HEALTH AND SPORT COMMITTEE

Wednesday 20 January 2010

Session 3

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CONTENTS

Wednesday 20 January 2010

HEALTH AND SPORT COMMITTEE
2nd Meeting 2010, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

*Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Michael Matheson (Falkirk West) (SNP)

THE FOLLOWING GAVE EVIDENCE:

Dr Andrew Buist (British Medical Association)
Dr Frances Elliot (NHS Quality Improvement Scotland)
David Forbes (Unison)
Linda Harper (Royal College of Nursing Scotland)
David Heaney (Centre for Rural Health)
Barbara Hurst (Audit Scotland)
Dr Paul Kettle (Remote Practitioners Association of Scotland)
Dr Ewen McLeod (British Association for Immediate Care Scotland)
Professor Allyson Pollock (University of Edinburgh)
Dr Susan Taylor (Royal College of General Practitioners Scotland)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 20 January 2010

[THE CONVENER *opened the meeting at 10:03*]

The Convener (Christine Grahame): I welcome everyone to the second meeting in 2010 of the Health and Sport Committee. I remind everyone to switch off their mobile phones and other electronic equipment. I have received an apology from Michael Matheson, so I welcome Joe FitzPatrick, who is his committee substitute.

Before we begin the formal business of the committee, I want to record the committee's regard for Bill McLaren, who died yesterday. He was a charming and articulate man, whose commentaries were a complete delight. He was a great ambassador for Scottish rugby and, indeed, for Scottish sport, and he is immortalised in the words, "They'll be dancing in the streets of Hawick tonight." I invite Ross Finnie, Richard Simpson and Mary Scanlon to say a few words on behalf of their parties.

Ross Finnie (West of Scotland) (LD): It is entirely appropriate that the Health and Sport Committee should pay tribute to an icon of Scottish rugby and broadcasting. Bill McLaren did a huge amount to popularise the sport. Rugby is a minority sport and many people who wanted to watch it found it quite difficult to follow, but Bill McLaren found a way to simplify it and make it enjoyable. His humour added much to people's enjoyment—I think that thousands and thousands of people who watched rugby on television genuinely began to enjoy it. Bill McLaren's commentaries made a big, big impression in the popularising of Scottish rugby.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I add to that by saying that the level of Bill McLaren's knowledge was outstanding—new broadcasters will be hard pushed to match it. He connected each player to their community and school—even their primary school. Such connections have diminished in the professional era and are even more important today. Bill McLaren contributed massively in the context of embedding rugby in individual communities.

Mary Scanlon (Highlands and Islands) (Con): I associate myself with what my colleagues have said. As we know from our inquiry into pathways into sport, every sport in Scotland needs an ambassador. There is no doubt that people like me, who have little knowledge of rugby, were able to understand, enjoy and appreciate Scotland games thanks to Bill McLaren. There is no doubt that he rose to the challenge as an ambassador for rugby in Scotland.

The Convener: Thank you.

Subordinate Legislation

10:06

The Convener: We will consider four Scottish statutory instruments that are subject to negative procedure. Members have a copy of each instrument and a note from the clerk, which sets out the purpose of the instruments and issues that have been drawn to the committee's attention by the Subordinate Legislation Committee.

Food Enzymes (Scotland) Regulations 2009 (SSI 2009/435)

The Convener: The regulations provide for the execution and enforcement in Scotland of certain European Union regulations and directives on the use of food enzymes. The Subordinate Legislation Committee raised an issue with the Scottish Government in relation to conduct that constitutes an offence under the regulations, and has reported that it is satisfied with the response that it received. If members have no comments, is the committee content to make no recommendation to the Parliament on the regulations?

Members *indicated agreement*.

Food Additives (Scotland) Regulations 2009 (SSI 2009/436)

The Convener: The regulations will revoke the Food Additives Labelling Regulations 1992 (SI 1992/1978), the Sweeteners in Food Regulations 1995 (SI 1995/3123), the Colours in Food Regulations 1995 (SI 1995/3124) and the Miscellaneous Food Additives Regulations 1995 (SI 1995/3187). The regulations will also re-enact, with changes and on a transitional basis, certain provisions of those instruments.

