties. We need to be mindful of the costs that are associated with providing the service against those of existing and proposed commitments.

Catherine Lush (Highland NHS Board): NHS Highland also broadly supports the initiative, but the access difficulties that we in Highland are experiencing with dental services mean that the initiative must be taken in tandem with every opportunity to develop the team approach and to maximise the use of professionals who are complementary to dentistry. The initiative will compound demand when the service is creaking to meet existing demand.

The Convener: I will ask members for their questions. I believe that Mike Rumbles wants to ask about Optometry Scotland.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I welcome Optometry Scotland's broad welcome for the bill. However, when I read some of its written submission, I was quite exercised. I will focus on one paragraph, which mentions the

"simple widening of access to a GOS sight test, the so-called 'free eye checks for all'".

The submission continues:

"To put it bluntly, such a change would be seen as being implemented only for political purposes since it would confer no health gain on the people of Scotland and, therefore, OS could not endorse such a proposal."

However, SPICe tells us that Optometry Scotland estimates that

"65% of patients are currently eligible to have GOS sight tests."

Hal Rollason: That is correct.

Mike Rumbles: Is it the logic of the submission that if there is no health gain for 35 per cent of the population, there is obviously no health gain for 65 per cent of the population—because the only difference is that the individual pays for the test? I would like some clarification about that because the submission makes a stark point.

Hal Rollason: That is precisely the point. There would be no new tests done if people got them free rather than paying for them.

Mike Rumbles: That is not my question. Your submission says that there will be "no health gain".

Hal Rollason: That is because there will not be any more tests done. That is what is behind that statement.

Mike Rumbles: So you are not saying that there will be no health gain. Surely it does not matter whether an individual pays for the test or not. There is health gain with sight tests.

Hal Rollason: There is health gain with the sight test. At the moment, it tends to be opportunistic health screening that occurs within a sight test.

Mike Rumbles: So when the written submission says that there will be "no health gain", it is not correct.

Hal Rollason: Our submission really says that there would be no health gain because there would be no new sight tests performed as the result of some people getting it free.

Mike Rumbles: But you are admitting that there would be health gain.

Hal Rollason: There is health gain in any sight test or eye examination.

Mike Rumbles: Right. Thank you. That is just what I wanted to hear.

Kate Maclean (Dundee West) (Lab): I did not see that article because I was otherwise engaged. However, my understanding is that even people who are currently eligible for free sight tests do not necessarily take them up. For instance, 20 per cent of school pupils have undetected levels of visual impairment.

The standard GOS sight test that is available at the moment is not a proper eye examination. If the bill introduced the right to such a test it would not necessarily lead to earlier detection of eye disorders or reduce future instances of visual impairment or blindness. Therefore, I conclude that unless the Executive ensures that the eye examination is a proper one, there will be limited health benefits for people. In that case, because there are people who currently do not take up the free eye tests to which they are entitled, it would be better for public health to target the money at those people, rather than to spread it so thinly that there is no significant health benefit. Is that correct?

Hal Rollason: There is a significant number of people in any category, such as drivers who do not pass the sight standard for the driving test, or people with diabetes who do not take up the diabetic check. There are all sorts of at-risk groups that do not currently have proper care. We are really promoting health care. The idea of the eye examination came about during discussions with the Scottish Executive. We could target a proper, health-based examination that is appropriate to the patient's symptoms.

Kate Maclean: So in your opinion, the groups that are most likely to get a health benefit from having proper eye examinations are the very groups that would probably not take up sight tests. I do not think that anything in the bill suggests that the sight test is compulsory, so those groups would need more assistance than just the availability of free sight tests.

14:45

Hal Rollason: There is certainly an education message that we have to get across to the effect that when someone goes for a sight test, it is based on legislation that came along 60 years ago that was largely designed to get specs for people who had come out of the war and were starting to work in offices. That is what the legislation that we work with at present was designed for.

We need legislation that acknowledges the fact that eye problems and general health problems can be detected in a routine eye examination or health examination. Those are the most important issues that we must focus on. Every day, I see somebody who comes in complaining about flashes and floaters, which might mean a retinal

detachment. It could be a child or an old person. They could be having migraines, which would be the common result. In any case, such complaints have to be investigated to ensure they are not something more serious. It does not matter whether the problem is cataracts, diabetes, glaucoma, possible retinal detachment, tumours, high blood pressure or hardening of the arteries—we look at a huge range of conditions every day, which need to be investigated in a more appropriate and thorough manner.

The Convener: Do any of the health board representatives have any comments to make on the issue of targeting? There are big sections of the population that appear never to access some of the services to which they are entitled.

Dr Wallace: We currently have that difficulty in targeting particular areas of deprivation with respect to breast-screening services, for example. We might reflect that money could be targeted at those areas. However, there is not always sufficient evidence about how we can reach out into the communities concerned to get people to take up the services. We might need to pilot initiatives to access such evidence.

The Convener: Is either of your health boards actively considering potential targeting mechanisms for eye and dental checks?

Dr Wallace: There is something called the Glasgow integrated eye service, which deals with the redesign of eye care. It is the interface between primary care and secondary care that is the issue, rather than targeting specific groups within the population.

The Convener: What is the situation in Highland?

Catherine Lush: I cannot comment on the optometry side of things, but we are trying to ensure that all children can access dental services. As for adult patients, we are dealing with the waiting lists and we are targeting our services there.

The Convener: Would it be the health boards that would do the targeting, even for optometry?

Dr Wallace: Yes.

Martyn Evans: The complexity of the charging system is a barrier to people taking up services, particularly in dentistry. We did a large piece of work on access in two primary care services. It became quite apparent through our talks that people thought that costs were higher than they were. People did not understand what the costs were, because they were not clearly displayed.

If we could take simplification measures, we might get increased take-up. The relationship between the charges to the patient and the costs to the practitioner is critical from the consumer's point of view. If the cost can be simplified, take-up can be increased. Then, there need to be discussions with the professions, which must establish what they are being paid for—what time they will be paid for to do what. That is a professional discussion. As I understand it, a dentist gets paid £6.80 for a dental inspection. That does not seem a lot of money for a reasonably thorough inspection, so there might be a case for increasing that amount. However, that is a separate matter from making the patient pay for that inspection.

