MEETING OF THE PARLIAMENT

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(*Afternoon*)

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CONTENTS

Wednesday 29 October 2003

Debates

SCOTTISH MINISTERS AND DEPUTY MINISTERS

FIRST MINISTER—Right hon Jack McConnell MSP
DEPUTY FIRST MINISTER—Right hon Jim Wallace QC MSP

Justice
MINISTER FOR JUSTICE—Cathy Jamieson MSP
DEPUTY MINISTER FOR JUSTICE—Hugh Henry MSP

Education and Young People
MINISTER FOR EDUCATION AND YOUNG PEOPLE—Peter Peacock MSP
DEPUTY MINISTER FOR EDUCATION AND YOUNG PEOPLE—Euan Robson MSP

Enterprise and Lifelong Learning
MINISTER FOR ENTERPRISE AND LIFELONG LEARNING—Right hon Jim Wallace QC MSP
DEPUTY MINISTER FOR ENTERPRISE AND LIFELONG LEARNING—Lewis Macdonald MSP

Environment and Rural Development
MINISTER FOR ENVIRONMENT AND RURAL DEVELOPMENT—Ross Finnie MSP
DEPUTY MINISTER FOR ENVIRONMENT AND RURAL DEVELOPMENT—Allan Wilson MSP

Finance and Public Services
MINISTER FOR FINANCE AND PUBLIC SERVICES—Mr Andy Kerr MSP
DEPUTY MINISTER FOR FINANCE AND PUBLIC SERVICES—Tavish Scott MSP

Health and Community Care
MINISTER FOR HEALTH AND COMMUNITY CARE—Malcolm Chisholm MSP
DEPUTY MINISTER FOR HEALTH AND COMMUNITY CARE—Mr Tom McCabe MSP

Parliamentary Business
MINISTER FOR PARLIAMENTARY BUSINESS—Patricia Ferguson MSP
DEPUTY MINISTER FOR PARLIAMENTARY BUSINESS—Tavish Scott MSP

Communities
MINISTER FOR COMMUNITIES—Ms Margaret Curran MSP
DEPUTY MINISTER FOR COMMUNITIES—Mrs Mary Mulligan MSP

Tourism, Culture and Sport
MINISTER FOR TOURISM, CULTURE AND SPORT—Mr Frank McAveety MSP

Transport
MINISTER FOR TRANSPORT—Nicol Stephen MSP

Law Officers
LORD ADVOCATE—Colin Boyd QC
SOLICITOR GENERAL FOR SCOTLAND—Mrs Elish Angiolini QC

PRESIDING OFFICERS

PRESIDING OFFICER—Mr George Reid MSP
DEPUTY PRESIDING OFFICERS—Trish Godman MSP, Murray Tosh MSP

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Finance	Des McNulty	Fergus Ewing
Health	Christine Grahame	Janis Hughes
Justice 1	Pauline McNeill	Mr Stewart Maxwell
Justice 2	Miss Annabel Goldie	Karen Whitefield
Local Government and Transport	Bristow Muldoon	Mr Andrew Welsh
Procedures	Iain Smith	Karen Gillon
Public Petitions	Michael McMahon	John Scott
Standards	Tricia Marwick	Mr Kenneth Macintosh
Subordinate Legislation	Dr Sylvia Jackson	Gordon Jackson

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Scottish Parliament

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(*Afternoon*)

[THE PRESIDING OFFICER *opened the meeting at 14:31*]

Time for Reflection

The Presiding Officer (Mr George Reid): Good afternoon. Our time for reflection leader today is the Right Rev Monsignor Philip J Kerr, parish priest of St Francis Xavier's, Falkirk, and Vicar-General of the Archdiocese of St Andrews and Edinburgh.

The Right Rev Monsignor Philip J Kerr (Parish Priest of St Francis Xavier's, Falkirk, and Vicar-General of the Archdiocese of St Andrews and Edinburgh): It is a privilege to be leading this time for reflection in the week following the ceremonies in which Archbishop O'Brien was appointed a cardinal of the Roman Catholic Church. To be appointed a cardinal is an honour for the archbishop, for the people of his archdiocese, for the Catholic Church in Scotland and for all in our country. It is a mark of respect for Scotland as a whole, but also an invitation to look at our country in a wider context—that of the whole world, for the Roman Catholic Church is to be found in countries throughout our world.

At the end of this week is a day that invites us to see ourselves in another wider context. A special day that we might first think of is Hallowe'en—perhaps not the most suitable topic for a Christian cleric. But Hallowe'en is the eve of All Hallows day, which we now call All Saints day. We Roman Catholics emphasise in particular our union with fellow church members throughout the world, but, along with other Christians, we also hold that we are in union or in fellowship with Christians who have preceded us in this world. In other words, we are at one with the saints. We might regard a saint as someone who is not quite real or properly part of our world, but the truth is that, if we examine the lives of those who are regarded as examples of true holiness, we find that they really were caught up in the circumstances of ordinary daily life in their time. They did not run away from the difficult issues before them.

Honouring saints helps us to see in a wider perspective the problems that face us—there is more to life than what is immediately apparent. Honouring saints reminds us that what makes us truly memorable is not material wealth or any practical decisions that we make for this world, but whether we are able to live selflessly rather than selfishly. Can we today live in that way guided by the spirit of God? St Paul said:

> "the fruit of the Spirit is love, joy, peace, patience, kindness, goodness, trustfulness, gentleness and self-control".

Let us pray that those qualities—the marks of true greatness—might indeed be evident in this Parliament, our country of Scotland and throughout our world.

Points of Order

14:34

David McLetchie (Edinburgh Pentlands) (Con): On a point of order, Presiding Officer. Does anything in standing orders enable you to make a statement to Parliament today on the Holyrood inquiry? You were jointly responsible for commissioning that inquiry, along with the First Minister.

I am sure that the whole chamber agrees that the impasse between BBC Scotland and the Fraser inquiry needs to be resolved. The BBC's refusal both to give access to interview tapes and to act responsibly in the public interest cannot be tolerated, as its non co-operation threatens the whole credibility of the inquiry that you jointly commissioned with the First Minister on behalf of the Parliament.

Many will say that this affair all too graphically illustrates the Achilles' heel of the inquiry—the lack of proper legal powers to compel the production of evidence. Some of us in the chamber expressed concerns about that from the outset. At the very least, the BBC should provide Lord Fraser and his inquiry team with private access to the interviews conducted with the late Mr Dewar and the late Sr Miralles so that Lord Fraser can decide whether they contain material that is relevant and pertinent to the inquiry. Others who gave interviews can, of course, come forward of their own volition to the inquiry and either give evidence in public or provide information on a confidential basis as so-called whistleblowers. Sadly, that is not the case for Mr Dewar or Sr Miralles. That is why we need to find another solution.

Presiding Officer, I would very much welcome a statement from you on this matter—as I am sure would the rest of the Parliament. It is time for the BBC to listen and to act in the public interest. If the Fraser inquiry is to be saved from falling into the same public disrepute as the Parliament building has, common sense must prevail. We need to find a way forward.

The Presiding Officer (Mr George Reid): I think that you will accept, Mr McLetchie, that since I took over as Presiding Officer in May this year I have followed policies of transparency and, on all occasions, of the fullest disclosure of information, in the interests of the Parliament and the public of Scotland. You are correct in saying that Lord Fraser was appointed jointly by me and the First Minister to carry out an investigation that would be full, thorough and independent. I therefore note what you say this afternoon about an "impasse" and "non co-operation". I am sure that Lord Fraser will study your suggestion about private access with some interest—as, indeed, will the BBC.

To date, I have not received any request from Lord Fraser to assist in this matter. It is right and proper that the matter is for Lord Fraser. Should he so approach me, I shall do what I can to help to broker some form of solution. Some indication of my position in that regard is that I have, of course, waived all rights in respect of the interview that I gave to Wark Clements.

Dennis Canavan (Falkirk West): On a point of order, Presiding Officer. Section 23 of the Scotland Act 1998 states:

"The Parliament may require any person … to produce documents in his custody or under his control, concerning any subject for which any member of the Scottish Executive has general responsibility."

Would it therefore be in order for the Parliament to impose such a requirement on the BBC to produce the interview tapes and to hand them over to Lord Fraser?

The Presiding Officer: I have received indications of other points of order and I intend to group them together and then give a general response.

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): On a point of order, Presiding Officer. The Scottish National Party certainly believes that the BBC should make available the 400 hours of evidence to the Fraser inquiry, not least because two of the principal witnesses to the inquiry do not, for obvious reasons, have the opportunity to tell their story now.

When the First Minister announced the inquiry, I recall that—in response to questions from me and other members on why the inquiry would not have full legal powers to require the attendance of witnesses and the production of documents, including tapes—he said that anyone who refused would be named and shamed. It appears that the BBC has a shame deficit.

Presiding Officer, I have given you written notice of three points of order. First, the justification given by the BBC for withholding agreement to pass over the tapes now appears not to be based on any duty of protection of the anonymity of sources. That is inapplicable, because Donald Dewar and Enric Miralles could hardly have been less anonymous. They willingly gave their interviews in the full expectation that those interviews would be shown long before now. The justification now appears to be that there are in existence legal undertakings and confidentiality agreements that are, I presume, signed by the contributors. I ask you to indicate whether you are aware of such documents having been signed by any Presiding Officer of the Parliament, any member of the Scottish Parliamentary Corporate Body, any

member of the Holyrood progress group or any member of the parliamentary staff.

Secondly, on section 23(1) of the Scotland Act 1998, although I fully support what my colleague Dennis Canavan said, is it not the case that under section 23(1)(b) the entitlement to require the production of documents affects only matters over which the Scottish Executive has general responsibility? That does not include the Scottish Parliament Holyrood project, because the responsibility for that lies with the Parliament. Does there, therefore, appear to be a lack or defect in the Scotland Act 1998 that, sadly, deprives us of the necessary legal powers to intervene should a request to do so be received from Lord Fraser?

I appreciate your indulgence on the matter, Presiding Officer, because of the importance of the issues that are involved.

Finally, do you consider that, in the absence of any legally binding undertaking between a contributor and the BBC, all the tapes of the contributions of the late Donald Dewar and Enric Miralles should be released?

The Presiding Officer: I will take the points of order together. I have to say, colleagues, that some of the points are of major significance and I can hardly be expected to give a definitive ruling from the chair at this point. Mr Ewing, your points of order came to me only a few minutes ago, because of other business.

I will take Mr Canavan's point of order first. You are correct, Mr Canavan, that under section 23 of the Scotland Act 1998 the Parliament has powers to compel witnesses and the production of documents

"concerning any subject for which any member of the Scottish Executive has general responsibility."

The other point of order was raised by Mr Ewing and relates to responsibilities of the Executive and the BBC. One must ask whether the Executive has responsibility for the BBC—that question is open to some interpretation. On your question, Mr Ewing, about documentation, guarantees and contractual matters entered into by the SPCB, the HPG and the Parliament's two Presiding Officers, I can hardly go through four years of documentation. However, to the best of my knowledge, no such collective agreements have been entered into. Therefore, one must look at the issue as a matter of contractual agreement between the individual who takes part in the programme and the film makers. I have to say that, when I did the interview for Wark Clements, I was given no guarantees, nor was I asked about the subsequent use of the footage.

On these matters, Mr Ewing, a number of points are still under consideration, some of which are of significant legal difficulty. I hope that I have given both you and Mr McLetchie a steer in the right direction, but I would like to reflect a little longer on some of the intricate matters that have been raised. I will write to you both at the earliest opportunity.

Dennis Canavan: On a point of order, Presiding Officer. Are you minded to accept for debate an appropriate motion to require the BBC to hand over the tapes so that the Parliament can allow Lord Fraser access to them?

The Presiding Officer: I cannot, of course, respond to eventualities that have not yet arisen, Mr Canavan. If such a motion were lodged, I would consider it at that point in relation to the wider picture.

Primary Medical Services (Scotland) Bill: Stage 1

The Presiding Officer (Mr George Reid): The next item of business is a debate on motion S2M-192, in the name of Malcolm Chisholm, on the general principles of the Primary Medical Services (Scotland) Bill, and one amendment to the motion.

14:44

The Minister for Health and Community Care (Malcolm Chisholm): More than 90 per cent of patients' contact with the national health service begins and ends in primary care, so the quality and accessibility of primary medical services are of huge importance to the people of Scotland. The bill represents a fundamental change in how those services are delivered and is a key part of our health reform agenda, ensuring that we improve the primary care experience for patients, staff, carers and the NHS as a whole.

The Health Committee took evidence on the bill from a range of interests, including the profession and patient groups. I thank the committee for its report and welcome its endorsement of the general principles of the bill.

I support the bill because I believe that the legislation and the contract that it underpins represent a good deal for staff and, even more important, for patients. It will mean more and better services and a team-based approach to care. It will boost recruitment and retention. It will put in place national standards and expectations for patient care while allowing NHS boards and local practices to agree on the best way of providing care in response to local circumstances.

Through the introduction of the quality framework, practices will be encouraged and incentivised to provide a first-class NHS primary care service. Practices will receive additional payments based on their performance against a set of clinical and organisational indicators that are designed to reward quality of service. High achievement against the quality standards will bring high financial rewards to practices and improved standards of care to patients.

I am particularly pleased that patient views will be strengthened through measuring patient satisfaction as part of the quality and outcomes framework. Practices that listen to what their patients say will earn more than those that do not.

Tommy Sheridan (Glasgow) (SSP): Will the minister give way?

Malcolm Chisholm: In a moment. I want to finish the first part of my speech.

Access is also important. By April next year, we want patients to be able to see a primary care professional within 48 hours. I believe that the new contract, along with the work of the primary care collaborative, will ensure that we meet that target on an on-going basis.

The contract will benefit patients in many other ways. There will be a patient services guarantee whereby health boards will be under a duty to ensure that the full range of primary medical services is available for people in their area. Resources will increase by 33 per cent over three years—that means an extra £142 million going into primary care. The new funding formula ensures a fairer resource allocation that is based on the needs of patients. Areas with a high level of patient need will receive higher levels of funding. As a result, general practitioners will have extra money to expand their services, so that patients will be able to access more services from their own doctor in their own practice.

Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): Will the minister give way?

Malcolm Chisholm: In a moment.

In particular, enhanced services will help the shift of work and, where appropriate, resources from the acute sector to primary care. Instead of having to travel to hospitals, patients will be able to access more specialised services in their own area.

As the contract is practice based, it will help to develop the multidisciplinary approach that we are already seeing in parts of Scotland. GPs, nurses, pharmacists, health visitors and a range of allied health professionals will pool their skills to provide better services in their local communities. In addition, there will be extra investment in information technology and premises in order to improve further the quality and integration of care.

Tommy Sheridan: The minister has talked quite a lot about the responsiveness of the NHS, and of primary care in particular, to patients. We all agree that we need that responsiveness. However, the bill will transfer the legal responsibility for out-of-hours services, which are currently the responsibility of GP practices, to NHS boards at precisely the time when the boards' responsiveness to patients is at rock bottom. Will the minister confirm that the boards will now be legally responsible for the provision of out-of-hours services?

Malcolm Chisholm: I was about to talk in detail precisely about out-of-hours services. On Tommy Sheridan's point about patient consultation, any change to out-of-hours services will need to be done with the full consultation of patients. I will now speak for at least two minutes on out-of-hours services, so perhaps the issues that Tommy

Sheridan raises can be addressed in that way.

The new right of GP practices to transfer to health boards the responsibility for providing care at nights and weekends has caused a great deal of debate. Although many practices will give up the responsibility, we expect a substantial number to be willing to contract with the health board to provide services. That will build on the positive changes that patients have experienced in recent years through the development of out-of-hours co-operatives, in which GPs take turns to provide cover at nights and weekends.

The change is not about cutting services; it is about providing the service in a different way. Anyone who needs access to primary medical services out of normal hours will get it. That is guaranteed. However, that does not mean that they will always get it from their own doctor. An anxious mother with an upset child might just need the reassurance of a discussion with an experienced nurse, but if she needs a doctor, she will be able to see one.

Work is already under way to support the changes. A national working group, bringing together all interested parties, including the Scottish Executive, the boards and trusts, the GP co-operatives, the Scottish Ambulance Service and NHS 24, has already met several times. It will support boards by, for example, sharing best practice and undertaking modelling work on possible options.

We are increasing the out-of-hours development fund to help boards to reprovide the services. The fund will increase by £3.7 million over three years, from £6.3 million in 2003-04 to £10 million in 2005-06. That funding will help NHS boards to fund reprovision of out-of-hours services. In addition to the out-of-hours development fund, NHS boards will have available to them £7,000 on average for each GP who gives up their out-of-hours responsibility. Boards are already beginning to plan for the change by asking practices to indicate whether they plan to transfer their responsibilities and whether they would wish to contract with the board to provide services.