The Subordinate Legislation Committee sought from the Scottish Government an explanation of the meaning of "an appropriate mixture" in the regulations on colouring agents for use in foodstuffs. In response, the Government clarified that the effect of the regulations is to implement directly the required EU directive on colours for use in foodstuffs, but it did not clarify how, in practice, persons would establish what an appropriate or inappropriate mixture of the specific colouring agents would be. The Subordinate Legislation Committee drew the clarification to the committee's attention. If members have no comments, is the committee content to make no recommendation to the Parliament on the regulations?

Members *indicated agreement*.

Food (Jelly Mini-Cups) (Emergency Control) (Scotland) Regulations 2009 (SSI 2009/437)

The Convener: This is going to be interesting. The regulations, which extend only to Scotland, will implement a European Commission decision to suspend the placing on the market of, and import of, jelly mini-cups that contain specified food additives. The Subordinate Legislation Committee made no comment on the instrument. Do members want to comment? Will no one even ask what a jelly mini-cup is? Members cannot be awake. Surely the question must be on your minds.

Ian McKee (Lothians) (SNP): You have challenged us, convener, so I will say that I know what a jelly mini-cup is: it is a product that dispenses a dose of confectionery down the throat. If jelly mini-cups are a danger to humans, I am slightly concerned that they could also be a danger to animals. The regulations seem to imply that they can still be given to animals. What are our views on animal health in this context?

The Convener: I think that we should refer your query to the Rural Affairs and Environment Committee. I am not sure whether people feed jelly mini-cups to sheep—I see that Ross Finnie is objecting.

Ross Finnie: No, no. I sense that you are beginning to wish that you had not asked us to comment on the regulations.

The Convener: Apart from that comment, which I have no doubt is now on the record for the Rural Affairs and Environment Committee, are members content not to make any recommendations to the Parliament on the regulations?

Members *indicated agreement*.

Food Supplements, Vitamins, Minerals and Other Substances (Scotland) Regulations 2009 (SSI 2009/438)

The Convener: The regulations will amend existing regulations on food supplements and the addition of vitamins, minerals and other substances to foodstuffs to comply with updated European Union regulations.

The Subordinate Legislation Committee drew our attention to several issues in the regulations, such as minor drafting errors or places where the regulations could have been expressed more clearly. Those are highlighted in the cover paper. The Subordinate Legislation Committee was satisfied with the response from the Government on those points.

If members have no comments to make, is the committee content not to make any

recommendation to the Parliament on the regulations?

Members *indicated agreement*.

Rural Out-of-hours Health Care Provision Inquiry

10:10

The Convener: Agenda item 2 is the committee's inquiry into out-of-hours health care provision in rural areas. This is the first of three oral evidence-taking sessions that are planned for the inquiry. Our call for written evidence on the inquiry closed on 6 November 2009 and submissions have been published on the committee's website. In the light of the evidence that has been received, the committee decided to take oral evidence from four panels of witnesses representing key stakeholders, as well as from groups that have petitioned the Parliament on the issue.

As part of its evidence gathering, the committee plans to hold a meeting in Kinloch Rannoch in Perthshire on Monday 25 January, weather permitting. The meeting will take place at 10 am in the Macdonald Loch Rannoch hotel and tickets can be booked in the normal manner from the Parliament's visitor services department. We plan to take evidence from local groups who have petitioned the Parliament on rural out-of-hours health care coverage as well as from key organisations such as Tayside NHS Board, Highland NHS Board, Borders NHS Board, NHS 24 and the Scottish Ambulance Service.