Andrew Lamb: It is in fact £7.08 now—not a significant increase. The problems in dentistry are similar to those in optometry. The system was designed 57 years ago to deliver particular things that were relevant at the time. Dentistry has moved on and we must focus much more on the prevention of dental disease than on the management of the disease once it has occurred. Most of the problems that patients will encounter in the oral tissues—tooth decay, gum disease and oral cancer—are preventable. Time needs to be spent with the patient to identify the risk factors among individuals and to deliver a proper oral health assessment.

By and large, all the costs of running a dental practice come out of the dentist's income. One or two allowances have been introduced in Scotland, which have been helpful, but most of the costs of running dental practices come out of the income that is derived from the patients or from the NHS. It costs about £120 an hour to run a dental practice, so you can see how much time can be spent for £7.08. It is that time that requires to be funded—it is that time that dentists are prepared to give to their patients, and they are prepared to move into the private sector to deliver that type of health care.

A simple dental check-up is not what is required. What is needed is a proper oral health assessment that takes into account the patient's general health and matters such as their diet—including their intake of sugary foods and fizzy drinks—and whether they smoke. If they smoke, they should be provided with smoking cessation advice or passed on to someone who can deliver such advice. Like optometrists, dentists are in a good position to identify conditions such as diabetes. All such work is part of the general health game and dentists must be part of that process.

The Convener: I will allow Mike Rumbles to come back in briefly.

Mike Rumbles: The bill is enabling legislation—all that it will do is extend the scope for the provision of free dental checks and free eye tests. It is clear that that is the case and that, when the

bill has been passed, the Scottish Executive will produce proposals on dental checks and eye examinations. Is it the professional view of the witnesses, as representatives of professional bodies, that the more people who can take advantage of professional examinations in the fields of dental health and eye care, the better we will all be? Do they agree that if everyone could have such access, that would be a marked improvement?

The Convener: Please be brief.

Andrew Lamb: In our written submission, we said that the British Dental Association supports that. There is no question but that removing the barrier of a patient charge will help patients to access dental care, although the problem is whether there is dental care to be accessed. You are right about the bill being enabling legislation.

Hal Rollason: There is not an access problem in optometry, because there are enough optometrists. There are more than 1,000 optometrists—850 full-time equivalents in about 850 practices—working in Scotland, so there is plenty of access. I welcome the idea of a new eye examination that is appropriate to people's needs and symptoms.

Mike Rumbles: For everyone?

Hal Rollason: Yes.

The Convener: Shona Robison wants to take up some of the access issues.

Shona Robison (Dundee East) (SNP): I have two questions. In its submission, the BDA says that because of the lack of detail it is

"unable to provide comment on the Bill's objective that it will improve the oral health of the Scottish population."

That is a powerful statement. It is unusual for the committee to receive evidence that strongly questions a bill's fundamental objective and its ability to deliver its intention. Do you think that the mistake has been that the lack of ministerial statements about the Executive's intention has left a policy vacuum that makes it difficult to assess whether the bill will achieve its objective? It would be interesting to hear the Executive's response on that general point.

I have a more specific question. You talk about access, funding and the workforce. As things stand, will the Executive be able to deliver free dental checks in any form, whether simple or comprehensive? Given the barriers that exist, do you think that that commitment can be met?

Andrew Lamb: I think that that commitment cannot be met. It is important that the oral health assessment—I am pleased that the phrase "oral health assessment" is in the bill—is part of the overall modernising NHS dental services package but, as yet, we are not clear about what the Executive will do in that regard.

Shona Robison: At the moment, you do not think that that objective can be met.

Andrew Lamb: The British Dental Association does not believe that that objective can be met.

Shona Robison: Can we hear from the Executive?

The Convener: Wait a second. Helen Eadie has a point on the issue in question.

Helen Eadie (Dunfermline East) (Lab): My point follows on from what you said about the existence of a policy vacuum. Will you expand on that and on how you would like dental policy to develop?

Andrew Lamb: There are several issues. First, we must keep dentists who are working in the NHS in the system. That requires a fundamental review of the way in which NHS dental services are configured and delivered. That is what we are waiting for from the Scottish Executive. I have already emphasised the need to take the preventive approach. There is certainly still a need for repair and replacement of missing teeth, but we need to emphasise the preventive approach. Access to a comprehensive oral health assessment will certainly help to improve the oral health of the people of Scotland, if they can get access to such a service. However, there are workforce shortages and there has been question after question in the Scottish Parliament about such shortages—I do not need to advise MSPs of that fact—and about difficulties in accessing NHS dentists. Indeed, in some parts of the country, it is difficult to access any dentist, so there is a serious problem, but it is a complex one.

We have heard about the role of PCDs. It is important to examine that role; that is all part of modernising NHS dental services. However, the comprehensive oral health assessment has to be delivered by the dentist. The dentist has to determine the treatment or management needs of the patient, but if some time can be freed up by the dentist not doing some of the other work that a PCD could do, that will improve the access problems significantly. That is one element of the issue.

We have already heard about the need for a six-monthly check-up. As part of an oral health assessment, it is important to determine the appropriate time to recall a patient. The appropriate time might be three months or it might be two years. If more patients move from six months to a year or two years, perhaps that will also free up some time. That is why we need to consider the whole package. Mr Rumbles asked a simple question, and if a patient can access an

oral health assessment, that will improve the oral health of that patient.

The Convener: Nanette Milne and Duncan McNeil want to ask questions, and Martyn Evans would also like to comment.

Mrs Milne: To some extent, my question has been answered already. Research has shown that the incentives that have been used so far to attract dentists back to the NHS or to keep them working in the NHS have not really worked. Do you agree with that research?

Andrew Lamb: Yes.

Mrs Milne: Have you anything to add to what you have already said about attracting dentists back in or keeping them in the health service?

Andrew Lamb: No. The incentives have worked spasmodically and only in some areas. The Scottish Executive has tried, but it recognises that they are short-term solutions—we call them sticking-plaster solutions. You have to look at the whole package. Rather than incentivising dentists with golden hellos, the whole package of the way in which NHS dentistry is delivered must be appropriate and must suit the needs of dentists and patients. It is the patients who come first, and the dentists want to deliver proper oral health care.