The transfer of responsibility will lead to services being delivered in different ways, but responsibility will be transferred only to an accredited alternative provider. I saw an example of how that is already happening when I visited Moray in the summer. A pilot scheme has been in operation in Buckie since April, in which ambulance staff work closely with colleagues in the community hospitals and health centres to triage, examine and treat patients out of hours. Staff morale has increased, as have staff skills and professional development. Patients are happy, as a high standard of care is delivered locally, which for some has avoided the need for admission to hospital.

Mr Stone: Will the minister give way?

Alasdair Morgan (South of Scotland) (SNP): Will the minister take an intervention?

Malcolm Chisholm: I will give way to Mr Stone.

Mr Stone: I suspect that Mr Morgan was about to make the same point as I am. Moray is one thing, but I represent one of the most sparsely populated parts of Scotland. A GP can be many miles away from any other GPs and I fear that the out-of-hours cover in my area may not be very effective. Can the minister reassure me that sparsity of population and distances will be taken into account when the welcome money that he said would be given to the health boards for out-of-hours services is distributed?

Malcolm Chisholm: The out-of-hours development fund will be used in part to compensate the small number of GPs in Scotland who are unable to transfer their out-of-hours responsibilities.

Alasdair Morgan: Will the minister take an intervention?

Malcolm Chisholm: I have to move on.

On the services that are to be provided under the new contract, the Health Committee is concerned about the lack of definitions. Let me clarify the matter. Under the new arrangements, there will be three main types of service, all of which come under the overarching new duty of "primary medical services". Services will be essential, additional or enhanced. Given the concerns that I know members have on that crucial area, I will spend some time on the detail of what patients can expect under each of those services.

"Essential" refers to routine, day-to-day GP work. It covers the management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected. It includes chronic disease management and the general care of terminally ill patients. Essential services also include health promotion advice and referral to other parts of the health service where that is required. All GP practices will have to provide the full range of those services.

"Additional" covers cervical screening, contraceptive services, vaccinations and immunisations, child health surveillance, maternity services, excluding delivery, and some minor surgery. Practices will normally be expected to provide those services but may choose to opt out. The reality is that more than 90 per cent of practices provide all those services at the moment; we do not expect the new contract to change that.

"Enhanced" is where there is scope to develop primary care and to transfer work previously

confined to the acute sector. Some enhanced services—those that we are calling "directed enhanced services"—must be provided by all NHS boards. They include more specialised minor surgery, for example, and they have national specifications and benchmark pricing.

There are also national enhanced services, which boards may decide to commission for their area. If they do, the service must be provided to national minimum specifications and with regard to the national benchmark prices. An example of a national enhanced service is more specialised services for patients with multiple sclerosis. Local enhanced services allow boards and practices to develop and agree a service to meet the specific health needs of the local population.

Definitions of essential and additional services have been in the public domain since the contract document, "Investing in General Practice", was published in February. The document also set out what might be included in enhanced services. Since then, the Scottish General Practitioners Committee and the NHS Confederation in Scotland have published specifications and benchmark pricing for five directed enhanced services and 12 nationally enhanced services.

We in Scotland have a unique opportunity to ally the development of community health partnerships to the implementation of the new contract and the delivery of local services. Community health partnerships will build on the best of local health care co-operatives by working with local communities to identify needs and to design services in new ways to meet those needs. They will do that in partnership with specialist services and other agencies—in particular, local authorities and the voluntary sector. Crucially, they will also be directly involved with NHS boards in planning services throughout an area.

In the context of the new general medical services contract, community health partnerships will play a key role in working with NHS boards to identify service needs, particularly those in the enhanced category. They will then work with local practices and other providers to ensure that those services are delivered in the most effective way in each community health partnership area. That will mean that a broad, multiprofessional and multi-agency approach is taken. Community health partnerships will be particularly well placed to support the development of new and enhanced services in local communities to continue to shift the balance of care from hospital to community.

The bill is accompanied by an unprecedented increase in funding for primary medical services. This year alone, we have increased funding by £42 million. Funding will increase further in the first years of the contract and will rise to £575 million in 2005-06. Two thirds of that new investment is in quality. As far as I am aware, this is the first time that money has been so directly linked to the quality of care that the patient receives. GPs' performance will be judged against a set of objective measures that are based on the best available research evidence. High achievement will bring substantial rewards, but poor performance will not.

The contract has twice been the subject of a formal consultation process and a ballot of GPs. On both occasions, GPs voted by a significant majority to accept it. The Executive has not carried out any further consultation on the bill. That reflects the bill's unique position. However, we are engaged in a consultation process on the way in which the contract is to be implemented. We have established a series of working groups to consider implementation issues; the membership of those groups includes the public and patient groups. I have referred to public consultation on out-of-hours provision.

The bill offers a legislative framework for the provision of primary medical services—the services that patients receive from their GP practices. It enables ministers to make orders that are subject to parliamentary approval to give effect to the terms of contractual arrangements that have been negotiated between ministers and primary care contractors.

I understand the Health Committee's desire to have the regulations early to see how the terms of the contract will be implemented through the bill and subsequent subordinate legislation. The committee will be given the opportunity to scrutinise and comment on the regulations before they are formally laid. I guarantee that the Scottish regulations that cover the disputes process and the listing of doctors who provide primary medical services will be shared with the committee by mid-November. The rest of the GMS regulations are being drafted on a United Kingdom basis, as we are implementing a UK contract. All the information that is available to me makes me confident that I will be able to share those regulations with the committee by the end of November.

Health Committee members are concerned about the fact that they can only accept or reject the regulations once they are laid. That, of course, is the position with all regulations that are put before Parliament. Even so, I repeat my offer to appear before the committee while the regulations are in draft form. That will allow the Executive to take on board comments from the committee and to consider any changes well before we lay the final versions.

Delaying the bill and the regulations could delay the introduction of the new contract. The contract is UK-wide, but it has some Scottish variations that

are advantageous to Scotland. The contract will be good for GPs, patients and the whole NHS. I want Scottish GPs and patients to profit from the undoubted benefits of the new arrangements as soon as possible. I am confident that we can find a way forward that allows us to make progress and to give Parliament its proper place in the scrutiny of the legislation.

It only remains for me to comment on the Scottish Socialist Party's amendment by pointing out that the vast majority of GPs are independent contractors and have been since the start of the NHS in 1948. Is the SSP really saying that that hard-working and dedicated group is any less committed to the NHS than, say, nurses, just because GPs are not NHS employees?

I move,

That the Parliament agrees to the general principles of the Primary Medical Services (Scotland) Bill.

15:00

Carolyn Leckie (Central Scotland) (SSP): The answer to the minister's question is, "Of course not." The Scottish Socialist Party is not saying that; we are asking why GPs should be treated any differently from any other NHS employee. The SSP amendment recognises the discontent of GPs and their undoubted commitment to the NHS. It also recognises the recruitment and retention difficulties in the NHS.

We understand the right of the British Medical Association to represent its members. Malcolm Chisholm rightly said that, from the inception of the NHS, a compromise was made for GP services—our primary medical services—that avoided the full integration of GPs into the NHS's universal health care for all. GPs were allowed to contract with the NHS as independent employers and businesses, which resulted in the unhappy spectacle of piecework, with GPs being rewarded per post-natal examination, smear or vaccination. I am sure that nobody would defend piecework as an ideal.

I ask the minister to consider what would happen if the situation that applies to GPs was applied to consultants in an acute hospital setting. Let us say that consultants were given the freedom that GPs have, for example to reduce staffing numbers on a ward in order to increase their salary by pocketing the difference from the funding that they receive from their health board. I am not alleging that the vast majority of GPs are interested in doing something like that, but why should that possibility be open to them? If a ward sister was given control of her budget and cut cleaning staff numbers in order to increase her salary, we would rightly hold that practice to be objectionable. Why GPs?

We believe that the public are interested neither in managing the status quo, which this bill does, nor in settling for primary care GPs continuing to operate as businesses that are contracted to the health service. If the political will was there, we could drive through the full and original vision of an NHS in which every professional—indeed, every worker—is employed by and accountable to the NHS in a fair, transparent and consistent manner.

I will move on to address the fears about some of the detail of the bill. I hope that the minister will take those concerns on board. I also hope that the Health Committee will consider some of the details. We should not avoid scrutinising the bill in great detail for fear of holding up the legislative process. If we do not scrutinise it, quite fundamental difficulties could arise. I hope that the minister can provide some of the answers to our questions on the detail.

There seem to be gaps between what GPs are expected to do, the right to opt out and the obligations of health boards, which—it has to be said—are undemocratic and unaccountable. The gap in my understanding was also evident in the evidence that the bill's supporters provided on how services are to be provided if they are not provided by GPs. I ask the minister where the other doctors and GPs are to come from.

If GP surgeries opt out of family planning, immunisation, heart disease clinics and so forth, there are no guarantees that the inverse care law, of which we are all aware, will be reversed. Members will know that more GPs per head of population work in GP surgeries in affluent areas than is the case in deprived areas. The bill does nothing to reverse that. Indeed, there is a risk that the bill could worsen the situation.

Malcolm Chisholm: I point out briefly another advantage of the bill, which I did not have time to mention. In the past, funding went in accordance with the number of GPs in a practice. The bill will ensure that funding goes in accordance with the needs of the population, which means that a more deprived area will get more money that it does at present.

Carolyn Leckie: There is no guarantee that the money will have to be spent on services or staff.

Concerns have been expressed about out-of-hours services and about the gap between the number of GP practices that have declared their preparedness to provide an out-of-hours service and the needs of the population. I am not reassured that out-of-hours cover will happen across the country. In the surveys that the BMA conducted, only three out of 545 GPs in one area in North Yorkshire indicated their willingness to provide an out-of-hours service to a population of

200,000. The BMA says that 95 per cent of GPs are likely to opt out of providing out-of-hours care.

The response rates to the surveys varied, and the rate in Glasgow was only 50 per cent. Nevertheless, in 95 per cent of responses, GPs said that they would opt out of out-of-hours care. We must remember that the survey was conducted at a time when GPs were trying to get these contracts through, what with the financial rewards and all the rest of it. Given that, how can the minister reassure me that the number of GPs who are prepared to give out-of-hours cover will go up and not down? There is a real gap in that respect and, unless we can nip some doctors to fill it, I am not reassured by any stretch of the imagination.

We have not had an explanation as to why, when there was an opportunity to write into the legislation a guarantee that health board moneys would not be diverted by contracting to private providers, the bill does the opposite. It expressly allows any person—and any company in which one shareholder is a GP—to provide primary medical services. Guidelines are not enough in this respect. If we have only guidelines, there is nothing to stop the BUPA bunny or a ministerial direction being pulled out of the hat somewhere down the line. In fact, the legislation would allow and facilitate that.

We must also consider the impact on other staff. The BMA argues, rightly, that it needs a consistent contract throughout the UK to avoid labour-market distortion. If that argument applies to GPs, it should apply to all health staff. However, the bill and the contract will allow GPs to have absolute flexibility to employ staff on varying terms and conditions and according to their will.

There has been talk of giving nurses, paramedics, midwives and so on an increased role to plug the gap created by GPs who are not prepared to provide either out-of-hours, additional or enhanced services. However, any nurses, midwives or paramedics I know would say, "You cannae nip us either." I seriously wonder whether the matter has been considered in the depth that it deserves.

The Deputy Presiding Officer (Murray Tosh): The member must close now.

Carolyn Leckie: Okay. Thank you very much.

We have an opportunity to address fundamentally and annihilate the inverse care law; to guarantee that services are provided to those in need and that NHS money will no longer be siphoned off for private profit; to ensure that all health professionals are treated and rewarded fairly, consistently and properly in recognition of their tremendous value; and to implement the real vision of the NHS, which centres on equality of access and entitlement to a universal health care system that is free, provided by people who are employed by it and is fully democratically accountable. That opportunity is being missed.

I move amendment S2M-192.1, to leave out from "agrees" to end and insert:

"does not agree to the general principles of the Primary Medical Services (Scotland) Bill because it would allow the contracting out of primary medical services to private healthcare providers and fails to guarantee the continuing provision of out-of-hours services to patients and believes that the Executive's overall goal should be to bring primary medical services under NHS control through moving towards GPs becoming salaried employees of the NHS."

15:08

Shona Robison (Dundee East) (SNP): On behalf of the Scottish National Party, I welcome the bill and indicate the party's support for its general principles. I should say from the outset that we will not support the Scottish Socialist Party's amendment. That is not because we are unsympathetic to some of Carolyn Leckie's arguments. In fact, I will raise some of the same concerns in a moment.

That said, I think that some confusion runs through the SSP's comments on this matter. For example, in his intervention on Malcolm Chisholm, Tommy Sheridan was concerned that transferring out-of-hours services from GP practices to health boards would be a bad thing because of the boards' actions. However, the amendment and Carolyn Leckie's speech make it clear that the SSP wants to do that very thing and transfer all GP services to the health boards that Tommy Sheridan criticised.

I do not think that Scotland's patients can wait for the complete overhaul of the system that the SSP has advocated. Instead, we require the immediate problems that face the health service such as the huge crisis in GP numbers to be addressed now. If that does not happen, patients the length and breadth of Scotland will suffer.

GP morale is at an all-time low. Indeed, a recent job satisfaction survey that was conducted on behalf of the Scottish Executive echoed the results of previous BMA surveys, showing that GPs' morale is low, that there are high levels of stress, particularly among middle-aged GPs, and that the source of that stress includes excessive bureaucracy, paperwork, increasing work load, lack of time and increasing demand from patients. That is leading to GPs saying that they want to leave general practice, with 21 per cent saying that they want to do so within the next five years.

That comes at a time when general practice is facing a recruitment crisis, with vacancies running at the highest level in years. Since 1995, the

number of full-time equivalent GP principals has increased by only 4 per cent, and worrying trends are developing in general practice, with many GPs retiring early, too few medical graduates choosing general practice as a career and an increasing number of those who do so choosing to work part time.

Alasdair Morgan: Does Shona Robison accept that the fact that a small proportion of GP practices, particularly in isolated rural areas, will not be allowed to opt out of out-of-hours provision, as the minister has acknowledged, will exacerbate the difference between those practices and the vast majority of practices that can opt out? Does she accept that the recruitment difficulties in those practices will be even worse than they are now?

Shona Robison: I agree with Alasdair Morgan on that point, and I shall go on to say more about that later in my speech.

When he gave evidence to the Health Committee on the need for more training places, the minister stated that there has been an increase in GP registrars, but I have to tell him that that is not true. The number of GP registrars was 284 in 2002-03—exactly what it was in 1999, when the Scottish Executive assumed responsibility for health provision in Scotland—which represents a huge drop since 1990, when there were 330 GP registrars. Since 1999, there has been no improvement in the situation in relation to GP registrars.

The new GP contract aims to address low morale within the profession, which is why we support it. It allows doctors to regain some control over their work load and to receive funding to enable them to deliver a wider range of services. It is hoped that, over time, that will improve recruitment and retention in general practice and, importantly, improve the service to patients. The contract will clarify for the first time what services the public can expect to receive from practices. Along with the Health Committee, the SNP welcomes the flexibility of the arrangements, but I would like to address the key issues of concern.

First, there is some contention about the way in which the bill has been introduced. We understand the nature of the legislation and the fact that it is part of a negotiation process. However, the fact that most of the detail will be contained in regulations—of which no one in the Parliament, including members of the Health Committee—has had sight is a matter for concern. How can a committee be expected to scrutinise legislation and report to Parliament that it has done so adequately when members have not seen the detail? I welcome the minister's assurances that we will see the regulations before stage 2—which just goes to show that, where there is a will, there is a way—but the situation raises questions about whether we need to examine the process to ensure that, in future, there is a better way of doing it. We cannot have committees signing blank cheques in good faith. That is not the way to make good law.

Tommy Sheridan: Does Shona Robison agree with the SSP that the wording of the bill should be much more specific about not allowing health boards to contract with private health care providers for primary health care?

Shona Robison: The purpose of the bill is quite clear. We know what the purpose of the bill is; it is to introduce the new GP contract. To try to widen the bill to include other issues of privatisation is not appropriate in this forum, as it is clear what the bill is trying to achieve.

Another matter of concern about the way in which the bill has been introduced surrounds the lack of public and patient consultation. For the minister to talk about consultation from now on in is, quite frankly, not good enough. The Executive talks a good game about patient and public involvement, and the Parliament has that as one of its key founding principles, but the bill is an example of a situation in which there has been virtually no public or patient consultation. That matter must be considered in some detail.

Essential, additional and enhanced services are another area of concern. I welcome the minister's attempts to clarify matters, but precise definitions of those services have not been included in the bill or in the associated documents. Again, we have been told that definitions will appear in the regulations. In evidence to the committee, the BMA agreed that the committee should see those regulations and have an input—in fact, it had strong views about the matter, which we welcome.

Opting out of the provision of additional services was a key issue in the evidence to the committee. All contractors will be required to provide essential services, but the contract will allow practices to opt out of the provision of additional services and will provide for the responsibility for those services to be transferred to health boards. It is a concern that there are no clear data on the projected opt-out rates for practices. Given that the responsibility for the provision of such services will then pass to health boards, I would have thought that such data would be crucial to plan how those services can be provided differently, if that is required. A key issue that Carolyn Leckie raised is whether health boards have the capacity to provide those additional services. We need answers to such questions.