In the event that weather conditions make it impossible for witnesses and members to travel to Kinloch Rannoch for Monday's meeting, the contingency plan is to hold that evidence-taking session here in the Parliament on Wednesday 27 January at 10 am. We will monitor weather forecasts and weather warnings over the next few days: should we be forced to reschedule the meeting, members, witnesses and public ticket holders will be notified as soon as possible.

I draw members' attention to the fact that a corrected version of the Scottish Parliament information centre briefing for the inquiry has now been posted on the Parliament's website.

We have two panels of witnesses today. The first panel is: Barbara Hurst, who is Audit Scotland's director of public reporting for health and community care and central Government; Dr Frances Elliot, who is the chief executive of NHS Quality Improvement Scotland; David Heaney, who is associate director of the centre for rural health; Professor Allyson Pollock, who is the director of the centre for international public health policy at the University of Edinburgh; and Dr Andrew Buist, who is the British Medical Association's lead on remote and rural areas

issues. I welcome you all to the committee. Some, but not all of you have been here before.

The aim in taking evidence from the first panel is to set the scene and outline the rural out-of-hours situation throughout Scotland. Members have full written submissions from each witness, for which I thank the witnesses—the submissions are useful—so we will move straight to questions.

Mary Scanlon: Reading the papers, I got a bit confused about NHS Quality Improvement Scotland's monitoring or auditing of out-of-hours provision. I will just go through it, if the witnesses do not mind. In the submission from the centre for international public health policy, Allyson Pollock says—

The Convener: Before you proceed, it will be helpful if you tell us which page that is on.

Mary Scanlon: It does not have a number on it, but it is page 3. The first paragraph says:

"In 2007, Audit Scotland ... highlighted: 1) no coherent national approach for monitoring and enforcement of standards; 2) a lack of clear quality standards ... and 3) no routine monitoring of how"

out-of-hours

"services impact locally".

I then read the BMA's submission, which says on page 3 that

"NHS Quality Improvement Scotland ... reviews … out-of-hours provision in Scotland against NHS QIS standards"

and that those standards

"have demonstrated that quality performance targets have been met".

I then went to the Audit Scotland submission, which says in the bottom paragraph on page 2:

"Only one in ten GPs ... responding to our survey felt that patient care had improved under the new arrangements. Over half (52 per cent) feel that patient access and the availability of out-of-hours services have not improved."

The witnesses can see why I am getting confused. My final quote is from page 3 of the Audit Scotland submission, which states:

"NHS QIS standards explore the processes and procedures underpinning the delivery of out-of-hours care rather than assess the quality of services provided to patients."

I really do not know what is being done, because the evidence is contradictory or confusing. What national monitoring or auditing of provision of out-of-hours services takes place, and against which patient standards are they judged?

10:15

The Convener: That brings Dr Elliot into the frame first.

Dr Frances Elliot (NHS Quality Improvement Scotland): The QIS standards were launched in 2004 and boards were initially reviewed against them in 2005 and 2006. Our overview report, which incorporated reports on each local system, was published in 2006. That was the first main review against all aspects of the three standards. The standards are about systems and processes, so Mary Scanlon is correct that the process is not about direct clinical care—that is not the locus of Quality Improvement Scotland in relation to the standards.

Mary Scanlon: So, QIS does not assess the quality of the service to patients.

Dr Elliot: No. QIS does not directly assess the quality of the service to patients.

Mary Scanlon: Do we have a system anywhere in Scotland that assesses the quality of care and access to out-of-hours NHS services?

Dr Elliot: The standards cover access. They ensure that boards have in place systems and processes that maximise access to care, but they do not involve direct feedback from patient groups to monitor access. It is expected that local boards monitor their care against the standards on an on-going basis. We have provided two overview reports—the first was in 2006, and in 2007 we did a follow-up report to review the actions that boards had taken, as against those that they had been expected to take.

Professor Allyson Pollock (University of Edinburgh): If the committee would like, I can send supplementary evidence. We have in the past year and a half just reported on a review of all the out-of-hours providers against QIS standards and on the quality of data. It is probably fair to say that the QIS standards are not fit for purpose when it comes to access, need and quality of outcome. They are fairly superficial; for example, some relate to waiting-time targets for ambulances.