There is no doubt that if the system is right, dentists will stay in it. What concerns me is that many dentists are opting out of dentistry completely when they reach their 50s. Our written submission refers to the fact that two thirds of dentists seek early retirement and a third of them do so because of stress. That is down to the treadmill of the current system of NHS dentistry. We are talking about dentists retiring, on average, at 57. If you kept them going for another three, five or seven years, until they are 65, that would help the access issue. Keeping those dentists in the system is important and is easier to achieve at this point than trying to recruit people from outside. The system must work well. It must keep the people in and it must allow them the time that they need to spend with their patients to deliver modern 21st century dentistry.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Your submission raised the issue of transferring practices and the need for some subsidy to enable new dentists to come in. Would an incentive there increase the likelihood of dentists retiring early? I shall let that question stick to the wall.

As you know, at our previous meeting we discussed a study that was carried out. You mentioned professionals complementary to dentistry. We are talking about how we will be able to deliver the services in the future, and the report said that a dental therapist could increase a dentist's output by 45 per cent and that a dental hygienist could increase a dentist's output by 33 per cent. Your submission seems to make the grudging recognition that professionals complementary to dentistry "may help". Will you assure us that the profession is totally committed to working in that wider team? Will you give us examples of what the profession has done to engage in and develop that process?

15:00

Andrew Lamb: We certainly welcome the inclusion of professionals complementary to dentistry as part of the team and support the principle that they should be allowed to work in all areas of practice. As I have said, dentistry has changed since the 1940s—it has become much more complex. The dentist should be required to identify the patient's oral health needs—which we have already discussed—and to carry out more complex procedures. More straightforward procedures can be undertaken by hygienists and therapists, and we would certainly welcome their inclusion in the dental team. However, dental teams should be led by dentists, who should determine patients' needs. The nation's oral health will certainly be improved by the provision of proper diagnosis and treatment planning and prescription to professionals complementary to dentistry.

I would like to pick up on the issue of the Scottish dental access initiative, which has made available funding to allow dentists to set up practices in Scotland. The problem with that initiative is that it has not supported existing practitioners—I think that Duncan McNeil alluded to that. Practitioners who have been committed to the NHS for some time have been unable to access funding, but somebody coming in from outside could set up a practice 200yd down the road and access up to £100,000. The problem with the initiative is that it requires people to commit themselves to substantial work in the NHS for seven years. It is not inappropriate for the NHS to want payback for investment, but in the vacuum of not knowing what the NHS will look like next week let alone in seven years' time, it is not surprising that the initiative has not been taken up. However, the profession as a whole certainly supports moves towards team working that includes professionals complementary to dentistry and the use of hygienists and therapists in appropriate circumstances.

Mr McNeil: But you see dentists as being the gatekeepers to the whole process.

Andrew Lamb: Absolutely—they must be.

Mr McNeil: Dentists deciding what would be appropriate would be the ideal. From that point of

view and in the light of the massive problems that there are in getting access to a dentist, what has your professional organisation done in the past year or so with the Scottish Executive and others to develop from the basis of the dentist being key and the team concept?

Andrew Lamb: Some of the things that we would like to see happening require legislative changes. The section 60 order has been delayed by the Westminster Parliament for another six months and proposals that we would like to come into place cannot do so until that legislation has been enacted. However, we are certainly discussing the future of NHS dentistry with the Scottish Executive and we are considering how professionals complementary to dentistry can be included within the modernisation framework. It might be more appropriate to ask the Scottish Executive about that matter.

Mr McNeil: As a representative of a profession who has something to say about the roles that people will fulfil, you have some responsibility to develop such roles as well as the professional organisation. We all have the public's interest at heart.

Andrew Lamb: We are in discussions with Governments throughout the United Kingdom on how professionals complementary to dentistry—

Mr McNeil: Is there anything specific that you have done to bring about team working?

The Convener: I remind Duncan McNeil that the committee has discussed the section 60 order that has been referred to. You might want to refer back to what was said, as some things cannot be done until it is brought into place. I say that as a matter of recollection.

Mr McNeil: I am making the point that the difference between the British Dental Association's written submission and the other submissions that we are considering today is that the other submissions show development and a willingness to see things change and they give some vision of people's future roles. Although the dentists' submission dwells on a lot of the problems, I do not think that it goes beyond them to give a vision of what dentistry will be like in the future.

Andrew Lamb: I reassure you that we will discuss the matter when we enter into discussions with the Scottish Executive over the modernisation of NHS dental services. The profession is training dentists and PCDs in a common environment, and the training arrangements for PCDs are now much closer within the training institutions. Undergraduate dental students are being trained in the same environment as PCDs, so that the young graduate will understand what the PCD can do. We are also looking at how the PCDs can operate within the primary care sector. It is all part of the overall package and, I am afraid, it involves some changes through a section 60 order.

Martyn Evans: The question is whether there is a capacity to deliver, now that the commitment has been made. Mr McNeil made my first point about professionals complementary to dentistry, which is in Professor Tim Newton's paper on access to dentistry. We made that point at the beginning and it is very important.

My second point is that there is a treadmill, at the moment. Because of the fee payment structure, dentists have to see their patients more often and have to do work that is not clinically necessary. The bill will alter that fee structure. We do not know what the structure will be, but it will be de-linked from patient charges. As we said at the beginning of our evidence, that is an important and progressive measure.

My third point concerns something that has not been mentioned—the local commissioning of services. Local commissioning, which is referred to in the bill, will allow a more flexible approach to be taken towards dental services and might well impact positively on the capacity to deliver. At the beginning of our submission, we say that we welcome the removal of the barrier of cost to looking at the initial inspection of teeth and eyes. We think that that is necessary but not sufficient to deliver access to services. There is a capacity issue, but we think that other things in the bill will help to create the capacity to deliver.

Kate Maclean: I have a brief question about the capacity to deliver. Andrew Lamb said earlier that, although under the current system everybody has a six-month check-up, that would not be necessary. People could have a three-month check-up or a two-year check-up, depending on circumstances. Would that be complicated to introduce? Would it affect the capacity to deliver the legislation?

Andrew Lamb: It is not complicated to introduce that; it requires the oral health assessment. It is a matter of identifying the risks to individual patients and determining, through consultation with the individual patient, when it is appropriate to recall them. As time goes on and a dentist gets to know the patient better, that period could be extended if the dentist knows that there are no risks involved—or it might have to be shortened. It is all part of the oral health assessment.