There are particular concerns about out-of-hours services in remote and rural areas, which my colleague Alasdair Morgan mentioned. What happens if GPs in such areas opt out of out-of-

hours services, but the health board cannot provide the service in any other way? It appears that those GPs will not then be able to opt out. That has severe implications for already over-strained and demoralised single-handed GP practices in remote and rural areas. The issue has not been adequately addressed by the minister. The Royal College of General Practitioners and others were concerned about the issue and it has been said that it remains unresolved. I understand that a working group has been convened to consider the issue, but it is very late in the day to try to resolve such a crucial issue. We are in the middle of debating the bill. Again, the matter should have been thrashed out well before now.

The success of the bill and the new contract is totally dependent on the staff capacity of the NHS being able to undertake the changes that are involved. Recruitment and retention issues must be addressed not just for GPs, but for all other health care staff if the proposals are to be made to work. For example, without adequate numbers of new practice nurses, the move to redesign services and to change roles and responsibilities will not be able to happen.

To tackle the shortage of practice nurses, I urge all GP practices to agree to sign up to the agenda for change terms and conditions as a minimum, as advocated by the Royal College of Nursing. I hope that many GP practices will go further, but that must be the minimum position.

We are happy to support the general principles of the bill, but I urge the minister to respond to the points that I have made and to issues of concern.

15:18

Mr David Davidson (North East Scotland) (Con): The Scottish Conservative party supports the general principles of the bill, but obviously we have reservations about the roll-out and implementation of parts of it. I think that everybody agrees that the bill has the potential to make working as a GP in Scotland more attractive. It would also radically change the way in which general medical services are delivered and therefore change people's access to services.

It has been said that, unfortunately, there has been no consultation with the general public or with patients who will receive the service in the future—that came out in the evidence that the committee received. That approach flies in the face of a document that came to the Health Committee yesterday from the Equal Opportunities Committee about the need to consult all stakeholders when any bill is introduced. I would have thought that there would have been consultation with patient groups and patient representatives as part of the progress of the bill. I am disappointed that that has not happened.

I am pleased that the bill will seek to remove differences, in pay scales for example, throughout the United Kingdom. That will help to address the potential brain drains of which we are beginning to see evidence.

The main thing is: will the bill make the role of the GP an attractive one for young medical students and young doctors? We do not want to go down the route that the Scottish Socialist Party would go down, which is to have employee GPs, who would possibly work a 40-hour week—I hate to think how all the other hours in the week would be covered. There would be movement of people around the system and no build-up of good relationships between GPs and individual patients, which have been the foundation of the success of GP services in the past. I also wonder where the funding would come from. I know that when Mr Sheridan talked about his budget before the election he said that everything was uncosted but he was aiming to set the standards. It would be interesting if he would respond to some of the questions.

Tommy Sheridan: I will respond immediately to the initial question. If we cancelled Governments' nuclear programmes, like the previous Conservative Government's one, we could afford this type of investment in the health service and much more.

Is David Davidson not worried about the staff implications of GP practices being able to pay different rates to essential support staff? Will there be no brain drain there, or does he not care about that?

Mr Davidson: I do. Mr Sheridan has heard me say in the past that we need to do away with some of the national pay bargaining schemes, other than to set a minimum level, because they are counter-productive in attracting key staff into areas to which they are currently not prepared to travel. I will leave it at that for now.

The current unrest among our GPs and their representative organisations is caused not by the Health Committee asking to do its job in scrutinising legislation correctly, but by the minister failing—before today, I might add—to give any idea of what the regulations will mean. Not only will the regulations influence what those who will receive the new contract will seek to get, but in rural and remote areas they will have a huge effect on what patients will receive and be able to access. I echo the comments of my fellow members of the Health Committee—I am sure that others will make similar comments—that it is regrettable that we have not had sight of even draft regulations at this stage. If there is any delay,

it is surely down to the minister and not down to the Health Committee.

Carolyn Leckie: Does David Davidson agree that the bill offers the opportunity for health boards to enter into contracts with the likes of BUPA and other private providers?

Mr Davidson: I was going to come to that. I suspect that a raft of new businesses will be set up in some areas, because currently many of the principals have their own funding and their own money tied up in premises. Will they be bought out and, if so, by whom? We lack an awful lot of detail about the practicalities of how GP surgeries and so on will be handled in future.

I thank the minister for giving us some more information about the essential, additional and enhanced services. However, he has said that not all additional and enhanced services will in future be offered by all practices. That could result in many patients having to travel quite a distance to get access to what they are entitled to under the NHS. That is much more worrying for patients in rural and remote areas than it is in an urban situation where another practice down the road would be able to offer the services.

Malcolm Chisholm: Does David Davidson not accept that the most important point about enhanced services is that some services will be delivered in primary care that were previously delivered in a hospital setting and were never delivered anywhere in primary care?

Mr Davidson: I welcome anything that improves access to the service for everybody in Scotland, regardless of where they live. That is a given and I think that all members of the Parliament would agree with that.

I have major concerns about the treatment, or potential treatment, of rural and remote GPs and, through them, of their patients. I am concerned that it might be decided that those GPs will have to handle out-of-hours services with no support from the health board—there is a question about whether the health board will have personnel to be able to give them support, holiday cover and so on.

I look for the regulations and the documents that come with them, and for the minister, when he comes to the Health Committee, to explain where the bodies will be in the health boards to cover the services that cannot be delivered under the new contract. We cannot go on with doctors working 100-odd hours a week, getting tired, having no support and obviously being under great pressure. That is resulting in doctors taking early retirement and in no one wanting to work in those settings.

We are all agreed that we must address the situation. Before we get to the stage 2 proceedings on the bill, it is vital that we have sight of the draft regulations, and I thank the minister for offering to provide them. The Parliament has a responsibility to ensure that all legislation that is passed is thoroughly scrutinised, that all the potential outcomes for the stakeholders are identified and that all the boxes are ticked. I do not like being part of the culture of ticking boxes and making everything work, but the time to do that is when a bill is being considered. If the bill improves doctors' work load and makes them more efficient, it is to be welcomed.

The bill could be a building block for the future of GP services and primary care delivery in Scotland. The Executive must work in partnership with the Health Committee on the bill and I take it from the minister's hints that that will happen. We must ensure that the bill is scrutinised. If the minister intends to rely on the patient guarantee to satisfy the needs of all patients, we must ensure that the minister and the health boards can deliver that guarantee. If that guarantee, which the minister mentioned when he gave evidence to the committee, is good, I hope that he will provide the details of how it will be backed up in every part of Scotland. Obviously, it will be difficult to do so in rural and remote areas, but it will be equally difficult to do so in some suburban areas, such as the large estates that surround our conurbations.

The bill could become a lasting piece of legislation that stabilises our vital GP services and encourages more people to become GPs. However, I ask the minister to ensure that all the points that Health Committee members have raised and on which we are still in the dark are answered at the earliest possible opportunity and before we reach the end of stage 2.

15:27

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The bill represents the biggest reform of the primary care sector in Scotland for half a century. It will help to simplify and streamline the primary care infrastructure, reduce bureaucracy and create the pay system and quality patient services that we need to take Scotland's local health services into the 21st century. The bill will be backed by record levels of investment, which will rise by 33 per cent in three years, from around £433 million last year to around £575 million by the financial year 2005-06.

Under existing legislation, health boards have no power to provide general medical services, other than in exceptional circumstances. At present, the Scottish ministers have an overarching duty to secure the provision of such services, which is generally considered to be too restrictive. The bill will change that situation by putting a new duty on health boards to provide those services directly or

to arrange for provision by others, according to local circumstances. The new GMS contracts will be held between GP practices and health boards and the present contracts, which are between individual GPs and the Scottish Executive, will be ended. The bill will end the barriers to effective integration of local health care teams with GPs, nurses and other health professionals who are involved in delivering local services. That is a key point.

I turn to the socialists' amendment. Carolyn Leckie feels so strongly about the bill that she has lodged an amendment that would throw it out, although she could not find the time to attend any of the Health Committee's consideration of the evidence at stage 1. She attended none of the oral evidence sessions, at which she could have quizzed representatives from the British Medical Association, the Royal College of General Practitioners, the Scotland Patients Association or the Scottish Association of Health Councils.

Carolyn Leckie: Will the member give way?

Mike Rumbles: I will in a moment—let me finish. Carolyn Leckie did not have the inclination, or perhaps she could not find the time in her busy schedule, to grill the minister when he came before the committee. It is much easier for the socialists to grandstand in the chamber than it is for them to work on improving legislation in the committees.

Carolyn Leckie: To be honest, I do not care what Mike Rumbles thinks; I am talking to people out there. How dare he allege that I have been sitting on my hands? I am extremely concerned about the bill. I point out that it is possible to access the evidence on the Health Committee's website and that, as Mike Rumbles will remember, I wanted to be a member of that committee.

The Deputy Presiding Officer (Trish Godman): Do you have a question?

Carolyn Leckie: I ask Mike Rumbles to withdraw his remarks and apologise.

The Deputy Presiding Officer: Please sit down.

Mike Rumbles: Thank you, Presiding Officer.

The Liberal Democrats will have nothing to do with the socialists' amendment. I made clear my views on that. I would have greater respect for a political party that bothered to influence events and tried to change the Government's approach. It is easy just to slap down an amendment and speak on it, without bothering to try to influence events. The socialists are interested not in improving services but in grandstanding.

Let me return to the bill. The bill allows the Executive to produce regulations that will set out definitions for three new categories of services: essential, additional and enhanced services. The bill will also allow GP practices to opt out of providing certain additional services and pass responsibility for them to health boards. That is where the Health Committee came up against real difficulties. We said in our report:

"The Committee recognises that the categorisation of services is possible and that Regulations and the GMS Contract itself will include such lists. However, in the absence of draft Regulations or model contract, the Committee remains concerned at the lack of available detail."

This is an important enabling bill but, as other committee members said, we would not be doing our job as parliamentarians if we simply passed it without having any real indication of how ministers will implement its provisions through the regulations. That is why I am very pleased that the minister confirmed today that the committee should see the draft regulations before we reach stage 2 consideration of the bill. I know that the minister has worked a great deal, especially with his UK counterparts, to ensure that that happens.

When taking evidence, the committee was also concerned about the impact on rural areas in respect of out-of-hours services and single-handed practices. Other members have raised points on those matters. I was pleased to hear Malcolm Chisholm make it clear when he gave evidence to the committee that, under the proposed changes, no current practice will be worse off and that most will be better off with the minimum practice income guarantee. The minister also made it clear to the committee that the Executive is to maintain levels of service irrespective of the restructuring of service provision.

I turn now to what I consider was a real difficulty for the committee when it was considering the bill.

Mary Scanlon (Highlands and Islands) (Con): Given that the biggest change in the budget is the £280 million in global sum payments in 2004-05 and given the member's experience of the Arbuthnott formula, is he satisfied, as a member of the Health Committee, that the bill will take into account the needs of rural and remote areas as well as islands?

Mike Rumbles: As far as I understand it, the bill's provisions are not Arbuthnottised. [*Interruption.*] I believe that the minister's gesture confirms that.

One of the fundamental principles of legislating in the Scottish Parliament is, as David Davidson pointed out, our concern to ensure that the people affected by a bill are consulted on it. It is all very well to consult GPs on their contract—indeed, they have been fully consulted and they even had a

ballot of members on it; I will return to that in a moment—but the group that has been almost completely ignored is the patients. They seem to me to be a rather essential piece of the jigsaw.

When I pressed the minister on that during our evidence-taking session on 9 September, he said:

"It was difficult to conduct a negotiation and carry out a consultation simultaneously."

I accept that, but surely the patients should have had an opportunity to have their input, too. Malcolm Chisholm also said:

"politicians in general—including ministers—are, at their best, the proxy for the patient. That is the justification for our involvement in health."—[*Official Report*, *Health Committee,* 9 September 2003; c 145.]

It seems to me that, in the rush to implement the contract after consulting the GPs, real input from patients was forgotten. It was the duty of the committee to point that out, which we did. However, I am pleased that the minister has taken that point on board and that there will be real consultation of patients on the implementation of the regulations. I believe that that is important.

I return to the GP consultation. I was struck by the fact that Dr Reith, the representative of the GPs who gave evidence to us, was confident that Scottish GPs were in favour of the bill. However, in the ballot of GPs the opportunity was lost to find out whether Scottish GPs really supported the changes, because the result of the ballot was declared on a UK-wide basis. I am sometimes struck by the inability of professional organisations to recognise the realities of the new constitutional settlement in Scotland. The result of the ballot was of little use to us in committee in gauging our own GPs' support for the new contract. I suspect that that was actually the purpose of having a UK-wide ballot, but it was a lost opportunity. I hope that such organisations understand that we have a responsibility for our GPs in Scotland.

Although the committee has concerns about the lack of scrutiny available to it on the detail of the contract, I am happy that the minister has agreed to provide the Scottish regulations and will endeavour to obtain the UK-wide regulations before stage 2.

I am confident that there will be no delay in the implementation of the new GP contract and that the bill will be warmly welcomed as an effective reform of the primary care sector and will lead to a better service for patients across the country, providing a local health care service that is fit for purpose in the 21st century.

The Liberal Democrats urge Parliament to support the principles of the bill and reject the amendment.

Carolyn Leckie: On a point of order, Presiding Officer. I beg your indulgence, as I have quite an important point to make. Mike Rumbles displayed quite a bit of insensitivity in his remarks—before you interrupt me, Presiding Officer, I assure you that this is a genuine point of order.

I am not a member of the Health Committee, despite trying to be, so I am not in a position to comment on Mike Rumbles's performance, but I would not make any comment about how hard anyone in the chamber works and I would not expect any member to make a comment about how hard any other member works. However, Mike Rumbles might be embarrassed to learn that my work and activities were restricted while the committee was taking evidence on the bill due to a family bereavement. If Mr Rumbles had chosen to approach me to find out why I was not present or had offered to help me to understand what had been said at the evidence-taking sessions, he might not have been in the position of making such insensitive remarks today.

The Deputy Presiding Officer: That is not a point of order; it is a debating point.

15:37

Kate Maclean (Dundee West) (Lab): I am going to support the bill. I broadly welcome some of the intentions of the bill although I have some grave reservations, not least those relating to the fact that the contracts that the legislative framework that we were expected to scrutinise and take evidence on had been negotiated nearly two years before and had been agreed to by the majority of GPs who took part in the ballot. That put the committee in a difficult position during the evidence-taking process and might have affected the quality of evidence that we heard. One witness thought that there was no opportunity to make amendments and, therefore, did not suggest any. I know that nothing could be done about the situation, but I feel that we might have been prevented from getting to the root of the witnesses' concerns.

However, if the bill achieves its aims, it should lead to an improved primary care service for those receiving and delivering the service and should allow health boards and trusts, in conjunction with GPs, to negotiate appropriate levels and types of services to meet local needs.

In agreeing to the principles of the bill, the committee was aware that all we are agreeing to at this stage is the framework and that the detail of the contracts will dictate whether the proposals produce a better service.

As it stands, the bill looks fine but, until we see the proposed regulations, many of the questions that I and other members of the committee have

will be unanswered. I am grateful to the minister for confirming the fact that we will be able to see them well before we move to stage 3.

My main concerns focus on the provision of additional and enhanced services and out-of-hours services. There was widespread concern about those areas in the Health Committee and the Finance Committee—as a member of both committees, I was fortunate enough to be able to hear evidence on the bill all day on Tuesdays.

People are concerned about the additional and enhanced services. I have been with the same GP practice in Dundee, the Wallacetown health centre, for 20 years. Fortunately, my visits there can be counted on one hand. On my recent visits there, I was impressed with the range of services that were available in addition to consultations with good GPs, including contraceptive services, immunisation, flu jabs, well women clinics, well men clinics and smoking cessation services. The provision of such services by health care teams in GP practices gives added value to the people we represent.

The minister is aware of my concerns about that. We had a rather bad-tempered evidence-taking session in the Health Committee on those issues. Such services and many more may be included in the regulations as additional and enhanced services. I am aware, because the minister points it out, that NHS boards will have a duty to provide the range of services that is currently available, but I am concerned about how they will be delivered and who will deliver them if GP practices decide to opt out. Will our constituents have to visit different locations to receive the package of services that they need for themselves and their families?

I am also concerned about out-of-hours services. Every one of the practices that responded to a Tayside NHS Board survey—65 out of 79 practices—said that they would opt out of responsibility for out-of-hours services. The minister said in his evidence that those services would still be delivered, but I ask him to tell me how much more it might cost to deliver out-of-hours services and whether that will have a knock-on effect on other services that might be delivered as enhanced services, particularly if no GP in a health board area is prepared to take on responsibility for them, which may well be the case.

We need to address the problems of recruitment and retention through legislation to improve GPs' conditions. Particularly in deprived and rural areas, it is sometimes a problem to get GP practices to operate. However, we must also ensure that the people whom we represent and the other health care professionals do not suffer as a result.