There are no coherent comprehensive data systems, so the situation is fragmented. In other words, data collection is far behind the policy changes that are taking place. We urgently need a comprehensive review of the data standards and the systems so that we can consider inputs, processes and outcomes. Our paper covers that. We also need consideration of the appalling fragmentation that David Heaney, Val Lattimer and others have commented on and which is going on north and south of the border. It has been picked up by Audit Scotland and the National Audit Office.

Dr Andrew Buist (British Medical Association): The existing standards were introduced at the time of the change in the contract. The BMA has recently been developing a document on the way ahead for general practice in Scotland. One of the six areas that we are

focusing on is out-of-hours care. When we launch the document in three weeks—in this building—one of our recommendations will be that the existing standards need to be reviewed to pick up on the points that Mary Scanlon has made.

Barbara Hurst (Audit Scotland): When the contract was introduced, it was a huge change for boards to cope with logistically. We found really strong evidence that they did the best that they could and that the standards that QIS used were good at the time, because it was a different system and we needed to examine the way in which the system was being embedded. However, our view was that, after that, the system needed to move on to consider the outcomes for patients of changes to the way in which services are delivered. I echo Allyson Pollock's view—we have been wrestling for some time with the quality of the underlying information. We need information that allows such judgments to be made.

David Heaney (Centre for Rural Health): I agree with what most of what has been said, but I have been concerned about one thing for a long time, which is that it is difficult to monitor outcomes in the delivery of out-of-hours services. It is much easier to do so for some of the process measures that are in place. I am not quite sure what can be done to examine quality of service; it is a difficult thing to do, and cannot be done easily using a tick-box or pro-forma approach.

Mary Scanlon: It is the role of every politician and everyone who has a commitment to the NHS to make sure that patient care and needs are met. If we are looking at the processes and procedures and forgetting about patient care, we are on a hiding to nothing. Perhaps that explains why we are here today, and why communities such as Kinloch Rannoch are left to their own devices. It appears that throughout Scotland there is almost a system of self-assessment and if someone turns up at the annual review and is feisty and assertive enough, they might get a little bit of attention. However, it is very difficult, even for a politician, to get a question in at the annual review.

The Convener: I cannot imagine that that is true of you, Mary.

Mary Scanlon: It is an important point, convener, but I will leave it for the moment.

Dr Simpson: My colleague, Mary Scanlon, has put her finger on one of the important points, which is whether the standards are fit for purpose. I think that the reply indicates that work still needs to be done on them.

The other main impressions I get from the papers are twofold. First, no single solution will work for rural and remote Scotland. The service has to be designed to meet specific local needs and to encapsulate the potential from the services that are available to the community. Secondly, and on the other side of the coin, we have a seriously fragmented approach to out-of-hours care. We have NHS 24, which has its own board and we have the NHS, which also has responsibility. In part, our general practitioners also—even if they do not have a written contract because they can opt out of out-of-hours care—have feelings of responsibility for their areas, which comes through very clearly in some of the individual submissions. How do we begin to get a picture of this highly fragmented service if there is no one at the centre to draw it all together?

Also with reference to that, paragraph 18 of Allyson Pollock's paper says that

"Through the mechanisms of risk pooling, service planning and reintegration, it is possible to arrive at efficient and clinically effective local solutions for OOH GP services, as in the case of Applecross and other rural areas."

Apart from the information about Fort William and hubs in Grampian, I cannot find much in the papers about where out-of-hours care is being delivered efficiently, how we can examine best practice, and how we can spread that best practice to other areas where it might appropriately apply. I am sorry that that question is slightly woolly, but it reflects the fragmentation in what we have at the moment. Would the witnesses like to comment?

The Convener: I am looking for someone to volunteer.