We will address in the next section the other issues that the patients' representative has raised. However, dentists are not carrying out unnecessary treatments; there is plenty of treatment out there that needs to be done, without dentists carrying out unnecessary treatment. The problem is in providing the care that the patients need. If dentists could spend more time in

assessing the patients' needs and perhaps preventing tooth decay by giving them dietary advice and so on, they might not take the current preventive approach, which is to cut a cavity because they are not sure whether something is going to become more significant if it is left for any length of time. If there was a proper review period, they would be able to decide whether a cavity needed to be cut. At the moment, the system does not allow dentists to take the preventive approach that is required. That situation needs to be changed, and we hope that the Scottish Executive will deliver that type of change in its programme.

The Convener: One or two questions have been indirectly put to the Executive official. Dr Wilson, I do not know whether you want to make any comment or whether you want to leave that until the final round-up session with the minister.

Dr Wilson: Certain points would be best dealt with in the final discussion with ministers. Nevertheless, I confirm that ministers have recently said that a response to the consultation on the modernisation of NHS dental services will be produced very shortly.

My only other point is that the bill's provisions on oral health assessment and eye examinations were intended to underpin the discussions to which Andrew Lamb and Hal Rollason have referred. The intention behind the bill is to move us forward and not to leave us stuck in the NHS's origins, as both representatives have said.

The Convener: We have covered many of the issues that I had expected would arise when we dealt with sections 12 to 14. As a result, instead of going through the whole process again, I ask whether anyone has any further comments on these sections, which deal with various changes to the provision of dental services.

Joyce Shearer: At the moment, parents are responsible for their children until they leave school. However, the number of people leaving school is huge. If, as one of the witnesses has said, those people had their dental assessment just after they left school and before they entered adulthood, dentists would be able to carry out more preventive work instead of having to deal with people who wait until much later in adulthood to visit them with problems that have arisen much earlier. The bill could target specific age groups. For example, university freshers weeks provide wonderful opportunities for examining young people's oral health before they set out on a career pathway.

The Convener: Do the health board representatives want to comment on sections 12 to 14?

Dr Wallace: No.

The Convener: So you simply stand by your previous comments on targeting.

Dr Wallace *indicated agreement*.

Martyn Evans: We welcome the assistance and support that health boards will be able to give dentists. For example, in our study on access to primary care services, dentists were the least physically accessible. Indeed, 75 per cent of the dentists whom we reviewed were located up a flight of steps. The dental profession will have to address a whole raft of legislation. This particular provision will lead to a reasonable public investment in more accessible services. We are also in favour of co-locating services, but we think that the bill represents a significant start.

Andrew Lamb: We welcome the removal of the link between patient charges and payments to dentists. As a result of the proposed legislation, a greater percentage of practices' income will not be derived from patient charges. We also welcome some direct reimbursement for premises, equipment, materials and so on.

Allowing health boards to determine the provision of oral health care services would provide a useful means of delivering that care to areas that suffer from such problems. In that respect, I hope that that there will be a Scotland-wide policy that can be locally implemented.

We have not yet mentioned access to secondary care, which is an area where local health boards could come into their own. One particular way of delivering specialist services could be extended into the primary care sector. The use of clinical networks and dentists with special interests in the primary care sector would benefit both patients, as it would give them access to services that they perhaps do not have at the moment, and dentists. One of the problems of recruiting particularly young dentists in so-called remote and rural areas is the sense of isolation and lack of support from their peers and the secondary care sector. As a result, working in a clinical network, which the local health board could set up, would be of benefit.

That said, Professor Tim Newton's report has highlighted the lack of information that is held by health boards. If the proposed legislation is going to work, health board chief executives and chairpersons must be aware of the dental agenda and the strategic need to deliver dental services in their area. It is important that the Scottish Executive engage at a high level with health boards. Down the ladder, there is a problem with delivering dental services within the available funding. However, we must still engage with key people in health boards to ensure that they understand that dentistry is an important aspect of health care delivery in their area. That will be

crucial if we are to deliver dental care in the so-called remote and rural areas. It will be helpful to allow health boards to support dental practices in some way other than through fees alone, and separating the dentist's income from what the patient pays is another way to do that.

15:15

Catherine Lush: I support the concept of flexibility for boards. Within NHS Highland, we have already enjoyed an element of flexibility in contracting with general dental practitioners to provide emergency dental services, which has been beneficial for patients in that they have been able to access care locally. Some flexibility at board level will be an important catalyst for change in service delivery.

I flag up the issue of premises. My vision for the future modernisation of dentistry is that dental services will be delivered in much larger teams. I expect dentists to continue to head up the teams, but we will make much better use of professionals complementary to dentistry, who will need premises. The dental therapists and dental hygienists will need to work in surgeries, so the challenge is not only to create the workforce and skill it up, but to ensure that we have the premises for the workforce to work in. We in NHS Highland are beginning to look at that, because we consider it to be a major challenge for the next 10 years. We need to have a premises strategy to ensure the sustainability of services.

On access to secondary care dental services, if significant numbers of patients cannot access primary care dentistry, they also cannot access secondary care support and advice. Dentistry is different from medicine, in that most people have a general medical practitioner. General medical practitioners make some direct referrals to hospital dental services, but a huge group of patients cannot access secondary dental services, so the creation of an intermediate skill layer in primary dental care is essential, and I support the BDA in that.

Dr Wallace: I was not going to say anything, because I agree with all that, but the co-management schemes that section 14 allows and the flexibility to have personal dental services, community dental services and GDS working together with salaried GPs are important. Our experience in Glasgow with sedation services and services for the elderly is that such flexibility is beneficial in targeting particular groups.

The Convener: I see that Hal Rollason from Optometry Scotland wants to speak, but the sections that we are discussing are about dental services.

Hal Rollason: I was going to make some comments about access, which is highly important in optometry and dental services. We consider access all the time. It comes back to the idea of education and of advertising the fact that services are available.

The Convener: That exhausts our discussion on sections 9 to 14. We move on to sections 15 to 17, which extend the list of those covered by disciplinary procedures to other dental and ophthalmic service professions. I invite the patients' representatives to comment at the start of the discussion.