The bill should proceed to stage 2 and be passed, subject to the outcome of the scrutiny of the regulations, which we will see shortly. That will enable the new contracts to start in April next year. However, we should also monitor the effect that the changes have on services and be prepared to take appropriate measures if we find that those services or the conditions of other health care professionals suffer as a result of the new system.

15:42

Christine Grahame (South of Scotland) (SNP): I will perhaps repeat much of what others have said. I want to thank all those who gave evidence on the bill. It has already been said that we did not have time to take enough oral evidence, as we had only two oral evidence-taking sessions. One was with representatives of the BMA—more of them later—and another with representatives of the Scottish Association of Health Councils, the Scotland Patients Association and the minister. That did not give the committee sufficient time to consider the important matter of changing the way in which we regulate GPs after many decades.

To rely on written submissions cannot be a satisfactory way of taking evidence. Those of us who have been on committees for many years know that it is often far better to get witnesses in before the committee when necessary to test their written evidence a bit more. After all, we had written evidence from the BMA and the Scottish Association of Health Councils, but it was useful to test that. Perhaps that took the BMA into waters it did not want to tread, but that was the evidence that it gave the committee.

The minister must have been having nightmares with "regulations, regulations, regulations" ringing in his ears. It became apparent to the committee that we did not know what we were doing. We could not know what was lying ahead for the greater Scottish public without sight of the regulations. The minister, perhaps unfairly, stirred the BMA up a bit for reasons into which we had best not go. I put that at his door. The BMA says:

"Scottish ministers have warned of an exodus of family doctors to England if implementation of the new GP contract is delayed north of the border.

Health and community care minister Malcolm Chisholm said that he could not guarantee that legislation to enable the new arrangements to be introduced in April 2004 would be passed on time."

I understand the minister's difficulty with UK draft regulations, but my understanding is that he had already given an undertaking that we would have the regulations before stage 3. That would mean only weeks of delay, not months at all. That comment has led to many of us having rather hysterical letters on our desks from GPs who think

somehow that the new arrangements will not be introduced in Scotland and that they will all have to rip up their families and move south. That was an unfair portrayal of the evidence.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The member might also mention that BMA representatives led on that issue. They led the committee to believe that there was a problem with the regulations.

Christine Grahame: That is quite true, and I agree with Duncan McNeil. However, the damage was done. I quote from oral evidence taking with the BMA. I asked:

"Is it therefore important that the committee see draft regulations that define those services before we deal with primary legislation? If people's livelihoods will be affected by the definition, should not we see that definition?"—[*Official Report, Health Committee*, 2 September 2003; c 79.]

Dr David Love replied, "Absolutely." That is unequivocal. The point was that the committee and the minister knew that we were talking weeks, not months. I have sympathy with the BMA in that regard. That situation placed committee members in a rather invidious position. After all, we unanimously wished to see the draft regulations.

The minister has got caught up in something that was going to become an issue one day before a committee or in the chamber. Committees want to see draft regulations, guidance or codes of practice in appropriate circumstances and if that is important to the proposed legislation that is being dealt with. That might have applied to the Adults with Incapacity (Scotland) Bill, the Freedom of Information (Scotland) Bill or the Land Reform (Scotland) Bill, for example—bills dealing with major issues.

The Health Committee has written to the Procedures Committee with a view to changing the rules in that regard and if we have to consider touching the Scotland Act 1998, so be it. A committee does no service to ministers or to the Scottish public if it does not take its time and take the measure of what is before it. Even if it causes some temporary hiccups, committees should be able to say that they need the information concerned before they can proceed further. I very much welcome the fact that committee pressure appears to have paid off.

15:46

Mary Scanlon (Highlands and Islands) (Con): The Minister for Health and Community Care has said that 90 per cent of patient contact with the NHS begins and ends with GPs. They form the front line of the health service, and they are known and trusted by patients throughout Scotland.

Although we are concentrating on the Primary Medical Services (Scotland) Bill today, we need to be aware that GPs do not work in isolation. They need the full support of all health care partners. If, in the Highlands, someone's relatives are not getting the home care for which they have been assessed, they will rarely, if ever, go to their councillor, who should take responsibility. Instead, the GP has to answer for the lack of care available. When patients in the Highlands have to wait for up to 71 weeks to see a neurologist and find out whether they have multiple sclerosis, epilepsy, Parkinson's disease or another neurological condition, or to access continuing care for those conditions, it is not the doors of Raigmore hospital that they will chap on; it is the GP, at the front line, who is expected to be answerable for the state of those and other health services.

Like many other Inverness residents, I was not notified that my out-of-hours service call would be handled by a call centre in Glasgow. Once people have given all their details to that Glasgow call centre, they are passed to a call centre in Aberdeen, only to start giving all those details again. We are constantly being told that the nurses working at NHS 24 do not diagnose over the phone. I can confirm that they do, even with the scant amount of information that can be given over the telephone line. Although I support, and have always supported, NHS 24, we need to monitor the service very closely.

The new contract largely focuses on out-of-hours provision, and I appreciate the crucial role of nurses and paramedics in that regard. Both professions are undoubtedly capable of delivering more health care. However, they should never be expected to have the assessment and diagnostic skills of a GP who has nine years of medical training.

I draw attention to the use of management executive letters or Health Department letters—MELs and HDLs—and guidelines. In particular, I understand that carrying out annual check-ups for over-75s was a contractual obligation for the provision of general medical services under the previous GP contract in the red book. Interestingly, performing those check-ups does not form part of the new GP contract, as the issue has been parked pending consultation.

I ask the minister to ensure that the consultation includes not only the BMA and the Scotland Patients Association and so on but elderly groups and patient groups that know how beneficial such check-ups would be. In particular, I ask the minister to consult Mrs Susannah Stone—the mother of that famous cheese-making clan from Tain—who has started a one-woman campaign to

reinstate the checks. I have to say that on this issue I support her fully.

The initiative would be an investment not just in terms of saving money but in the health of older people. In the annual check, the doctor is expected to examine sensory functions, mobility, mental condition, physical condition, including continence, social environment and the use of medicines—very similar to the criteria for assessing entitlement to free personal care. I ask the minister to bring the consultation on the annual check-up for the over-75s out of the parking lot and into the mainstream. I hope that members of the Health Committee will ensure that it is on the agenda and that there is a statutory guideline on it in future.

15:51

Eleanor Scott (Highlands and Islands) (Green): I will not speak against the bill. That sounds a bit grudging, and it is. I am basically in favour of the bill, but I have a lot of concerns, which I will come to in a minute, after I have spoken about Carolyn Leckie's amendment. I have a lot of sympathy with what Carolyn said about the bill possibly paving the way for private contractors to provide medical services. That is a concern, especially if we end up in a situation akin to the general agreement on trade in services whereby private contractors can come from absolutely anywhere. We have to consider that issue. It is a bit of an anomaly that GPs are paid in a different way from any other health professional and indeed from any other doctor in the NHS. However, I will not support the amendment, not because I do not agree with it but because it is a matter of timing—we need a much longer lead-in to unpick an historical anomaly of 40 years and put GPs' salaries on a more rational footing.

I have slight concerns about timing, resourcing and informing the public. I do not want the bill to be delayed, because that would not be productive, but there is an issue of timing for health boards. They are engaged in major redesign in moving from local health care co-operatives to community health partnerships. That is taking up much of their energy and I am not sure how much time and attention they are focusing on the implications of the bill.

We have heard an awful lot about out-of-hours services, which will be a big issue, particularly in the Highlands and Islands. It is all very well to say that only one or two remote and rural practices that are run single-handedly might not be able to opt out and might be the preferred provider of out-of-hours services, because there is no other provider. If the preferred provider would prefer not to provide, we will have a real problem. We have a recruitment and retention problem in areas such as the Highlands and Islands anyway and we know that morale in the health service has a major effect on recruitment and retention.

We have to ensure that having two reorganisations at the one time does not have the adverse effect on morale that previous serial reorganising has had. The reorganisations are good; they will perhaps provide an end point and this could be it. We have to be aware of how people regard reorganisation.

There are a lot of inducement practices. The most recent information that I got from the BMA was that it was discussing inducement practices with the Scottish Executive and was close to agreement on that. Perhaps the minister will reassure me that that has been sorted out as it is an issue particularly for remote and rural areas.

I appreciate the reasons that the minister gave for the Executive not being able to consult the public, but it would be quite nice to tell the public about the changes, because they will happen quite soon. People are going to realise that what they still regard as the family doctor service will look different. Patients will still be able to go to their doctor if they are ill, but for many services they might have to go to another practice or another location.

The list of additional services contains services that we might consider to be core services. Many of them are the reasons for people going to doctors—for example, for cervical smears, to get their children immunised, or for antenatal care. Funnily enough, many of those services seem to affect women and children. It seems that GPs will be treating men all the time while the women go elsewhere. The wider public are not prepared for the changes and a big public information exercise is required. It should start now because it is not very long until the measures in the bill will be implemented.

GPs in the Highlands and Islands whom I have talked to are not saying that the bill is bad or that it should be delayed, but they are raising concerns about resourcing out-of-hours cover. GPs are especially concerned about single-handed practitioners, who seem to be disproportionately affected because there may not be an alternative. I ask the minister to take those points on board.

15:55

Des McNulty (Clydebank and Milngavie) (Lab): Like most speakers today, I welcome the bill and support its general principles. It addresses issues that GPs have raised consistently for several years. During my time as a member of Greater Glasgow NHS Board, I heard about a number of those issues. The bill will also address a number of deficiencies in the way that the

present system operates, which patients and experts have identified over the years. Those are good reasons for implementing the legislation.

As has been said, we all know about the problems that are due to stress, early retirement and shortages, especially in some rural areas. Those are also good reasons for agreeing to the bill. However, a better reason is that the legislation will underpin the process by which current service delivery can be improved through, for example, greater flexibility and greater specialisation on the part of GPs. The bill should be seen as part of a general realignment of functions and roles in the health service to ensure that we provide a better service for patients and people who are in need of health care.

The role of GPs—who are charged with delivering services—can be more clearly defined. For example, the role of those who deliver acute services can be better balanced without disturbing the proper relationship between primary and acute care. The mechanisms in the bill will encourage GPs to develop new services and will encourage NHS boards to commission enhanced services. I see those as practical improvements that will lead to better outcomes for patients.

As well as the contents of the bill, I can think of other good measures that have been introduced. For example, NHS 24 provides people with direct access to health advice. All such measures deliver positive changes in health provision. We are putting a lot of resources into the health service, but those examples show how our delivery of health services is improving. We can expect to see positive effects.

GP stress is not the only issue that we are tackling. We are also providing a mechanism for improving the operation of multidisciplinary working in the NHS by considering the work of pharmacists, nurses and professionals who are allied to medicine, who all deliver services to patients. Within the new framework, they will be better able to do that.

Points have been raised about consultation on the bill. There was a lot of consultation with the professional community, but patients are especially interested in how services will be delivered to them in their areas. I have to praise highly the local health care co-operatives and the GP practices in Clydebank and Milngavie; they have gone out of their way to consult patients and other interested parties—including me, the local authority and others who have an interest in health provision in the area—and to discuss how services that are already offered might be developed and improved. The mechanisms in the bill will encourage such consultation and will provide some resources to implement what comes out of consultation. The bill will also give leverage for local communities to say to health boards, “This is what we want; can you help us to deliver it?” It is important that health provision is designed to meet local circumstances. We must consider health care in an holistic way.

The agenda is not just about dealing with patients who are ill. We must support people to be healthy. The health improvement agenda is fundamental to improving the health of the population in Scotland. I hope that the bill will have a big impact on health improvement. That is obviously essential in areas such as the one that I represent, where health is poor.

Duncan McNeil, who is here in the chamber, is from Inverclyde and there are members here from Glasgow. We all know about the problems of ill health, about mortality and about the need to tackle dietary issues. The contract and the bill will assist GPs in addressing those issues actively, instead of waiting for patients to come to them when they find that they have a health problem.

I will highlight two issues that were identified in the Health Committee. The first is unmet need. We recognise that the health service’s data collection is not perfect and that there will be a problem if, as part of the move to the new contract, new needs are identified that cannot be funded quickly because of the move to a new capped system of funding. I would like an assurance from the minister that he will consider how data collection feeds into the identification of health requirements and how responsive health boards and the minister can be in identifying and tackling those new issues.

The other issue that came out of our study was the professional community’s acceptance that the minimum practice income guarantee could not be withdrawn, as the advisory notes that accompanied the memorandum seemed to suggest. The minimum practice income guarantee will not only affect remote rural areas—or indeed, rural areas that are not remote—but protect income levels at a significant number of practices in Glasgow. I hope that the minister will consider sensitively how that mechanism is dealt with, to ensure that there is consistency in how we deliver income to practices and I hope that we move towards the enhanced service agenda, which I know that the minister wants to progress.

16:02

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I am a member of the Health Committee and I share the committee’s concerns.

I thank and congratulate my long-suffering ex-colleagues in primary care, who have been working so hard within the current 1990 contract, which will be replaced by the new contract in April.

There is a need for change. The more experienced among my ex-colleagues will probably have little faith that any new contract will offer much improvement over the previous one—much will depend on the regulations.

Just before the 1990 contract came into force, I attended a large meeting at which 300 GPs voted against the contract. Only one poor, lonely man put up his hand in favour of it. Our leaders—some of whom had perhaps taken part in negotiating the contract and might well later have repented at their leisure—persuaded us not to march on Westminster. Doctors did not do that sort of thing; it was better to talk. I must say that that was not always for the better, because the contract was imposed on us.

I worked in an area where there were high levels of deprivation. Under the contract, deprivation payments were made, which were welcome. However, when not-so-deprived areas had their payments taken away, ours were also cut.

The best thing to come out of the contract was the practice nurse system. Practice nurses were worth their weight in gold and they were entirely reimbursable. In general practice, sadly, a lot of paper is shuffled to head office and not everything is reimbursable. GPs have to work hard to claim their moneys and to make up the practice income—out of which everything has to be paid. What is left over is their salary. Any measure that makes it easier to pay practices must be welcome.

It is good practice to run, for example, asthma and diabetes clinics, but we were not paid at all for the extra work that we incurred when we did so. Even the receptionist, who had to pull out heaps of notes and return them, was not paid for the extra work that she did. Our health centre had 10 practices, 30 doctors, only two part-time typists and one manager—all were excellent, but we were never allowed to have more help.

Why do I tell members all this? I do so because there must be change for the better. The new contract that is set out in the bill must raise morale and help to retain staff. It must build in longer consulting times, as well as time for GPs to think and to attend postgraduate courses without affecting the practice's income. GPs must be given time to think—that is as important as paying them for the job that they do and it shows that they are valued. The new contract will be cost-effective and will lead to better clinical outcomes, so patients will benefit. Time is precious: even repeat prescription checking and signing takes up at least an hour every day.

Twenty-four hour responsibility is a strain to live with. Health boards will now have to find doctors who are willing to take that responsibility and they will have to pay them. I know that doctors in rural areas fear that too much responsibility will fall on nurses, of whom there are too few to do the job at present, so there are problems.

At present, the profession literally pays itself to do out-of-hours deputising. Doctors in Scotland are the lowest paid in the UK. One young man whom I met at the health centre long before I retired rejected a job at another practice. He said that he had turned it down because it would not pay him enough. I told him that I knew that doctors in England got paid about £10,000 or £15,000 more. He laughed and said, "Oh, much more than that"—not bad for a new start, but why should there be a difference? When I retired, it was thought that I could not be replaced because the practice could offer only a part-time salary for full-time work.

It is hard to believe that I earn more now as an MSP than I did as a senior principal in general practice. Many people imagine that all GPs are paid the same. However, until now their pay depended on other factors, including whether they met their smear test or immunisation targets. It is possible for GPs to fail on a target through no fault of their own, which is not fair. Not all doctors' jobs are similar; it is easy to see how town and rural work may differ, but it is difficult to make people aware that inner-city practices differ in many aspects from those in leafy suburbs.

In Springburn where I worked, from 1975 to 1980 the doctors were like nomads. In that time, I had three surgeries, as did many of my other colleagues. We lost count of the number of times that we were flooded or burgled and of the number of times that cars were vandalised. In addition to all that, I was attacked. I am grateful that I lived to tell the tale, unlike some doctors who have lost their lives. The health centre was built in 1982—it was a great idea at the time—but it was no longer adequate to cope with the new contract in 1990. In the 1980s, we were herded into health centres. Now, if a practice could find land, it would be allowed to build.

It is little wonder that doctors are dying for a new contract to give them a new lease of life, but it is understandable that, despite all the hard negotiations, experience of past contracts leads to apprehension about what the contract will mean. We have had far too much change, especially during the past 12 years. Doctors and nurses do not have an appetite for more change—they must see improvement soon.

Believe it or not, I support the principles of the bill. I also support the Health Committee's claim that it should be able to see the regulations—we were voted in by the electorate to do that. The contract will provide for the greatest change since the inception of the health service and it will affect us all sooner or later. We should remember that.