Dr Buist: I will start by giving some background. I am a GP in Blairgowrie in Perthshire. For about 11 years, I provided out-of-hours care as part of my practice rota. There is no doubt in my mind that the ideal for any patient—for any one of us—is to have their own GP available to them out of hours. However, the world has moved on. In 1995, co-operatives were introduced. Many of the big city areas were able to form co-ops but in rural areas, including in my own, we were not able to do that. Other changes have taken place. For example, more women are coming into medicine. Although it does not apply to GPs, the European working time directive applies to the younger doctors who are in training in hospitals.

With the new contract in 2004, the changes meant that approximately 95 per cent of GPs in Scotland took up the option to pass responsibility for out-of-hours care to the health boards, which left about 100 GPs and 51 small practices in Scotland to provide the out-of-hours care themselves. One of those practices was Kinloch Rannoch.

I welcome the opportunity today to consider the wider issues around rural out-of-hours care, which is an important and challenging issue, but we must remember that Dr Simmons was on duty for two

weeks at a time—24 hours a day for 14 days. I sat beside him on the appeal panel when he was given permission to opt out. One of the most convincing things he said—it struck a chord with the lay person on the panel—was that although his father was dying in the south of England, he could not visit him: he could not leave his area because he was tied to the arrangements.

We need to move on. The view that one size does not fit all has come up in most of the evidence that the committee has heard today, but I think that we probably all mean different things by it. When some people say that, they mean that they want a GP back in their village; but when I say it, I mean something else. We need to stabilise the existing arrangements so that the single-handers in rural areas who are still doing the on-call work are supported by their health board both financially and in terms of training and relief.

We need to think about how we organise out-of-hours care. Health boards need to have local groups where the ambulance service, NHS 24, GPs and accident and emergency departments can sit down together to discuss patient pathways so that they can deliver the most efficient system. The system needs to be integrated—as Richard Simpson said, there is a lot of work that we could still do in order to get the services working together better. We need to ensure that patients understand how to use the system properly. In rural areas, we need community resilience—we need the community to get involved. David Heaney is a community first responder, which is a worthwhile project that I support. We need a modern and flexible local system.

We cannot turn back the clock to the 1960s—the world has moved on. We need to stabilise and improve rural practice. We need to encourage young doctors to consider working in rural practices. We need to create rural fellowships and ensure that young foundation year 2 doctors are exposed to rural practices so that they want to work in rural areas. There are some fantastic places to work in rural Scotland—Kinloch Rannoch is a wonderful place to live and it has a fantastic daytime service that is well resourced by NHS Tayside. Many people who live in urban areas have problems getting appointments with their doctors, but there is no problem at all in Kinloch Rannoch—people can practically walk in off the street and see their doctor. One of the key things behind the Government's health policy is anticipatory care. Because the number of patients per doctor in rural areas is quite low, the doctor has much more time to deal with each patient, which is important for planning things such as diabetic care and for avoiding problems emerging out of hours.

The key thing is to create an integrated system. That means that we must get all of the key players around the same table, thinking about patient pathways.

Professor Pollock: I will start with Richard Simpson's comment about there being no single solution. We are in danger of being ahistorical. The national health service has been heavily devolved and decentralised since 1948. If you read the work of historians such as Rivett and Webster, you will see that there has never been a single solution. However, the danger of Richard Simpson's analysis is that he is conflating that fact with the removal of a universal entitlement.

There were two impulses behind the UK general medical services contract. One involved deregulation, fragmentation and the bringing in of alternative providers; and the second involved a privatisation agenda, which is being pushed south of the border. Deregulation needs to be closely examined, because it is being used as a cloak for removal of a universal right and entitlement to 24-hour-a-day GP services. Kinloch Rannoch is important because it is a case study. If the situation continues, it could pave the way for the same thing to happen in the rest of Scotland.

There are two important points to note. First, the removal of a universal entitlement went ahead in the absence of public consultation and proper accountability because of the deficiency in the legislation; the committee can look at my first briefing on that from 2007. That is a travesty, and it is happening, at least south of the border.