Martyn Evans: The Scottish Consumer Council approves of the extension. We think that it is sensible to have provisions on fitness to practise and to have all those who are practising on a list. We approve of the idea that somebody who is debarred from practising locally should be barred from practising in other areas—if a practitioner is a danger to patients in one area, they might be a danger to patients in other areas. We also approve of the disclosure requirement for new entrants to the list and want to know why those who are on the list currently will not be subject to the same disclosure requirement, as it is in patients' interest to know that there is nothing for them to be concerned about in relation to a person's fitness to practise.

All in all, sections 15 to 17 make it clear who will be subject to the NHS disciplinary procedures. At the moment, only principals are on the list and so are subject to the disciplinary procedures, so extending the list makes great common sense.

The Convener: Ms Shearer, is there anything that you want to add?

Joyce Shearer: Not really, except that the length of time that disclosures take can disrupt services.

The Convener: What are the views of the professional bodies? Are you content with the proposals in the bill in this regard?

Andrew Lamb: You have our written submission and we are content with the proposals.

Hal Rollason: Our only comment was that the proposals should happen in the least bureaucratic way possible so that extra expense will not be incurred.

The Convener: Martyn Evans asked why the requirement does not extend to existing list members.

Martyn Evans: As I read it, there is a requirement for someone coming on to the list to make a disclosure, but that is not a requirement on someone who is already on the list.

The Convener: Will the Executive official clarify whether that is a fair reading of the bill? If so, why was the provision drawn up in that way?

Dr Wilson: I will come back to the committee on that.

The Convener: Thank you. Are the health boards happy that what is proposed is workable?

Dr Wallace: We certainly support the proposals because they introduce greater accountability for the professions. There will need to be a modest increase in administration to work the lists.

The bill uses the phrase

"standards of performance and patient care",

which raises questions about whether there is expected to be a proactive system of appraisal for all NHS contractors and whether that means that we will pick up on complaints or detect under-performance. I would prefer that, but it would cost the boards more to fund it.

Catherine Lush: I agree with everything that has been said. It is important that we respond to patients, who are looking for increased accountability. I see the proposals as an important part of that.

The Convener: Those sections appear to be relatively uncontroversial, with the single exception of the issue that Martyn Evans raised on which the Executive official has agreed to come back to the committee.

We move on to section 18, which deals with pharmaceutical care services. The representatives from the dental and optometry bodies can now leave and we will have a changeover of witnesses.

I welcome Mary Morton, the acting chief pharmacist in NHS Highland; Alex MacKinnon, who is the head of professional services development at the Scottish Pharmaceutical General Council; James Semple, the chairman of the Scottish Pharmaceutical Federation; and Chris Naldrett, team leader of the primary care division in the pharmacy issues team of the Scottish Executive Health Department. Eric Gray, also from the Scottish Executive, gets a bit of a break.

We will go through the process again. I invite the patients' representatives to make any specific comments on section 18.

Joyce Shearer: I have one issue to raise about prescribing practices. A doctor can obviously prescribe—

The Convener: Mrs Shearer, you will really have to speak directly into the microphone because people are not picking up what you are saying. Try not to turn round and look at me; I know it is difficult because I am really easy to look at.

Joyce Shearer: The point I want to raise is about prescribing. If someone goes to an optician, the optician cannot prescribe an antibiotic. The patient has to go back to their GP, so their journey is disturbed. Equally, there seems to be a discrepancy between what a dentist and a doctor can prescribe. I would like to think the bill would address prescribing issues, to lessen the patient's journey because of trips back to their GP, in particular from the optician.

The Convener: That will be difficult, because this section is to do with pharmaceutical care services. A question about prescribing perhaps ought to have been directed to the dentists and the optometrists, but they have gone now. I do not know whether others can comment, or whether we can find a way to return to the issue.

Martyn Evans: I have a comment on the more proactive role that health boards will now have in planning pharmacy provision in their areas. We were much more supportive of the Office of Fair Trading report "The control of entry regulations and retail pharmacy services in the UK" than were the pharmacy profession and others. It had some partial answers to the lack of competition and some of the access issues. We welcome the increase in planned provision that is in the bill.

We would like greater clarity on the national standards that might be applied possibly not in the bill, but in the regulations that follow. The first example that we gave in our written submission was services in supermarkets, which the Office of Fair Trading report found were open longer than community pharmacies—79 hours compared with 50 hours. We would also like clarity on national standards for pharmacy services in places such as railway stations and airports. Both those examples are being dealt with in the English context.

Overall, under the current system, provision is unplanned and is based on the existing services that pharmacies provide. The bill represents a move towards more planned provision, which is welcome. It perhaps does not go as far as we would like it to, but we welcome it.

The Convener: Does the Scottish Pharmaceutical Federation want to comment? Obviously, the issue is pretty important for your business.

James Semple (Scottish Pharmaceutical Federation): Sure. Would you like me to comment specifically on that point or generally on the bill?

The Convener: You can comment specifically on section 18, then pick up the point that Martyn Evans raised.

James Semple: On section 18, we broadly support the proposed legislation. We are happy that the Executive has not gone down the route

favoured by the National Consumer Council, which was the OFT route of having a free market. The best idea is for health boards to maintain the ability to plan services properly and to put them where they are needed, not just where the nearest honey pot is to which all contractors will rush to make money.

On services in supermarkets and railway stations, within a planned system there would be an ability to put services where there is an appropriate need, so that would not be a problem.

Alex MacKinnon (Scottish Pharmaceutical General Council): The Scottish Pharmaceutical General Council welcomes the opportunity to give oral evidence. As a member of the team that is negotiating the new contract, we fully support the policy intention of modernising NHS community pharmaceutical care services. We fully support "The Right Medicine: A strategy for pharmaceutical care in Scotland".

This is all about improving patient care. We fundamentally support the overarching aim of improving patient care through better use of pharmacists' key skills. The proposals represent a major service redesign and a major change in the way in which community pharmacists work. They will move from providing pharmaceutical services to providing pharmaceutical care services. I fundamentally believe that we will reposition community pharmacy as an integral part of the modernising primary care team.

Because we do not have the detail of the regulations and directions, there are some concerns. Throughout our submission, we take the view that where something is agreed on a national basis according to national service frameworks and standards, that should not be diluted as it goes down through the boards. It is important that we have a national set of criteria and guidelines against which the pharmaceutical care services plan can be formulated. We stress that community pharmacy is involved in a participative and positive way, as one of the key stakeholders in the delivery of the plan.