The legislation has to be a success; I cannot bear to contemplate the outcome if it is not. We must get the regulations right.

16:08

John Farquhar Munro (Ross, Skye and Inverness West) (LD): I welcome the aims of the bill, especially if it will help to reduce bureaucracy and increase the quality of patient services. I am sure that those are its aims and objectives. In particular, I welcome the 33 per cent increase in investment that, spread over three years, will back the bill. I hope that that will help to stem the seemingly continuous downgrading and closure of a broad range of medical services, in particular in rural areas.

I plan to use my slot in the debate to express concerns that I expect will be raised by other rural MSPs. I want to highlight the on-going concerns surrounding out-of-hours care. That is a big issue indeed, which has quite an impact on rural areas. Some GPs in remote communities might not be allowed to opt out, as can those in urban practices. The British Medical Association accepts that in some situations it might be impossible for the GP to opt out of out-of-hours responsibilities. For example, a single GP on an island or in a remote location might find that there is no practical alternative—there will be situations in which it is simply not feasible for the GP to opt out. In such circumstances, GPs should be supported appropriately and should receive help from the health board through provision of locums and periodic relief from out-of-hours work. Their remuneration should be enhanced because of their unavoidable out-of-hours responsibility.

The Executive does not view the changes to out-of-hours services as radical. It says:

"The reality is that new arrangements are already in place for those services. In many parts of Scotland, co-operatives provide out-of-hours cover. It may well be that many GPs will continue to work through the co-ops … GPs might opt out of responsibility for out-of-hours services, but they might not necessarily opt out of the provision of those services."

For a considerable time, the Liberal Democrat position has been that although the bill represents a very good deal for doctors, patients would not vote for it. It marks an end to the one-stop shop for patients, who might have to go to one place to see their GP for a particular purpose and to another for other treatments. That reduces access and goes against the trend towards increasing the role of family doctors in the NHS.

As members will appreciate, the situation in remote and rural areas is dear to many of us. Remote and rural general practices are hardest hit by current recruitment difficulties. We have problems almost daily. I am sure that members have heard my colleague Jamie Stone speak in the chamber about the crisis in Helmsdale, a small Highland community that recently lost its local practice, which merged with a neighbouring practice in Brora because of recruitment problems. Throughout the country, vacancies that a few years ago would have attracted four or five candidates are lucky to attract one or two. I know that locums can fill the recruitment gap in the short term, but they are a costly alternative.

I understand that Malcolm Chisholm, the Minister for Health and Community Care, has said that no practice will be worse off. That is a welcome statement. He has also said that service levels will be maintained, which is excellent. However, doctors from my part of the world are still to be convinced that the changes to their contracts will not put extra pressure on out-of-hours cover. We accept that the provision of medical services in rural parts of Scotland is not as it should be. In some areas, doctors are becoming increasingly difficult to replace because of the demands that are placed on them and because of other general difficulties with recruitment and retention in rural areas.

It is important not only that the minister reinforce the Scottish Executive's commitment to service and income in the bill, but that he explain in detail to doctors in rural practices how the process will work. By doing so, I hope that he will help to bridge the growing confidence gap between doctors and the effects of the legislation on rural practices.

16:13

Dr Sylvia Jackson (Stirling) (Lab): Like most other members in the chamber, I welcome the bill. As the minister said, it will bring about fundamental changes in the NHS. I listened carefully to what he said about the need for a team-based approach. Des McNulty spoke about providing enhanced services—the money that will be made available to do that is very welcome. There will be more specialised services in local areas, a multidisciplinary approach and more financial help for out-of-hours services. Altogether, the bill represents a good start.

Des McNulty also mentioned the fact that health centres—especially those in more disadvantaged areas—will take a more proactive stance. I am sure that that will be welcomed in those areas.

I will talk about the subordinate legislation angle. As an aside, I say that the Subordinate Legislation Committee had a wee problem with the Scottish socialists, who did not want to take up their seat on the committee, but that is by the by.

I am sure that most members know that subordinate legislation—also called secondary

legislation—includes orders, rules and other statutory instruments that are made under an act. As we have heard, the regulations that are to be made under the bill have become an important factor, so the Subordinate Legislation Committee has become important. Perhaps the Scottish socialists would like to think again about joining it.

The Subordinate Legislation Committee has two important functions—I am sure that other committee members will keep me right if I miss anything out. First, the committee asks whether the balance between primary and secondary legislation is right. We ask whether the important provisions in the bill and the other necessary provisions are in regulations.

Secondly, we ask whether the procedures that apply to regulations are correct. Should we use the negative, affirmative or super-affirmative procedure? That relates to the main point about the bill that the Subordinate Legislation Committee passed on to the Health Committee. In several cases, we thought that the negative procedure should be changed to the affirmative procedure. Some provisions in the bill for making subordinate legislation are so important that the minister should seriously consider changing the procedures. Those provisions are proposed new section 2C(5) of the National Health Service (Scotland) Act 1978, regulations under which will set out what are and are not primary medical services, and proposed new sections 17K(1), 17N(1) and 17N(4)(b) of the 1978 act. That information is in our report.

Our report also discussed the timetable for introducing the regulations, which has been well debated. I very much welcome what the minister said about producing the Scottish regulations, over which he has control, by the end of November. At the committee meeting when we spoke to Scottish Executive representatives, we were told that the regulations to be made under proposed new sections 17O and 17P of the 1978 act would be more difficult, but I assume from what the minister said that those regulations will also be produced by the end of November; perhaps he could clarify that. It is important to have the sample regulations so that the Subordinate Legislation Committee can judge whether the subject matter of the regulations is appropriate, and so that necessary amendment and discussion can take place.

The possibility of an illustrative list of primary medical services under proposed new section 2C(5) of the 1978 act was discussed. The committee argued that that would be useful, but the Executive argued that such a list could become definitive. We were interested that the National Health Service Reform (Scotland) Bill contained an illustrative list, so we wonder why one bill and not another can have that. Perhaps we will find out about that later.

A general subordinate legislation issue was discussed in the letters that passed between the Health Committee and the Procedures Committee. It was suggested that standing orders should be changed to enable subject committees to amend regulations. I agree with Iain Smith, who is the Procedures Committee's convener, that the issue is a major one. The Subordinate Legislation Committee and the Procedures Committee are thinking of holding a major inquiry on the matter, so that is in hand.

There is an important matter related to rural areas. I welcomed what the minister said about present discussions—he said that the Scottish General Practitioners Committee and the Rural Practices Association are discussing inducement practices, but the subject is a concern in my constituency, because Killin practice is an inducement practice. What is the progress on that and when will we receive a report on the proposals for inducement practices? Recent media coverage in *The Press and Journal* has shown that people are worried about the issue. However, the letter that I received from the minister, which I passed to the Killin practice, has somewhat allayed those fears for the moment.

16:20

Mr Rob Gibson (Highlands and Islands) (SNP): It has been said that the bill will result in one of the biggest changes to GPs' conditions of service for the past 50 years. So we need to ensure social justice for the patients who will experience turbulence during the changeover. The minister must give us some responses today that answer some of the questions that have been asked around the chamber about what conditions will be like when the changes take place.

Patients have been promised that there will be no reduction in the quality of the services that they will receive from primary health care, but the health boards that must deliver those services are in the midst of changing the local health care co-operative structure to community health partnerships. Health boards also have to deal with all of the nitty-gritty problems which, for health boards in remote and rural areas such as the Highlands where I come from, mean that they will have to deal with the problem of finding enough locums to take up the posts that will become vacant when doctors opt out of the out-of-hours service.

Member after member has identified pressure points, so between now and next April, the minister should give Parliament regular progress reports on implementation of the contract. Perhaps the minister who is to reply to the debate can tell us about the means by which that could be done. Ministers need to allay the fears of the voters out

there, who are the people who receive GP services. This is such a big change and people ought to know the parameters of the change as it goes along.

Some GPs to whom I have spoken talk about a chaotic service, about their concerns about the present state of change and about the pressure to change out-of-hours services. Let us consider what patients might face in the case of an opt-out by their local GP. Those patients might be dealt with by a paramedic, a nurse, a pharmacist, another GP practice—if there happens to be one on the islands on which some patients live—by NHS 24 or by the accident and emergency unit of the local hospital. We are in the midst of massive change, which is destabilising the service that people receive.

Like most members, I support the bill generally. However, the detailed negotiations that are going on mask the fact that although the regulations are expected to tell us a good deal more of the detail, real problems could prevent delivery of any kind of guarantee that the patient will get the same level of service that they receive at present—not that the level of service was as adequate as it should have been in every case.

Remote and rural areas and the inner cities face the biggest difficulties in recruiting and retaining staff. That being so, during the process of change, the minister had better be able to tell us that a good deal more GPs are to be trained and students recruited into the service than has been the case up to this point. To be frank, the levels of increase are nowhere near what will be required to carry the out-of-hours service.

The cost of locums and the cost of the kind of private companies that are getting together to provide out-of-hours services is enormous. The Scottish Association of Health Councils has expressed concern about the enormous problems in the way in which the changes could impact on patients.

I will deal with one final point because of the short time that is available to me. We look to primary care to deliver public health principles and we ask GPs to try not only to deal with sickness, but to encourage health. Problems could arise in respect of the additional services that are to be met by payments for tests such as high blood pressure, diabetes and the like. However, will there be time for services that deal with mental health problems, which are not so easy to test for? After all, in 90 per cent of such cases, the point of contact is a GP. I am concerned that the various targets and the means by which doctors' pay will be enhanced—as it should be—will not take into account the difficult areas in those services.

We need some thorough answers to those questions if we are to achieve early implementation: I hope that the minister will deliver some in his summing-up.

The Deputy Presiding Officer (Murray Tosh): I express my regret to the three members who had hoped to take part in the debate. There is no time for me to call them. I must move now to closing speeches.

16:25

Tommy Sheridan (Glasgow) (SSP): It is right and fitting that many speakers in today's debate have mentioned the absolutely essential role that GPs play in Scotland's health and in providing a health service throughout the country. We have an army—unfortunately, a very small army—of dedicated men and women who have had to deal with increased pressure, bureaucracy and paperwork and who regularly tell us in correspondence that they have far too little diagnostic time to spend with the patients who come to see them. We require to take urgent action to address the delivery of this essential service. After all, members have already pointed out that 90 per cent of patients who use the health service will receive primary medical care.

However, the bill before us is not the solution. Although it has been referred to as one of the biggest changes to the health service in 40 years, there has been virtually no consultation with or involvement of patients in it. The bill before us is designed to address the practice of contracting services for the delivery of primary medical care. On the SSP amendment, which calls for GPs to become salaried members of staff, I found it absolutely ridiculous to hear some members say that that could not be done because the practice of paying for private contracts for GPs has been around since 1948. I thought that we were in favour of progress, modernisation and change.

I have to say that there is certainly an anomaly in that respect. The founders of the health service in 1948 had to deal with a particular social milieu that is radically different from the one that exists today. Doctors were by and large unwilling to play ball in the formation of the health service. As a result, it was anomalous to allow them to have individual contracts. In changing our health service, we should move towards a more modern and progressive system of employment for these health service workers who are as essential to the service as other workers.

Mike Rumbles: This debate is supposed to be about the Health Committee's report on the stage 1 evidence that it took on the bill. However, not one of the six SSP members turned up at any of the committee meetings at which we considered the matter. In fact, the issue that Tommy Sheridan raises was not mentioned during the stage 1

consideration of the bill. Why is he raising it now as a central objection to the bill?

Tommy Sheridan: We are raising the matter now because it needs to be raised. In any case, I should point out that no SSP member is a member of the Health Committee. It is absolutely ridiculous—indeed, it is a red herring—to suggest that members who do not attend a committee meeting are somehow or other not allowed to speak in the chamber. [*Interruption.*] I hope that members will allow me to address the central concern. First and foremost, the bill is about a reorganisation of primary health care. However, it does not go far enough. It does not represent modernisation or progress because it does not offer the means to do what we should be doing. It should deliver a system of salaried GPs on flexible contracts to ensure that we address the points that have been raised about demands on GPs.

GPs should be paid well. The BMA tells us that the current average salary is £61,000. Under the new contract, a GP's salary will rise by between 10 and 50 per cent to an average of £80,000 per year. One of the criticisms is that, although there will be a massive increase in salaries, there will be less demand on individual GPs. The biggest single fear—the source of which is there in black and white in the bill, although it does not have to be—is that the bill will lead to a massive privatisation of primary services. If the minister wants to assure us that that will not happen, he can write the bill accordingly to rule out boards contracting from the private sector. Of course, much of what the bill aims to achieve is driven by Westminster, not by the Scottish Parliament, and everyone knows that there is a drive at Westminster to privatise further our health service. That is why there is an essential worry about the ethos driving the bill.

More legal responsibility will be placed on already unaccountable, unelected health boards. In the city of Glasgow, the health board is already responsible for savaging our acute services and it is about to try to annihilate our maternity services. I am quite sure that the people of Glasgow do not want the health board's hands on our primary health services. From that point of view, support for the bill across the chamber has been reluctant, to say the least. We are saying that the general principles of those parts of the bill are not acceptable, because they will not improve patient services and they will allow the further privatisation of our health service. That is something that we must stop in its tracks here and now.

16:31

Donald Gorrie (Central Scotland) (LD): As has been said, the Liberal Democrats support the bill and welcome the revolutionary change to primary care in the country. There are two aspects to the debate: the question of process and the question of substance. Various members of the Health Committee have criticised the process severely and expressed their view that they were not given adequate time to examine the matter. It may be that this debate is the wrong occasion on which to dig in our heels, because there are other reasons for the bill to proceed through Parliament, but I feel that ministers ought to reflect on whether it is always necessary to treat Parliament in such a way, as has happened with a number of bills during the past four and a bit years. Sooner or later, there will be a rebellion and members will say, "Look, you cannot take us for granted."

In addressing the question of substance, we must first consider the issue of money. A lot of extra money has been promised and that is very important and very welcome. On the other hand, the money is capped, and that raises concerns for some people. We have to be reassured that the money is sufficient for the recruitment and retention of GPs in the areas where there is a shortage of them at the moment, whether those are rural or poorer urban areas. As to whether the Executive will deliver that recruitment and retention of GPs, the proof of the pudding will be seen in a wee while.

The detail is important, and I was concerned to read that a target has been set at Westminster that all GPs should see any patient within 48 hours. I am not sure whether that is an English thing or a Scottish thing, but that sort of target can be counterproductive. Many of us have routine things that we have to see a GP about, but it is not a big issue if we wait for a week or 10 days. A GP must be able to give adequate time to the people who really need to see him, rather than churn through people rapidly. I hope that any targets and systems that we propose will be more intelligent than that.

The question of rural areas has been mentioned by many speakers, but one of the attractive aspects of the legislation is that it could create genuine local control—which is dear to the hearts of Liberals—rather than the centre telling people what to do. If that works out correctly, it will be a great boon. Islands, rural areas and city centre areas must be treated differently and local people should have a proper say about how services are delivered in their areas.

I was encouraged by the BMA's saying that the new system would reduce bureaucracy—there must be a first time for everything. Reforms in the past have not reduced bureaucracy, but I hope that the proposed reforms will do so. That is important.

That regulations still need to be made has been mentioned. It is important that the regulations are properly scrutinised by the Parliament and by the Health Committee in particular.

The wording of the bill could encourage people who are not involved in traditional medical professions to get involved in group practices and so on. We want arrangements that encourage people to stay healthy, not merely arrangements whereby people are looked after when they are ill. There could be fitness advisers in practices or people who would cheer up people or develop activities in the community to keep people busy so that they do not fall ill. There must be much more active arrangements to keep people healthy. The bill provides an opportunity for such arrangements, and I hope that that opportunity will be taken.

The debate has been helpful. That minority Opposition parties can raise awkward issues is good—that is what members are here for. I support the bill, but we will have to wait and see whether the Executive delivers what it has promised.

16:36

Mrs Nanette Milne (North East Scotland) (Con): The passage of the Primary Medical Services (Scotland) Bill is crucial to the future of primary care in this country, as recent years have seen a crisis in morale in the service. There has been a drop in recruitment and retention and an increase in early retirement to the extent that it is becoming well-nigh impossible to provide adequate primary care in parts of Scotland, particularly in the more rural and remote areas. Jean Turner—who is a former medical classmate of mine—gave a graphic description of the reasons for falling morale over the past 12 years. My husband retired early from practice for such reasons. He now helps to keep the system going by doing locums, which gives him the freedom to practise medicine as he was trained to do.

The new contract, which focuses on the primary care team rather than on the GP alone and bases funding on patients' needs as well as list size, will allow GPs to improve the service for patients and, at the same time, to be more in charge of their work load. They will have more time to spend with their patients and will be relieved of their responsibility for the 24-hour provision of patient care. For the first time, they will be rewarded for any enhanced services that they provide for patients over and above the essential and additional services that are currently provided by most practices. That is good news for patients in most areas and for the profession in general. A majority have voted in favour of the new contract.

However, I would like to make a case for an important section of the profession that is more than a little concerned about the future. I refer to those GPs who also run community hospitals, of which there are many in rural Scotland. Such hospitals are not part of general medical services, but are an integral part of medical services in the areas that they serve, such as in Inverurie, Stonehaven, Huntly and Brechin, to name but a few places in the north-east. Currently, their staff deal on a 24-hour basis with accident and emergency attendances, daytime and overnight admissions, acute management of relatively unstable patients and palliative care, among other services. If those hospitals become nurse led out of hours because the local GP is no longer available, there will be inevitable limitations on what can be dealt with. Currently, the service that is provided is a service of extended care that uses an integrated team approach, including the community hospital, and patients in those areas already receive significantly more than core and additional services.

The GPs in those areas find their work professionally rewarding and see the new contract—particularly its out-of-hours provision—as a potential threat to the high standard of care that they provide, unless it is appropriately resourced. Many of them do not see an out-of-hours co-operative as being able to provide the standard of service that is currently available to their widely scattered practice population.

It is clear that primary care is not uniform throughout Scotland and it is important that the contract does not create disincentives to the pattern of care that I have just described. Otherwise, communities that are remote from acute services and depend on extended primary care could find themselves without access to a generalist diagnostician who has the clinical authority and experience to make decisions on future care. Patients in those areas would, by default, be referred to acute services, with all the consequential implications that that would have, such as delayed discharges, blocked beds and lengthening waiting lists.

I am a little disappointed that the Health Committee has not heard evidence from the Scottish Association of Community Hospitals, because it has an important case to make. I hope that the Minister for Health and Community Care will pay heed to what I have said and take what steps he can to ensure that this invaluable resource is properly funded in the interests of patient care and the health service in general.

Christine Grahame: I advise Nanette Milne that if associations such as the Scottish Association of Community Hospitals want to give evidence, they should get in touch with the clerks to the Health Committee and we will hear what they have to say.

Mrs Milne: I thank Christine Grahame for that information and I will pass the message on to the president of the SACH.

All I will say about the Scottish socialists' proposals is that they would decimate primary care because, were they to be accepted, GPs would leave the service in droves. The Scottish socialists clearly did not consult many GPs before lodging their amendment, because most GPs greatly value the independent status that they have held since the inception of the NHS. Only in exceptional circumstances would some of them accept a salaried service.

The lack of availability of draft regulations for scrutiny is, of course, of concern to us all. I hope that the minister will be able to let the Health Committee have them within the time scale that he promised today.

I understand the concerns about patient consultation and welcome the commitment to carry out such consultation before the bill becomes law, but clearly there was an urgent need to negotiate a contract that was acceptable to GPs. Without it, many patients would be struggling before long to receive primary care, given the rate at which practitioners are leaving the profession.

The legislation that we are discussing today is essential if we are to secure the future success of primary care in Scotland. It is important that the new contract is implemented at the same time as that south of the border, so that practice in Scotland is not compromised by delay. It is clearly also important that the new GMS regulations are scrutinised by the Health Committee before the bill is allowed to make significant progress. Although we are happy to support a bill that should help to address the current crisis in primary care provision I am, like my colleagues, concerned that the draft regulations are not yet available for scrutiny.

16:43

Stewart Stevenson (Banff and Buchan) (SNP): This is an interesting and important debate, which has raised a number of issues.

Donald Gorrie suggested that we should be cautious about a 48-hour target for a patient first being seen. If my memory serves me right, target 6 in the draft health and community care budget for 2004-05 commits the Executive to providing 48-hour access to a GP, nurse or other health care professional. I say that from memory; the Deputy Minister for Health and Community Care can correct me if I have got the data wrong.

One of the things that that commitment does not appear to do is provide access to dentists; however, that is an issue not for today but for another occasion. The Minister for Health and Community Care may be sure that it is one to which I and other members in the chamber will return—will we not, Mr Rumbles?

John Farquhar Munro spoke eloquently about the issues in rural areas. The opt-outs cover from 6.30 in the evening until 8.00 in the morning, weekends, bank holidays and public holidays. However, what are bank holidays? By and large, the banks do not observe the legally defined Scottish bank holidays any more, so which dates are we talking about? Only two public holidays are nationally recognised in Scotland—does the opt-out also apply to local public holidays? There are lots of little ambiguities.

Perhaps the real issue is that in rural areas throughout Scotland there are more than 100 incentivised GP practices that have particular problems and for which the opt-out may not be available. Another issue is that if we are allowing practices that have access to the opt-out to stabilise their work load and take some of the distress out of the job for GPs—stress is good, but distress is bad—do we not leave rural GPs still having difficulties in arranging holidays, for example, because it is difficult to find and pay for locums?

The worthy proposals that are before us today may exacerbate the differentiation between the quality of life of rural GPs and that of urban GPs, but the answer is not just to provide more money for rural GPs and their practices. I am given to understand that around 300 people now practise as locums in Edinburgh, because they can make more money doing so and can be more in control of their work load. Is the NHS to follow the path that has afflicted nursing? The NHS is in the precarious situation of relying increasingly on expensive bank nurses. Will we see bank GPs?

On the basis that we should welcome any measure that will shrink the differentials between GPs in England and Scotland, we welcome the bill. I am not quite sure what David Davidson was saying when, seven minutes and 15 seconds into his speech he said that he did not like to be in the culture of making anything work. That simply confirms what we knew about the Tories' attitude to the NHS. We will have to read the *Official Report* of the meeting, but I think that David Davidson will find that that is what he said.

We have had some discussion and further illumination of the distinction between essential, additional and enhanced services, which is welcome. Paragraph 2.9(vi) of the NHS Confederation's document "Investing in General Practice: The New General Medical Services Contract" mentions the "cryocautery of warts"—which means burning them off—as an additional service. If that service is additional, not all GPs will necessarily provide it, so perhaps we should reconsider those definitions. My GP father used just to hand me the necessary instrument and I burned my warts off, although I am scarred as a

result. The world has changed a little since then. Amusingly, under the heading "Influenza immunisations", that document also says that "Informed dissent will apply." I look forward to finding out what that means.

Carolyn Leckie's intervention was rather ill judged. There is no question but that all members of the Parliament extend our sympathy to her in her personal circumstances, but we cannot excuse the disengagement of her party from the process of the bill. I say to her: engage or be ignored and marginalised.

I have counted 39 instances of the word "may" in the bill, but only 13 instances of the word "must"—the debate has been tedious at times. An important point about secondary legislation underlies that comment. Normally, when a committee considers at stage 2 a bill that is of importance to people in Scotland, we would expect all members of that committee, and people beyond the committee, to lodge amendments that seek to improve and enhance the bill. The Executive has a good record of responding to sensible amendments from all parties. To move the essence of the bill into secondary legislation denies parties the opportunity to lodge such amendments—we can say only yes or no. That point is not only for the Health Committee and this bill; it is a general one for Parliament.

The SNP is happy to support the bill's general principles and we wish it good speed.

16:49

The Deputy Minister for Health and Community Care (Mr Tom McCabe): The debate has been excellent and has shown how effectively our parliamentary system can work. In line with Malcolm Chisholm, I offer my acknowledgement of the Health Committee's work in scrutinising the bill at stage 1. I welcome the committee's recommendation that the Parliament should approve the bill's general principles and I fully acknowledge the concerns that have been expressed about the regulations. If our system is to work properly, it is important that committees have all the information that they think is required to scrutinise proposed legislation properly. The situation is not ideal and we hope that it will be vastly improved in future.

The Health Committee recognised, rightly, the bill's potential for improving the present situation with regard to the delivery of primary medical services and the recruitment and retention of NHS staff. Shona Robison made a number of points around that. My first point in response is that we believe firmly that the contract will make GP practice far more attractive. That in itself must be a tremendous advance. Currently, there are 156 vacancies. However, to put that in perspective, that figure is out of a total of 4,166 positions in Scotland, and 60 of the new vacancies are a result of new money that was put into the system. The latest figures tell us that, for each filled post, there was an average of 2.2 applications.

Shona Robison referred to the minister's evidence to the committee on registrars. Registrar numbers have gone up by 18 per cent since 1997 and extra money was made available last year to take the number of registrars in training up to 284.

As Malcolm Chisholm and others have said, more than 90 per cent of the Scottish public's experience of the NHS begins and ends in the primary care setting. The bill will have a crucial role to play in how services are delivered to patients in GP practices across Scotland. It is arguable that the bill offers the biggest opportunity since 1948, when the NHS was established, to introduce fundamental and far-reaching changes to how primary care services are provided.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Can the minister give an assurance that the parliamentary timetable will enable the legislation to be in place on 1 April next year?

Mr McCabe: I am happy to give that assurance. We are confident that that can be achieved. Malcolm Chisholm has given assurances about the provision of regulations. It is not for me to determine exactly how the Health Committee will complete its work, but we are confident that there is sufficient provision to allow the timetable to be adhered to and to allow the bill to take force within the agreed time scales.

It is reassuring to note that the Health Committee welcomes the potential flexibility of the new contract arrangements. Perhaps one criticism of the old system was its lack of flexibility. Understandably, and perhaps inevitably, the committee expressed reservations in its stage 1 report. Members have raised similar reservations during the debate. In the time allowed, I will do my best to cover at least some of those reservations.

Out-of-hours services have featured prominently in the debate and I will try my best to address concerns about that issue. One of the key elements of the new GMS contract is that it will bring to an end GPs' 24-hour responsibility for their patients. I reassure members that that does not, and must not, represent a diminution of services to patients.

Carolyn Leckie: Will the member take an intervention?

Mr McCabe: Not at the moment.

The choice to transfer responsibility for providing services is for GPs. No practice that currently provides out-of-hours cover will be forced to give that up, although we anticipate that many will choose to do so. That does not mean that all GPs will stop doing out-of-hours work. As Malcolm Chisholm said, although many GPs will give up the responsibility, we expect a substantial number to be willing to contract with health boards to provide out-of-hours services.

Carolyn Leckie: Will the member take an intervention?

Mr McCabe: Not at the moment.

To make it possible for GPs to exercise their choice and to ensure that patients continue to receive out-of-hours services, the bill establishes that health boards will have to take on the responsibility if and when a GP practice withdraws from its out-of-hours service. That does not mean that health boards should be held to ransom. We know that that aspect will require careful and rigorous monitoring to ensure that the costs of providing an out-of-hours service do not spiral out of control.

Christine Grahame: Paragraph 35 of the Health Committee's report states:

"The Committee was surprised that the Executive has not undertaken any formal data collection for the projected opt-out rate for practices in Scotland and recommends that this exercise should commence immediately."

Has that exercise commenced?

Mr McCabe: As I will allude to later, much work is going on through the health boards. I also point out that 75 per cent of out-of-hours cover at the moment is provided through co-operative services and not directly through GP practices. To keep matters in perspective, we must bear that in mind.

The new contract means that patients will still have access to services, no matter what time of day or night it is, or whether they live in the middle of a busy city or in a remote island community.

Carolyn Leckie: Will the minister give way?

Mr McCabe: No. I am a bit pushed for time and cannot take any more interventions.

Carolyn Leckie: I let Malcolm Chisholm in.

The Deputy Presiding Officer: Order.

Mr McCabe: It is important to remember that boards will have until 31 December 2004 to have accredited alternative provision arrangements in place. No one is in any doubt about how much work needs to be done at a local level to make the new contract work. Health boards are not wasting any time and are taking steps to ensure that they have alternative providers in place to provide care in the out-of-hours period when it becomes their responsibility.

Mr John Home Robertson (East Lothian) (Lab): The minister is talking about access to services, which is important. We all hope that the bill will guarantee access to general medical services but what about dental services, which other members have referred to? Too many of our constituents are being denied NHS dental treatment. Can the minister do anything to get dentists on board?

Mr McCabe: I have acknowledged previously the strong concerns that have been expressed in the chamber on the provision of dental services. We hope to be able to say something in that regard in the near future.

On out-of-hours services, I want to pick up on one important aspect, which is the standard of the services that are being provided. Although existing out-of-hours co-operatives are monitored, there is no formal accreditation process for out-of-hours services. For the first time, the new contract will ensure that GPs can transfer their responsibility only where there is not only an alternative, but an accredited alternative, in place.

Carolyn Leckie: Mr McCabe has not made reference to the concerns that we have raised about the spectre of increased privatisation. Can he guarantee that he will consider an amendment that would ensure that there would be no contracting out of any providers in relation to primary medical services?

Mr McCabe: We are obliged to consider all amendments, but we are not obliged to give guarantees.

We are tight for time—

The Deputy Presiding Officer: I can give you two minutes more, at most.

Mr McCabe: Rob Gibson raised a legitimate concern relating to the level of mental health services that will be delivered. I assure him that those services will be monitored through the quality framework.

It is important to emphasise that patients will not be required to register with several practices for the provision of a comprehensive range of services. If a patient who receives essential services from one GP has to attend another to receive, for example, specialist diabetes treatment, the patient's own practice will make the necessary arrangements to send them for the specialist treatment. Under no circumstances will the patient be left to find their way unaided around the new system.

It is simply not possible in the time available to deal with all the points that have been raised in

today's debate. Stage 2 and the provision of the regulations will, of course, provide further opportunities for scrutiny. We look forward to working with the Health Committee and the entire Parliament as we move towards modernised and improved primary medical services.

Primary Medical Services (Scotland) Bill: Financial Resolution

16:58

The Deputy Presiding Officer (Murray Tosh): The next item of business is consideration of motion S2M-213, in the name of Mr Andy Kerr, on a financial resolution in respect of the Primary Medical Services (Scotland) Bill.

Motion moved,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Primary Medical Services (Scotland) Bill, agrees to any increase in expenditure of the Scottish Ministers payable out of the Scottish Consolidated Fund in consequence of the Act.—[*Malcolm Chisholm.*]

Business Motion

16:59

The Deputy Presiding Officer (Murray Tosh): The next item of business is motion S2M-523, in the name of Patricia Ferguson, on behalf of the Parliamentary Bureau, setting out a business programme.

Motion moved,

That the Parliament agrees the following programme of business—

Wednesday 5 November 2003	
2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Executive Debate on Scotland's Transport
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 6 November 2003	
9.30 am	Scottish Green Party Business
12 noon	First Minister's Question Time
2.30 pm	Question Time
followed by	Executive Debate on Common Agricultural Policy Reform
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 12 November 2003	
2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Justice 1 Committee's 3rd Report 2003, Inquiry into Alternatives to Custody
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 13 November 2003	
9.30 am	Executive Business
12 noon	First Minister's Question Time
2.30 pm	Question Time
followed by	Executive Debate on Celebrating 150 years of Public Libraries in Scotland
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business—[*Patricia Ferguson*.]

Motion agreed to.

Parliamentary Bureau Motions

16:59

The Deputy Presiding Officer (Murray Tosh): The next item of business is consideration of two Parliamentary Bureau motions, motion S2M-520 and motion S2M-521, on the designation of lead committees.

Motions moved,

That the Parliament agrees that the Justice 1 Committee be designated as lead committee in consideration of the Criminal Procedure (Amendment) (Scotland) Bill at stage 1.

That the Parliament agrees that the Justice 2 Committee be designated as lead committee in consideration of the Civil Legal Aid (Scotland) Amendment (No.2) Regulations 2003 (SSI 2003/486).—[*Patricia Ferguson*.]

Decision Time

17:00

The Presiding Officer (Mr George Reid): There are five questions to be put as a result of today's business. The first question is, that amendment S2M-192.1, in the name of Carolyn Leckie, which seeks to amend motion S2M-192, in the name of Malcolm Chisholm, on the general principles of the Primary Medical Services (Scotland) Bill, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Boyack, Sarah (Edinburgh Central) (Lab)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Curran, Frances (West of Scotland) (SSP)
Fox, Colin (Lothians) (SSP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Sheridan, Tommy (Glasgow) (SSP)

AGAINST

Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Mr Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Davidson, Mr David (North East Scotland) (Con)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Douglas-Hamilton, Lord James (Lothians) (Con)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Gallie, Phil (South of Scotland) (Con)
Gibson, Mr Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Grahame, Christine (South of Scotland) (SNP)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)

Johnstone, Alex (North East Scotland) (Con)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Campbell (West of Scotland) (SNP)
Martin, Paul (Glasgow Springburn) (Lab)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Rt Hon Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Morgan, Alasdair (South of Scotland) (SNP)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow) (SNP)
Swinney, Mr John (North Tayside) (SNP)
Tosh, Murray (West of Scotland) (Con)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

ABSTENTIONS

Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Swinburne, John (Central Scotland) (SSCUP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Presiding Officer: The result of the division is: For 7, Against 102, Abstentions 9.

Amendment disagreed to.