Our other main concern centres on how a new contract will be granted in future, because it is highly likely that the current criterion, of assessing the need for a contract on the ground that such a contract is necessary or desirable, will go. Because we do not have the detail of the regulations, we are unsure what that will mean for community pharmacy. However, we fully support the need to address areas of underprovision throughout rural Scotland and in areas of extreme social deprivation.

We fully support the listing arrangements under which non-principals and principals will be fully accountable for their actions. In fact, such listing is best practice; it encourages best clinical governance.

Our colleague from the Scottish Consumer Council raised the subject of choice and also mentioned England. In rejecting the Office of Fair Trading recommendation, the Scottish ministers did not reject competition and choice. They made a pledge and commitment to the people of Scotland to improve patient care and access. The fact is that 85 to 95 per cent of community pharmacies' work involves the NHS contract and not their retail business.

What does the word "choice" mean? In England, the word is used as a noun: choice probably means another 100 new pharmacies that could, I agree, sell paracetamol at a cheaper price. It will mean 302—or thereabouts—PCTs all having a different community pharmacy contract—

15:30

The Convener: Excuse me, but what is a PCT?

Alex MacKinnon: It is a primary care trust. There are more than 300 PCTs in England and part of the English contract will be left to the decision-making process in each primary care trust. Where does patient choice, post-code inequality and the need to get rid of such inequality fit in a system like that?

In Scotland, the word "choice" is used as an adjective. Choice means the delivery of quality and consistency. The new community pharmacy provision in Scotland will try to deliver core, essential services across every community pharmacy in Scotland. We want to make a fundamental difference to the health of the people of Scotland through their pharmaceutical care.

The Convener: We move on to the health boards. Given the specific issues that relate to the situation in remote and rural areas, I invite Highland NHS Board to go first.

Mary Morton (Highland NHS Board): NHS Highland broadly supports the policy of implementing pharmaceutical care plans and enabling boards to plan the delivery of pharmaceutical care services across their area. As Alex MacKinnon mentioned, it is extremely important that national guidelines are set so that all boards can consider the needs in their individual area in the same way. That is how we will develop a plan for the delivery of services in our area.

Obviously, given the issues of remoteness and rurality in the Highland area, we have a broader difficulty in providing services across our area. We welcome the opportunity to plan pharmaceutical services instead of being at the beck and call of

individuals who might or might not want to provide services in the area.

Dr Wallace: Pharmaceutical care services plans are a good thing. That said, it is inevitable that the plans will place an additional requirement on boards. Health boards should have the ability to provide or contract cost-effective services. That would give us choice about where we go for such services. It would also allow us to provide supplementary services in areas where there are gaps: methadone dispensing in Glasgow is one example of that. Greater Glasgow NHS Board believes that the plans are a good thing.

The Convener: Mr MacKinnon went on to talk about the pharmaceutical care services contracts in section 19 and the extension of the list in sections 20 to 21. Do you want to comment on those sections or to respond to what Mr MacKinnon had to say?

Dr Wallace: We support the amendment of the 1978 act that section 19 proposes, in particular proposed new section 17S(1). Some work is under way at the moment on a definition of "supervision" and we would like to see the conclusion of that work. We also welcome proposed new section 17T(3) of the 1978 act, under which we would see a move towards the incorporation of standards in contracts. As I mentioned, boards will require additional capacity to monitor aspects of the contract, but we support the proposed amendments to the 1978 act.

The Convener: Does Highland NHS Board want to say anything about the sections that deal with the pharmaceutical care services contracts and the pharmaceutical list? You might not have a comment—please do not feel obliged to make one.

Mary Morton: Broadly, NHS Highland supports all the comments that were made in the response from the Royal Pharmaceutical Society of Great Britain and the vast majority of those that came from the Scottish Pharmaceutical General Council. The bill will develop the ability of community pharmacy to provide the services that patients require by extending use of the workforce. I hope that that will give us the ability to provide the services that the public require.

The Convener: Mr Semple, you originally confined your comments to section 18. Given that we seem to have drifted on to the other sections, is there anything that you want to add in respect of the pharmaceutical care services contracts and the extension of the pharmaceutical list?

James Semple: I reiterate the point that Alex MacKinnon made. Although we completely support the thrust of the bill, the devil is in the detail. We need to wait until we see the regulations, as that is where the day-to-day problems might arise. We warn against the law of unintended consequences. Ideas that look good might in the long term affect the stability of what is currently a hugely effective network of pharmacies that dish out hundreds of thousands of prescriptions every day in a safe, effective manner. Representatives of the profession must be involved at all points in the process. Hopefully, at the end of the day we will get a new contract and make "The Right Medicine" work.

The Convener: Does Martyn Evans want to comment on the other sections of the bill?

Martyn Evans: We welcome and have no problems with the extension of the list. I would like at some point to comment on the planned provision of pharmacy services.

The Convener: Now would be a good time to do that.

Martyn Evans: I am concerned to make it as clear as possible that, although there are issues with the physical location of pharmacies in rural areas, there are competition issues in a range of other areas in Scotland, related to opening hours, quality of service and facilities. James Semple said that the devil is in the detail. The bill does not say how contracts will be arranged, and that affects a significant part of the service that pharmacies provide to the public. The Office of Fair Trading saw competition issues being raised, but planned service issues—how we plan for better service in local areas—are also raised. In its report, the OFT found that there were local pharmacy services monopolies whose delivery of services to the general public did not differ significantly. Where there were fewer pharmacies, especially in rural areas, the quality of service was lower. A smaller range of services was provided, because competition was not present.

The Office of Fair Trading saw competition as the solution to the problem. It argued that, if the control-of-entry requirements were removed, there would be greater competition. Despite what James Semple thinks, we did not fully support that approach. We said that there must be either more planned provision or more competition—the status quo would not work. We welcome what is planned, but we say that the devil is in the detail of how it will work.

We would like to see national standards. There are issues that cannot be decided in 15 different ways if there are not to be 15 different ways of providing the service. It is important that there should be national standards for supermarket services and for the provision of service at points of transition. Although we are generally in favour of competition, our research shows the value that is placed on pharmacy services. We support "The Right Medicine" as a way forward. There is much

support in community pharmacy for working within that agenda. However, we must bear in mind the fact that the current system of having a static market, which we are moving away from, has not helped to improve the quality of service that is delivered to the public.