The Presiding Officer: The second question is, that motion S2M-192, in the name of Malcolm Chisholm, on the general principles of the Primary Medical Services (Scotland) Bill, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Mr Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Davidson, Mr David (North East Scotland) (Con)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Douglas-Hamilton, Lord James (Lothians) (Con)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gibson, Mr Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)

Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Campbell (West of Scotland) (SNP)
Martin, Paul (Glasgow Springburn) (Lab)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Rt Hon Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Morgan, Alasdair (South of Scotland) (SNP)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Tosh, Murray (West of Scotland) (Con)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

AGAINST

Byrne, Ms Rosemary (South of Scotland) (SSP)
Curran, Frances (West of Scotland) (SSP)
Fox, Colin (Lothians) (SSP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Sheridan, Tommy (Glasgow) (SSP)

The Presiding Officer: The result of the division is: For 113, Against 6, Abstentions 0.

Motion agreed to.

That the Parliament agrees to the general principles of the Primary Medical Services (Scotland) Bill.

The Presiding Officer: The third question is, that motion S2M-213, in the name of Andy Kerr, on the financial resolution in respect of the Primary Medical Services (Scotland) Bill, be agreed to.

Motion agreed to.

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Primary Medical Services (Scotland) Bill, agrees to any increase in expenditure of the Scottish Ministers payable out of the Scottish Consolidated Fund in consequence of the Act.

The Presiding Officer: The fourth question is, that motion S2M-520, in the name of Patricia Ferguson, on the designation of a lead committee, be agreed to.

Motion agreed to.

That the Parliament agrees that the Justice 1 Committee be designated as lead committee in consideration of the Criminal Procedure (Amendment) (Scotland) Bill at stage 1.

The Presiding Officer: The fifth question is, that motion S2M-521, in the name of Patricia Ferguson, on the designation of a lead committee, be agreed to.

Motion agreed to.

That the Parliament agrees that the Justice 2 Committee be designated as lead committee in consideration of the Civil Legal Aid (Scotland) Amendment (No.2) Regulations 2003 (SSI 2003/486).

Children's Panels (Membership)

The Deputy Presiding Officer (Trish Godman): The final item of business today is a members' business debate on motion S2M-364, in the name of Scott Barrie, on children's panel membership. The debate will be concluded without any question being put.

Motion debated,

That the Parliament recognises the huge contribution made to public life by volunteers; notes that the children's hearing system has now been in operation in Scotland for over 30 years; applauds the dedication and commitment of children's panel members in undertaking a difficult and demanding task; recognises the Scottish Executive's current recruitment campaign for additional panel members, and encourages people from all sections of the community, but in particular men, to consider applying for membership of the children's panel in their local area.

17:05

Scott Barrie (Dunfermline West) (Lab): First, and as is customary, I thank the many members of all parties and none who supported the motion in my name, and who have therefore allowed children's panel membership to be debated in Parliament tonight. I do so in all sincerity, as I believe that such support shows members' interest in and commitment to the children's hearings system. I look forward to hearing other members' contributions.

I wish to pay tribute to the past and present contribution to society of members of children's panels; to highlight the need for more people from communities across Scotland to come forward to serve on panels in their local areas; and to emphasise the contribution that children's panel members make, not only to child protection and youth justice systems, but to their employers by enhancing their own value as employees.

Scotland's unique system of dealing with youth justice and child protection was set up through the Social Work (Scotland) Act 1968. That radical piece of social legislation followed from the work of the Kilbrandon committee, which had reported some four years earlier. The 1968 act was innovative and far-reaching in its reform of children's justice and welfare and in the inclusion of other key provisions, such as the duty placed on local authorities to promote social welfare and the bringing together of many different services into newly created social work departments.

A key part of the children's hearings system is the fact that panel members make up a lay body drawn from the local area that the hearing covers. Members give up their time freely and come from a wide range of occupations, neighbourhoods, income groups and backgrounds. They are unpaid and they all have a keen interest in the welfare of children and young people.

There are currently more than 2,100 panel members in Scotland. As the first phase of the annual recruitment process has just ended, children's panel advisory committees up and down the country will be organising interviews and selection and training events to ensure that that number is maintained over the coming year.

For the children's hearings system to work effectively, it is essential that children's panels reflect diversity within local communities. The stereotype of a typical panel member as some matronly figure in a twinset and pearls could not be further from the truth, although it is still the case today—as it was when I attended my first children's hearing as a social work student in Bathgate in the early 1980s—that not all socioeconomic groups are adequately represented. In that respect, I refer not simply to those groups that are traditionally excluded. The under-representation of men on children's panels is of particular concern. Men make up nearly half of society but barely a third of children's panel members.

A possible explanation is that men might appear to have less spare time in which to volunteer for membership, due to work commitments, and I will return to that point later. It is also suggested that an interest in child issues and child welfare is disproportionately a woman's interest. By statute, a children's hearing must consist of three panel members, of whom one must be male and one must be female. I might be wrong in my recollection, but I cannot recall any more than a handful of hearings that I have attended involving two men sitting on the panel. That, coupled with the possibility of a female reporter, female social worker, female teacher and female educational psychologist, as well as the mother, can make it an unrepresentative experience for the young person who is attending, who, sadly, is more often a young man. Just as we need to encourage more ethnic minority panel members and working-class members, we certainly need more male members.

During our all-day debate on antisocial behaviour earlier this month, Bill Aitken suggested that a reason why so many members resigned from their local panels was their frustration at the limited powers available to them at hearings. I disagreed with him then, and I would disagree with him were he here tonight. Figures that I have received show that, over the past five years, the proportion of members resigning during their first year of membership has varied between 12 per cent and 18 per cent. The overwhelming reason for their resignation was either family or work commitments. Having spoken to members of various children's panel advisory committees

throughout Scotland, I know that that is also the major reason given by panel members who resign before their term of appointment expires.

Serving on a children's panel is no easy task. The issues with which panel members are confronted are sometimes distasteful. They can be distressing and, in my experience, they are often harrowing. Those stresses are exacerbated if members also come under pressure from their employer because of the time that they are taking off work to undertake their children's panel duties.

Panel members have a statutory right to reasonable time off, but we all know that one person or employer's definition of reasonableness can be dramatically different from someone else's. I draw that to the minister's attention and ask the Scottish Executive to promote the benefits that children's panel membership can bring to organisations.

We often talk about transferable skills in the modern marketplace and, given the expertise that panel members gain through training and the skills required at hearings, employers get a favourable return—in employee development—on the modest amount of time off. A couple of years ago, I participated in an event organised in my local area at which a number of employers spoke favourably about their support for the hearings system because of what panel members contributed to their organisation. More events like that need to be held and the Scottish Executive needs to ensure that the message is heard adequately in the private sector, in both large and small businesses, so that panel members who are in employment are not drawn disproportionately from the public sector.

Some members have expressed concern about there being an upper age limit for panel members. Indeed, Christine Grahame has lodged a motion to that effect. I have stressed already this evening that it is essential that panels are representative of the whole community and must include older people. We would not want panels to be comprised only of octogenarians but, likewise, older people should not be excluded from membership solely because of an arbitrary age limit. There used to be flexibility in the system and I know from discussions with the children's panel advisory group that it would like to see that flexibility restored. I draw that, too, to the minister's attention.

Every day in Scotland, children's hearings meet to discuss the particular personal needs of individual young people. Panel members have to grapple with many different and complex issues, which could include sexual abuse, non-attendance at school, offences by the child, or the child being beyond parental control. Sometimes all those issues can emerge during one session, as in most areas three cases will be considered one after the other.

The skills required to conduct the hearing vary and panel members must deal well with difficult situations. It is a credit to children's panel members both today and in the past that they do that mostly unacknowledged and unthanked by society at large and that, in the vast majority of cases, they arrive at the right decision. Too often, members have been critical of the system, either directly or indirectly, because of the inadequacy of the resources available in a particular area. However, this evening we should recognise the dedication and professionalism that panel members bring to their role and acknowledge the immeasurable contribution that they make.

The Deputy Presiding Officer: A considerable number of members wish to speak, so I ask them to stick to a tight four minutes.

17:13

Fiona Hyslop (Lothians) (SNP): I congratulate Scott Barrie warmly on bringing this issue to the chamber as it is one to which we must return again and again. It is not just about congratulating warmly those who take part in the children's panels. They would welcome our support, but they would also want a commitment from us to stand by them and to ensure that they are supported. They would want us to ensure that the system develops and that it is given the financial support that it requires.

I read recently a report produced by Iain Gault called "Study on Youth Offending in Glasgow", which was written in April 2001 and published on 6 October 2003. Its content is relevant to what we are discussing. We must remember that the children's panel system is not just a nice thing to have and something on which we can shine a torch and about which we can say that it is a Scottish solution to youth care and justice issues. It is essential and integral to our care system and youth justice system.

I will concentrate my remarks on the connection between care and justice. The report studied persistent offenders—children who had had 10 to 19 referrals and children who had had more than 20 referrals. Among those who had had 10 to 19 referrals, the average age of first referral was at 8.7 years, but the average first-offence referral was at 11.9 years. More than 40 per cent of those who had had more than 20 referrals and 47 per cent of those who had had 10 to 19 referrals had been referred originally on care and protection grounds. It is essential to consider that point in our continuing debate on antisocial behaviour. Our responses to youth issues must be integrated and must emphasise care and the importance of referrals and support at an early stage.

I contacted the Edinburgh children's panel. Although its referral rates between 2000 and 2003 have gone up by about 600, referrals for offences have actually gone down. There is a perception that our children's panels have, all of a sudden, been swamped by offence referrals. However, Edinburgh's biggest increase in referrals is in cases of alleged lack of parental care, the number of which has gone up from 1,700 to 3,200. We should reflect on that. If children's panels are considered essential in our youth care and justice system, they must be placed centre stage and given the support that they need.

Scott Barrie spoke about the value of children's panels in offering experience and transferability of skills. If more private sector employers knew the value of such things, they might, instead of sending people on training sessions on this, that or the other, consider the valuable benefits that adult volunteering can offer to everybody, not only the participants.

Many people over the age of 60 can contribute a great deal. Many members of children's panels have been members for 10 to 15 years. They feel a social obligation. For them, to stop being a member is very difficult.

Children's panels are only as good as the partnerships that surround them. We cannot address the children's panels system without acknowledging the problems in social work recruitment and with the support that social workers can offer the panels. If the panels do not have support from social work departments for their disposals, those disposals will be ineffective. If things are referred to local authorities, we have to be sure that local authorities are able to support the recommendations of members of children's panels. If we are serious, we must address the social work crisis that exists in many local authorities. We have an obligation to support this essential and integral system of care and protection in Scotland.

17:17

Colin Fox (Lothians) (SSP): I very much welcome Scott Barrie's motion and the positive points that he raises. As the Scottish Socialist Party's justice spokesperson, I have taken three opportunities in recent weeks to meet various professionals in the Scottish children's hearings system. Indeed, I sat on a panel in Edinburgh last month. I offer my impressions, not with Scott Barrie's expertise and experience, but perhaps as an objective outsider.

I am full of admiration for the service and the work that volunteers and professionals do. The 2,200 volunteers, in particular, show dedication, pride and a sense of putting something back. They illustrate some of the most admirable qualities in civic Scotland today. Like Scott, I am fully persuaded of the benefits of the system. It is far-sighted and has the best interests of children in its viewfinder.

However, I have detected—and Scott mentioned this as well—a certain slump in morale in the service in recent years. The mood is that the ethos engendered by Kilbrandon all those years ago is at odds with the prevailing political climate. People have an overriding sense that their efforts are being undone by insufficient support, as Fiona Hyslop mentioned. In reading about the service at the time of the Kilbrandon report in the late 1960s and early 1970s, I was struck by the difference between the atmosphere then and now. I was struck also by the ethos of the children's hearings service then, which considered the welfare of the child by considering the whole child. What strikes me about the children's hearings system now—and Scott highlighted this in his motion—is that its very ethos is being criticised. I feel that it is being criticised unduly. Some quarters say that it is soft on yobs, and there have been renewed calls for the system to be replaced by juvenile courts like those in England.

Reading about the contrast between the situation in England and Wales and that in Scotland is illuminating. In the past 10 years, there has been a 100 per cent increase in youth custody in England and Wales and an 800 per cent increase in the number of 12 to 15-year-olds in custody. A total of 3,200 youngsters are now behind bars in England and Wales, which is the highest number since 1908.

We need a champion for the children's hearings service in Scotland and we need further development rather than abandonment. Some 65 per cent of children who are referred to children's panels are there for care and protection and not because of offences. The question is: how can we extend the service and how can we get volunteers?

Scott Barrie: Will the member give way?

Colin Fox: I will give way as long as I get some extra time.

The Deputy Presiding Officer: Please be quick, Mr Barrie.

Scott Barrie: I hear Mr Fox's criticisms of comments that are made about the children's hearings system, but does he agree that one of the difficulties with the current system is the sometimes unimaginative recommendations of social workers and the unimaginative use of disposals by children's panels? Disposals could be far more effective than they are at present; the system is not being used to the extent that it could be.

Colin Fox: I fully accept that and I will come to the question of social workers in the 30 seconds that I still have available. The point that Scott Barrie raises is not so much that we need volunteers in the service and that the service needs to be expanded but the question of how we do that. I note the remarks of the former Bishop of Edinburgh, the Right Rev Richard Holloway, a man who is more acquainted with the field than most. Last week, he suggested at a conference at Edinburgh sheriff court that if we offered expenses to working-class people to attend panels, and if we held the panels in local areas rather than in city centres, we might get people more involved. It might also encourage more younger people to get involved, which I think is part of the motion.

In my last 30 seconds, I will touch on the point about teamwork and social work provision, because that is critical. The social work service in this field sometimes appears to be in meltdown—I am told that, at 40 per cent of hearings, no social work report is available—and that has a detrimental impact on the service that is available to us. As Scott Barrie highlighted, we need to find more ways to get volunteers and to attract social workers to the field.

The key thing that we must do is to celebrate the success of the children's hearings system rather than denigrate it, and we must dedicate to it the resources that are needed for it to develop during the next 30 years as well.

17:22

Mary Scanlon (Highlands and Islands) (Con): I, too, welcome Scott Barrie's motion, which acknowledges the huge contribution, dedication and commitment of children's panel members, and I welcome the opportunity to debate the issue. I am sure that Scott Barrie will understand that I cannot speak for Bill Aitken, who has had a bad accident and is trying to cope with crutches and a wheelchair. I am sure that he will respond to Scott Barrie's comments when he returns to Parliament.

Although I commend the recruitment campaign, which I hope will bring forward more men as well as women, we should also focus on the retention and morale of existing panel members, as Fiona Hyslop and Colin Fox mentioned, particularly given those members' experience and the training that they have undertaken.

A briefing from the city of Edinburgh children's panel notes that panel members are not a bunch of do-gooders from the Morningsides of Scotland; they reflect the communities in which they live and serve. As others have said, we are unlikely to retain those committed volunteers unless they are supported by local authorities. Although a hearing can in theory impose wide conditions, if the resources that are needed to follow those conditions through are not available, their effectiveness is undoubtedly muted. That is a demoralising factor for panel members. I understand that the promised additional 29 places in secure accommodation are not yet finalised, but perhaps the minister will confirm that.

Conservatives would also support more detox and rehabilitation services for young drug and alcohol abusers. It is simply not good enough to tell a person who is ready to try to kick his or her habit to come back in a few months. I represented a 15-year-old in Fort William, who had been referred by the children's panel to detox and rehabilitation services in Lincoln in England, but the council said that it could not afford to pay for that treatment. However, the council eventually paid after quite a bit of intervention from elected members.

The responsibilities and decisions of the children's panel can be made more difficult when a wide range of disabilities are misinterpreted as antisocial behaviour. Such disabilities include mental health problems, autism spectrum disorders, learning disabilities and emotional, social and behavioural problems. A recent report by the Audit Commission indicated that 90 per cent of children who have been permanently excluded from primary school and 60 per cent of children who have been permanently excluded from secondary school have special needs. It might, therefore, be more important to ensure that assessment is made of whether behaviour is the result of disability before further sanctions are considered.

If we want to be successful and effective in recruiting and retaining volunteers for the children's panel, we could do no better than address the points that were raised in the Audit Scotland report of December 2002. I want to pick just a few points from that report, which has been mentioned by other members. Unless we pay attention to that, the children's panel members will continue to be demoralised and feel that their contribution is not effective.

Scott Barrie: As I tried to point out in my speech, the reason that was given by panel members for stepping down before their time has expired was not that they were demoralised because of a lack of disposals, but that they found it to be an impossible task to deal with the work load that was being asked of them while holding down full-time employment. Does the member accept that we need to press employers to give panel members adequate time off?

Mary Scanlon: Employment is one issue, but I can only reflect the points that have been put to me by the panel members whom I have met in the Highlands. If Scott Barrie thinks that he knows

better than Audit Scotland, he should challenge its report.

Finally, let me mention what Audit Scotland said should be tackled to assist the children's hearings. It takes an average of five and a half months for a child to reach a hearing, during which time much more offending behaviour can take place. It takes seven and a half to eight and a half months to get a court decision. About 400 children are not getting the service that they need and to which they are legally entitled because of staff shortages, lack of specialist services and lack of social workers. More programmes should be focused on persistent young offenders who are under 12.