The Convener: Janis Hughes has indicated that she would like to come in. One or two other members have also raised their hands. Before Janis asks her question, can Mr Naldrett say whether he has any indication of when the regulations will be available to us?

Chris Naldrett (Scottish Executive Health Department): We are working on the assumption that we will need something for stage 2. We are doing preparatory work on the regulations.

The Convener: So the regulations will be available at some time between now and our first stage 2 session.

Chris Naldrett: The regulations will be skeletal in parts and quite full in others. It will take a while to produce them, because we are still in the process of negotiation. The committee will appreciate that some contract conditions will still be the subject of negotiation in the summer.

Janis Hughes (Glasgow Rutherglen) (Lab): I have a question for the Scottish Pharmaceutical General Council, specifically on section 18 of the bill. In your submission, you say that you have grave concerns about

"The potential to allow for unilateral variations"

in the regulations, which at the moment say that a health board may unilaterally vary the terms of the contract. What kind of conditions do you think should be included in the contract, if you do not favour the use of the word "unilateral"?

Alex MacKinnon: The word "unilateral" has too broad a meaning and does not tie the matter down. We are working towards delivery of the four core service elements that we want to be present in every community pharmacy in Scotland. Could there be a way of changing the conditions or of tweaking them after they have been agreed? I cannot give a specific example, but I find that the broad meaning leaves too many openings for a contract to be changed at a later date, which worries me.

Janis Hughes: The alternative to using "unilateral" would be to be specific about what it is intended the legislation will allow health boards to do.

Alex MacKinnon: We are probably seeking engagement and collaboration with the profession in order to achieve a change in a service. There should be a negotiated change, if there has to be one, rather than a health board imposing change. The appropriate word is, perhaps, "engagement".

Janis Hughes: That is helpful. Thank you.

Mary Morton: I want to pick up on Martyn Evans's point about extended hours. Currently, the contracted hours of community pharmacies tend to be 9 until half past 5, with an hour off at lunch time. The additional hour for which some stores are open is beyond the terms of their contracts with health boards. I would not like the committee to think that quality of service equates to the opening hours of the service. I hope that we will, in the new community pharmacy plan, be able to consider what out-of-hours services are required, and to ensure that they are available in appropriate places across the area, rather than stipulate that they should be in supermarkets or whatever.

Martyn Evans: I understand the issue about contracts, but there is some confusion in my mind. One route down which one goes to find better services is the competition route. A variety of competing organisations find out what the public want and what makes a successful business. As somebody said earlier, 80 per cent of pharmacies' income is from the NHS; therefore, the pharmacies are a service of the NHS.

The other way to find better services is to have a centralised planning system. However, centralised planning has not worked well in Scotland; we do not have a good history of it, so we must be careful about how we plan services and ensure that they are not dominated by the professional interest. I acknowledge that the professional interest is important, but it is only one interest among a wide variety of interests in the community. This goes back to access to primary care services. One of the key criticisms came from working people who cannot access pharmacy services when they want them because of the lack of competition within pharmacy.

I support the move towards a more planned service; however, it should not just be about the physical location but about the quality of service. I agree with Mary Morton: the question is not just about opening hours, although opening hours and other services, such as home delivery, are important to patients. The evidence is that there has been less competition in those respects in the past, especially where small chains have a monopoly on local services. Increasingly, pharmacies are becoming expensive to buy. They cost about £500,000, and the only way someone can enter the profession is by buying a pharmacy. There is a capacity-to-deliver issue at the moment in dental services. Pharmacy may have a capacity issue in the future because more and more young pharmacists are unable to buy pharmacies. The pharmacies will be taken over by bigger

businesses which, as in the Office of Fair Trading's report, buy locally and then have local monopolies.

The Convener: Two members are waiting to ask questions. I will bring you back in after them.

Mr McNeil: I am keen on developing the role of community pharmacists and getting them back into the communities of which they used to be an integral part. I accept the benefits of competition and the convenience of going to a supermarket, but supermarkets are for people who have cars. Some people are automatically excluded from that choice because they live on estates. I would like to be encouraged to think that pharmacists—or local chemists, as they would be known in my area—will return to such areas. What would encourage them to do that?

A wee bit of explanation of the top of page 3 of the Scottish Pharmaceutical General Council's submission is needed, because it seems to describe a barrier. I need an explanation of the different methods of provision. The submission refers to the principles of "The Right Medicine: A strategy for pharmaceutical care in Scotland" and talks about delivery

"by a mixture of supported, salaried and managed service provision".

What are the differences between such forms of provision? What are the pluses and minuses? What will encourage more re-engagement with marginalised communities and allow them the benefits of a local pharmacy?

15:45

Alex MacKinnon: I will go back one stage and touch on out-of-hours access, which is a big issue that we intend to address in the new pharmacy contract and will be part of the planning process of a pharmaceutical care services plan. Some health boards are already piloting creative and innovative ways to improve access and out-of-hours access to pharmaceutical care, which will all be part of the process.

The key strengths of community pharmacy at present are its position in the community, its accessibility and the fact that people do not have to make an appointment with a pharmacist, who can probably be accessed for advice within five or 10 minutes maximum. I have been a pharmacist for 30 years. We truly believe that the only way to make a significant difference to the nation's health from a pharmaceutical care point of view is to have some services agreed and delivered in every community pharmacy.

I suggest that if we are 100 per cent committed to resolving under-provision in an area, that should not involve a partial contract; the people in such an area deserve more than just part of a service. The point that I have tried to make is that there is concern that if we use different bits of the service to deliver different bits of an overall service package, the people in a deprived area might not receive the full spectrum of pharmaceutical care services. Services such as management, a chronic medication service, a public health service with advice and even diagnostic testing must be delivered where any pharmaceutical care services are provided. We must provide all the services if we want to get rid of postcode inequality in pharmaceutical care for the patients of Scotland.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The questions that arise in my head about competition and the health boards taking over supply of pharmaceutical services relate to the British Medical Association's concerns about doctors dispensing. Dispensing by doctors is an advantage to patients in rural areas, but the situation is a worry for doctors, who receive an extra fee for dispensing, which is an enhancement that encourages doctors to work in areas to which it is difficult to attract them. I ask somebody to comment on how the proposal will affect dispensing practices.

I also wonder about security. When I started to work in general practice, chemists' shops were open late, but as security became a problem, fewer chemists have opened late, so people have had to travel considerable distances to obtain prescriptions after a certain hour. That is difficult for people who have no car.

Another advantage to patients relates to prescribing. Some pharmacists are allowed to prescribe in line with protocols and agreements with doctors. I think that some dentists, orthoptists and what have you might also be able to prescribe, but I certainly know that some pharmacists, especially those in rural areas, can already do so. The proposed changes might be a good idea, but what will happen when the pharmacist goes on holiday? Will the service still be provided to the community if the doctor is not available? Will the locum pharmacist be able to prescribe? Has that been considered?

Dr Wallace: I defer to Mary Morton on rural issues.

On access, I hope that opening hours and locations of pharmacies will be considered in the pharmaceutical care services plans. We will need public involvement and engagement in developing those plans; community health partnerships' patient participation forums could be one of the main ways of engaging with the public on that.

Clearly, more work needs to be done on the core elements of the pharmacy contract and I do not want to second-guess what those should be.

However, as I said, I think that health boards will want a narrow remit for provision of services such as methadone dispensing. We will not want to be constrained to provide the whole service, but we will want to be able to provide a niche service in areas where a contractor cannot meet demand.

Mary Morton: I agree with Iain Wallace's point about services such as methadone dispensing. My understanding is that, if a dispensing practice can meet the pharmaceutical care needs that have been identified in a rural NHS board's area, the NHS board would use that practice for provision of those services. I expect that practices that currently provide such services will continue to do so, but the process of deciding who should provide which service will need to be very open. There will need to be a level playing field for all, whether or not that causes discomfort to various individuals. It would certainly cause discomfort to community pharmacists if they felt that a new entrant could threaten their patch, so I can quite understand that there might be some discomfort for dispensing practices. However, we do not yet know the detail of how it all will work. I welcome the flexibility that the new system will provide.

James Semple: I want to reply to Martyn Evans, who made a good point about how local monopolies might previously have resulted in poor service by failing, for example, to provide home deliveries and all the other things that people tend to do when they are competing against each other. However, he has missed the point about the new contract's fundamental change, which is that we will no longer be paid a piece rate for sticking labels on boxes. Once we start to be paid for delivering quality services, the driver will not be not so much to do things better than the guy down the road but to get paid, because we will no longer be paid simply for sticking labels on boxes. That is why I think that the issue he highlighted will not be a problem any longer.

Alex MacKinnon: On prescribing, I think that pharmaceutical prescribing will be key to the success of the new pharmacy contract. Under the new contract, it is intended that the minor ailments service that has been piloted by Ayrshire and Arran NHS Board and Tayside NHS Board will be rolled out across Scotland. By enabling pharmacists to write prescriptions for products from a national formulary for the treatment of minor ailments of exempt patients, access to medicines for such patients will be improved. We now have more than 200 qualified supplementary prescribers who can work with GPs on certain conditions by amending doses and so on. Supplementary prescribing will also be key to the planned chronic medication service, which will incorporate the model schemes of pharmaceutical care. Our vision for community pharmacy is that, further down the line, we will have independent prescribing pharmacists. That will only enhance pharmaceutical care for the people of Scotland.

Dr Turner: What will happen when pharmacists are on holiday? Has that been worked out—

The Convener: I remind Jean Turner that she is supposed to direct her questions through the chair. She must ask her question in a way that allows the rest of us to hear it.

Dr Turner: Sorry. My question is about what will happen with locums. The prescribing pharmacist might provide a good and effective service on which the community depends but, if the service is specific to a pharmacist, will there be difficulties when he goes on holiday if the locum is not a prescriber? Has thought been given to that issue?

James Semple: That is a good question, which goes back to what we said about national standards. We have to upskill everybody. At the moment, people might have done emergency hormonal contraception training, for example, in one health board, but not in another. Once we get national standards—I speak also as an owner of a locum agency—the locums will have to show what they have done and will be sent only to places where it is suitable for them to work. That can be handled easily.

Martyn Evans: I want to make a point about pharmacies in areas of multiple deprivation and low-income areas. The most important aspect of pharmacies is their convenience. At the moment, pharmacies tend to cluster around general practices, because that is where people get their prescriptions and they want to have them dispensed fairly quickly. We do not believe that having more choice of pharmacies in supermarkets and travel stations will reduce the convenience of pharmacies near general practices; they will still be attractive. The issue is that sometimes a local pharmacy will move out of an area because the GP moves out of the area. Co-location and planning of services are important to us.

Secondly, there are provisions in the bill to relax the requirement for a pharmacist to be present on a variety of occasions, which we think is a more modern approach to pharmacy provision. We accept that there was sense in the pharmacist's being present in the place where pills were dispensed when, as in the old days, the pharmacist physically made up pills. Now sometimes, if a pharmacist goes away and conducts a short consultation in a private room, dispensing cannot take place, so we think that the bill makes more modern provisions in that respect. Although patient safety will be maintained, the bill will allow greater flexibility in delivery of a modern pharmacy service.

Alex MacKinnon: The new pharmacy contract in Scotland is different from that in the rest of the UK, because it could involve patient registration. The issue of clustering around health centres will not be so important in the future in that the patient will register with the pharmacy of their choice to receive a package of pharmaceutical care.

The Convener: We have heard frequently this afternoon that the devil is in the detail. I do not know whether the devil's representative wants to make a final comment.

Dr Wilson: You have heard from Chris Naldrett about the regulations and we accept that more detailed work needs to be done. On planning, which was mentioned a number of times, the intention is to produce national guidance on the local planning process. Boards also have a responsibility to plan for primary medical services, so there is therefore the opportunity to ensure complementarity, which is relevant to the point about dispensing doctors, who are not covered formally by the bill but by the Primary Medical Services (Scotland) Act 2004. That has not changed and it is not intended that provision of those services will be affected directly. Indeed, there is an opportunity for the two professions to work together more closely than they have done in some areas in the past.

On supervision, the Medicines Act 1968 determines the nature of, and requirements for, supervision by pharmacists; we are partly dependent on that. On prescribing, the number of healthcare professionals who can prescribe either independently or in a supplementary sense is increasing, which will add to the complexity of the relationships within primary care between community pharmacists and those who are prescribing. The detail must take account of that.

The Convener: I thank all the witnesses for coming and everybody else for participating. That ends our public businesses.

15:59

Meeting continued in private until 16:27.

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