The Deputy Presiding Officer: Please wind up.

Mary Scanlon: I will be very quick.

Over £60 million is spent on residential and custodial places, but only £25 million is spent on community-based services. There is also an increased, and increasing, vacancy rate for social workers in children's services. However, children's panel members need support.

17:27

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I congratulate Scott Barrie on securing tonight's debate. Along with other antisocial behaviour measures, an effective children's hearings system is an important part of protecting vulnerable children.

I am sure that we will be forgiven for being late at the Office of Gas and Electricity Markets reception across the street tonight. Ofgem wants to educate us about its priorities and objectives for the future, but what is new about that, given that this is what we do all the time? We might be at a school on a Monday, at a committee taking evidence from experts on a Tuesday and on a Wednesday we might be at a parliamentary debate such as today's debate on changes in general practitioners' contracts.

The events that we attend are such that I learned a bit more about the children's panel system during one lunch time when I—I think back in June—along with other members, met the chair of my local children's panel. For me, that did wonders in dispelling the popular misconception, which I think I shared with others, that the hearings system was only about dealing with young offenders. We have concentrated on that a bit tonight, but I learned then that that is only part of the job. The panels also exist to look out for kids who need care or protection. It was explained to me that a child can be referred to a panel for many reasons, from being the victim of an offence to misusing alcohol or drugs. It is up to the hearing to decide what is in the best interests of the child.

As has been made clear in the debate, the unstinting work of the panels, which consist of unpaid trained volunteers, is what has made the hearings work and endure over the past three decades. People give up their time to take part and in an age when people say that volunteering and community spirit is dead, the panel members contradict that wonderfully.

I was delighted to learn that Inverclyde children's panel boasts 58 members. Good as that is, when one considers that the panel deals with 1,000 referrals a year and holds five hearings a week, it is understandable that the panel wants to boost numbers further. As the three panel members who make up a children's hearing may not all be female, the panel is particularly keen to recruit more men.

Making the right choices for children is a huge responsibility, but we must send out the message that panel members do not need to be child care experts or top lawyers. As I discovered when I dropped into a training session one Sunday morning, children's panel members come from all walks of life. Although people were committed for a whole day, the place was packed.

We can all argue in support of children's panels, but we need to convince people, such as those in my area who may not be in employment but who have skills that they have built up over many years through working with apprentices, and who are blessed with common sense, that they can care about their community and kids. We should encourage them to become panel members.

17:31

Ms Sandra White (Glasgow) (SNP): I congratulate Scott Barrie on securing this debate and thank him for enabling us to debate an issue as important as children's panel membership. I also extend my heartfelt thanks to all members of children's panels. I know many of them, especially in the Glasgow area. They do stalwart work, spending many weekends and evenings trying to put something back into society. They tell me that they see that as their duty.

Scott Barrie and other members have highlighted a number of issues. It is important that we examine the way in which agism affects membership of children's panels. I know many people who are 70 or 80 years of age and who could put me to shame, never mind younger people.

We also need to consider the under-representation of ethnic minorities on panels and the fact that, for some reason, men are not taking up places on panels. Scott Barrie suggested that that may be the result of work commitments, but during the past 30 years, as children's panels

have evolved, men have had more time to get involved in the voluntary sector. More women now work, and if they can find the time to serve on children's panels I am sure that men can do the same. The Executive has run an advertising programme to encourage men to become more involved, and further advertising would be more than welcome. I urge more men to consider serving on children's panels.

As Duncan McNeil said, the members of children's panels come from all airts and pairts and should include people who have worked in shipyards with apprentices. We need to involve everyone in panels—their membership should be much more wide ranging than it is at the moment.

I congratulate the Executive on investing more funds in children's panels, especially in the Glasgow area, and I thank it for doing so. Some people may disagree with the fast-tracking of social workers, but not everyone opposes it when the aim is to enable more social workers to assist children's panels. We could say that children's panels are absolutely marvellous. The volunteers who offer their services to panels are marvellous and panels do a good job. However, we cannot ignore the fact that there is a lack of social workers, which is a big problem. We all recognise that.

I will not repeat everything that children's panel members have said to me. However, children's panels were set up as a means of intervention before children become involved in criminal activities. Unfortunately, at the moment we are failing those vulnerable children, because some of them do not have social work reports.

Scott Barrie made the point to Fiona Hyslop and Mary Scanlon that people leave children's panels because of work and family commitments. Like the children's panel members whom Mary Scanlon mentioned, the members of the Glasgow children's panel to whom I have spoken are leaving out of frustration. They do not feel that their work is being undermined, but they feel that they are not able to fulfil the duty for which they volunteered. They believe that they are failing the children whom they set out to serve.

I know that we are actively involved in trying to recruit more social workers, but we must monitor what happens in the long term. We can throw money at any problem, but if there is no monitoring to determine whether that is working it is hardly worth while.

I sincerely congratulate everyone who offers their time and energies to children's panels. It is up to the Scottish Parliament to ensure that adequate resources—whether money or social workers—are provided to enable them to help kids who are desperately in need. I thank Scott Barrie for lodging his motion.

17:34

Donald Gorrie (Central Scotland) (LD): I do not disagree with anything that members have said so far. I sincerely congratulate Scott Barrie on raising this issue. That has become a cliché, but it is particularly important for the Parliament to show that it values the work of volunteers on children's panels.

British society relies heavily on well-trained volunteers, whether they are on a children's panel or in a citizens advice bureau, or are sports coaches, youth club workers or people who help the elderly. It is important to maintain the flow of volunteers, who must feel that they are making a difference. That is what life is all about.

Some sections of the media have attacked children's panels. Sometimes, politicians have done that because they are understandably concerned about the disruption to communities that some persistent offenders and difficult young people cause. Some remarks that politicians make are interpreted as hostile and disparaging to children's panels, so it is important to show how much we value children's panels.

Scott Barrie discussed how more people could be attracted to join children's panels. He is right to say that we must have propaganda for employers. We can tell employers that if they moan about young people misbehaving, they can do something by letting people off work to act as children's panel members.

Agism has been mentioned. There are people who are considerably older than me who have a much younger outlook than some people I know who are middle-aged at the age of 25.

We also want to encourage among Scottish men a non-macho attitude and what I think are called soft skills in some quarters. Sensitivity is considered unfashionable in some sections of Scottish society, but we must try to develop that sensitivity. To care about people is not unmanly. We must put across that message to encourage more men to join children's panels.

It has been said that, because of the shortage of social work support, the procedure is too slow. That causes people to criticise the system, because they see the local tearaways whom nobody seems to be dealing with. I hope that the minister can assure us of a genuine increase in social work support for panels and for bringing people into the system more quickly. In addition, once a panel has made a decision, that should be given effect more quickly.

We can draw on advice from panel members on many issues, such as how to deal better with family breakdown, the problems of people who need care and protection and antisocial behaviour.

We can also draw on their advice on the measures they have found that work and what we need more of in order for the system to work better. As everyone knows, persistent offenders cause a disproportionate amount of trouble and we do not deal with them effectively. I am sure that children's panel members would have good advice for us on many of those issues.

I thank Scott Barrie for the debate. We must support panel members, attract more volunteers and make their work worth while by giving them adequate support.

17:38

Ms Rosemary Byrne (South of Scotland) (SSP): I thank Scott Barrie for giving us the opportunity to have the debate and to recognise the contribution of volunteers in the children's panel system. In my previous existence as a pupil support teacher, I often attended children's panels with pupils from schools and the base from which I worked and with parents. One of the most frustrating aspects for panel members and professionals is the fact that different social workers represent pupils and young people at different times, simply because of the shortage of social workers and not through any fault of social workers, who are very dedicated.

Often when I attended a panel meeting, I would meet one social worker who represented the young person; then, at the review meeting further down the road, I would meet a different social worker. That does not help with providing the best that we can for our young people. I agree with all the speakers who said that the social worker shortage must be sorted out nationally.

We know that things are happening at the moment, but all of us would like clarification of exactly what is going on in the recruitment campaign for the social workers, who are crucial to providing the best that we can for our young people.

The Executive should be congratulated on its recruitment campaign to attract volunteers into the children's panel system. Without a wealth of people from our communities who dedicate themselves and give up their time, the system would not continue to work in the way that it has done up until now.

We want to keep and value our children's hearings system. I hate to hear people say that they want to do away with the system and replace it with something else. We should fight strongly and do everything in our power to keep our system. I agree with Scott Barrie that employers should be approached—encouraging employers to support the system is a great idea. In addition to support for social services and recruitment of social workers, there is a need for increased resources.

Panels often find themselves toothless because no alternatives are available to them. It can often be the case that a young person has reached the stage at which they are out of parental control and need to be placed elsewhere. Sometimes, the local children's unit, which is the only available option, is not appropriate for the young person, as they would find themselves with other young people whose problems were incompatible with their own. If one young person has a problem with severe truancy and another has a drug abuse problem, the young person with the truancy problem can also end up with a drug abuse problem. We have to ensure that specialised placements are kept open for young people who need them.

Just before the recess, towards the end of June, we had a debate on the closure of Red Brae School. We have to watch the situation carefully to ensure that establishments such as Red Brae are kept open. Such centres of excellence across the country support young people and their families. We need those centres for the small percentage of young people who cannot be maintained in their own school and community. They need a place to go to in the short term that can help them become reintegrated into their community.

That is the kind of approach that we need to take rather than the punitive approach that we hear about with the proposed antisocial behaviour bill. Such a positive approach would be much more helpful for all of us.

We should applaud Scott Barrie for securing the debate. We should also applaud the work of the volunteers in the children's panel system. That said, we should also look at the resources that are being provided to let people in the children's panel system do their jobs.

17:43

Mrs Margaret Ewing (Moray) (SNP): Like others, I thank Scott Barrie for bringing this subject to the Parliament. I emphasise that one of the great strengths of the Scottish Parliament is that individuals such as Scott Barrie who bring a wealth of skills and knowledge from their backgrounds can make a firm impression on the issues that come before the Parliament and can influence the outcome of legislation by contributing to debates in the chamber or at committee meetings. As legislators, I suppose that that is what all of us want to do.

I think that I am the only member present who has also served at Westminster. I remember well people from England and Wales asking me with great envy about the working of the children's

hearings system in Scotland. They were envious of the strategy that had evolved from the Kilbrandon report and the passing of subsequent social work legislation. Those of us who represented Scottish constituencies were proud of what had been achieved in Scotland. The comparison with the system in England and Wales was sad to see. Not least of the proponents of the Scottish system was our late First Minister Donald Dewar, who spent a great deal of time working as a reporter in the system. I remember sitting in on one or two occasions when he undertook that role.

I became involved with the children's hearings system as a teacher and a politician. Like Rosemary Byrne, I was involved in special needs teaching. I was always impressed by the sensitivity of the volunteers and by the way in which they questioned the youngsters and tried to draw out what the real problem was. I was also impressed by the heart-searching way in which they decided what should happen to the child after they had gone through a hearing. The lack of the adversarial aspect that we see in juvenile and other courts often meant that youngsters did not feel threatened and could open up. Like other members, I pay tribute to the volunteers for their work over the 30 years that the system has been in place.

Tonight, I am pretending to be Christine Grahame. In fact, I turn up on these benches in various guises, although I have to say that it is easier to imitate Christine than it is to imitate Stewart Stevenson. However, I know that the minister is well aware of Christine's views on agism. On that point, I have a note from the chairman of the city of Edinburgh children's panel, who says that

"many of the younger members do not stay as long as others – reasons being that their employment needs to be more mobile, or if they are at university, they move elsewhere after graduation. Younger folk also can find employers less obliging in allowing them time to attend panel hearings – often the panel member does not wish to be viewed less favourably in the promotion stakes for this very reason."

He goes on to say that the panel often involves grannies and points out that their experiences of life and life skills can substantially help youngsters with their needs.

The Deputy Presiding Officer: You have one minute.

Mrs Ewing: I do not think that I am going to take all of it.

The gender balance on panels seems to have improved very slightly since the recruitment campaign began. I think that the ratio used to be four women to one man; it is now three women to one man. However, although there has been a slight improvement, we should still try to recruit men as volunteers.

Moreover, we should not simply assume that everyone who volunteers for the children's hearings system is a reader of *The Guardian* or turns up in a twinset and pearls. If we made a bit more noise about the system in the tabloid press, people from other areas might become interested in volunteering.

I ask the minister in his closing remarks to give us an update of the results of the campaign that was launched on 25 August. At the campaign launch, he made a very favourable statement about the importance of the system and I think that such an update would be very helpful. Finally, I should say that training and support are essential for all our volunteers.

17:47

The Deputy Minister for Education and Young People (Euan Robson): I congratulate Scott Barrie on securing the debate and warmly endorse the sentiments expressed in the motion. Moreover, I thank members for their helpful and heartening speeches.

The debate gives me the opportunity to express publicly the Scottish Executive's gratitude for the time and energy given by members of the public who have supported Scotland's children's hearings system. I include in that group not only panel members but those who volunteered for the children's panel advisory committees. Scott Barrie rightly pointed out that the results of the recruitment campaign for those advisory committees will be worked on. Although the role of those volunteers is a little less visible, it is no less important to the system.

I am heartened by the support for volunteers that has been expressed this afternoon in speeches and tributes from all parts of the Parliament. Of course, some of the comments come from members' personal experience and we have benefited greatly from that experience in the debate. Many members have worked closely with the hearings system and know well the contributions of members of the public. I agree with Donald Gorrie's point about the importance of volunteering in Scotland. The hearings system is a very good example of how volunteers are making a significant difference.

In the few moments that I have available, I will try to respond to a number of points. However, many good points were raised and members will forgive me if I do not manage to respond to all of them. First, I should say that children's panel membership is of immense benefit to employers. Indeed, we have tried to make that very point on a number of occasions. Apparently, a campaign on this specific issue was launched in 1999. An

employers' awareness campaign was introduced in 2001 and a further campaign is due to commence in March 2004. Members might like to take advance notice of that campaign and use it to reinforce the message, because it is extremely important that employers allow people to have time off.

Men are under-represented, and that is an historic problem. I understand that the current balance is 41 per cent male and 59 per cent female, but there are local variations, as members have said. It is extremely important that we get men to come forward and volunteer, and I am pleased to be able to tell Margaret Ewing that the 2003 campaign has produced about 3,750 expressions of interest, from which we hope to draw about 450 new panel members. I think that I am right in saying that, so far, there has been a 19 per cent increase in the number of men who have put themselves forward. To see how that translates into the number of male panel members who eventually come through, we shall have to see how the children's panel advisory committees take their decisions, but they are well seized of the situation, as the Executive is, and I know from the speeches that we have heard tonight that members are too.

Scott Barrie mentioned the fact that the prime reason stated in the Executive's figures for people leaving children's panels is family and work commitments. I recognise the figures that he quoted from Executive sources, and we must understand that family and work commitments can cause people to retire from panels. We now accept that mobility in employment means that, unfortunately, people will resign from panels, but we want to ensure that that does not happen as a matter of course. As Margaret Ewing said, we have invested in training, which is generally accredited to be good training. It gives volunteers the self-confidence to participate. If they feel that they are well trained, have facilities available to them and are supported in their activities, that is immensely important, and we want to ensure that that continues and that the support that volunteers get is the best that can be achieved.

I turn now to other points that were made in the debate. Mary Scanlon mentioned secure accommodation. Progress is being made on that, and the Executive is apparently currently in discussion with the agencies that will be delivering the 29 places. Unfortunately, I cannot tell her quite how far we have got, but those discussions will be on-going.

Mary Scanlon: Where are those 29 places likely to be?

Euan Robson: I hope that Mary Scanlon will forgive me, but I shall have to write to her about that. I have in the back of my memory where those places will be, but I would not want to mislead her. The places have been identified and, if I may, I shall write to her about that.

The question of age has been raised tonight and on previous occasions. Scott Barrie alluded to the fact, and members will recall, that it was Kilbrandon who suggested that the age profile of panel members should fit the potential age of parents. That is why there was originally some concern that there should not be panel members over the age of 60. There has been some flexibility, and although Mary Scanlon said that that flexibility had been reduced recently, that is not my understanding. As I understand it, the current system does not allow new appointments of people who are over 60, but it is considered acceptable for people who reach 60 once appointed to continue.

As I have said, there is some flexibility, but I would like to make it clear that a review is soon to be announced. That is something that I have talked about on a number of occasions. That review will make it clear that age considerations can be looked at so, if members have points to make as part of that review, we want to hear their views on whether the age restriction should be lifted or amended in any way. The review will be announced soon; we have trailed it regularly, and age is one of the areas that it will cover.

I am conscious of the time, Presiding Officer—in fact, I have strayed over my time. I will close by joining members in extending our grateful thanks on behalf of Scotland and Scotland's children for all the work of the unpaid volunteers who are involved in the children's hearings system. In partnership with paid professionals, they are doing a great deal to improve the lives of all Scotland's most vulnerable children and Parliament must express its appreciation for that.

Meeting closed at 17:55.

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