10:30

Secondly, the removal occurred without there being any legal remedy. In Scotland, unlike in England, there is no proper public interest litigation, so a judicial review could not be undertaken—KLR tried that. Today's meeting is very important, as it is the first opportunity for that community and the rest of Scotland to consider what the removal of a universal entitlement will mean for GP care.

Deregulation has allowed many alternative providers to come in, but those were meant to be complementary rather than substitute services. I am concerned about pushing the community responder under the umbrella of the community resilience agenda. We have prepared another paper—and a briefing—which shows that there is no evidence to support a cost-effective approach for community responders, even as a substitute for GP services. They may be a good back-up, but they are very limited in what they can do and they are not a substitute.

The universal right and entitlement that the Scottish people have had since 1948 is imperilled,

and we need to keep coming back to that and the evidence around it.

The Convener: You referred to a paper that you have prepared—I presume that it is a substantial academic paper. It would be useful if you could provide the committee with a summary of the issues that it raises.

Dr Buist can respond to those comments, but I will let David Heaney in first—although I see that Dr Simpson has a question.

Dr Simpson: I would like to ask Professor Pollock about Applecross, which seems to be an interesting model.

Professor Pollock: You are right to pick that up. The reference to Applecross is based only on conversations with local GPs and the public in that area about how they perceive that their service is working.

Dr Simpson: That is fundamental.

Professor Pollock: I have also had conversations with health boards, some of which have said that they have managed to find their own solutions with regard to the provision of 24-hour GP care.

David Heaney: The main piece of work that I have conducted was a study of out-of-hours services in 2005, which involved extensive research into the views of GPs in particular. One quote from that report sticks in my mind: a GP in a remote and rural area said that trying to change out-of-hours services was like wrestling with an octopus. We are still doing that. It is a very difficult issue, and the same problems remain in 2010.

In some areas, we have moved far away from the concept of being able to contact one's own GP out of hours but, in others, people can still do that. We need to build on the current situations, and develop teams to provide support in the future. One solution will never fit all—it is not appropriate to think about the issue in that way.

Greater integration of services is needed. We, and the public, are confused about what to do and which service to contact. In some areas, the Scottish Ambulance Service, the local GP service and NHS 24 are co-locating, which has to be the way forward. Those services should get together closely and work together in a way that they are not doing in most areas. I have to say that even when I see services doing that, they are still wearing their own uniforms, as it were. They need to break down barriers and work together, so that when a patient contacts the service they are not bandied from one to the other. That would be a major development if we could get it right.

Dr Buist: I just want to come back on two points that Allyson Pollock made, one of which was on the reasons behind the new GMS contract. Allyson said that it was about deregulation and privatisation. From the BMA perspective, it certainly was not; it was about the fact that we were facing a recruitment and retention problem in general practice and people were not coming into the profession. Rather than simply not having an out-of-hours doctor, some of these areas would not have had a daytime doctor either.

The other point is that some of the submissions have implied that no doctor is available to places such as Kinloch Rannoch out of hours. That is not true: patients in Kinloch Rannoch have the same access to a GP that my patients in Blairgowrie have at night—they are covered by the NHS Tayside out-of-hours doctor. On 19 occasions in the year up to when I prepared evidence for the chairman of NHS Tayside, one of those doctors drove into the village or into the area to see someone at home. On other occasions, the patients would travel to the Pitlochry or Aberfeldy minor injury unit to be seen. They are covered by the same service as all other patients in NHS Tayside. The community first responder is not an instead of but an as well as; they are complementary to all the other services that are available.

The Convener: Thank you. That is what the committee is really about: hearing robust evidence. The evidence is contradictory, if I may say so, but it is important that we test it all.

Ian McKee: We have received some interesting submissions. I seek some help in sorting out the issue of the GPs who at present continue to provide out-of-hours care in rural areas. The paper from the BMA says that 51 practices are still responsible for providing such care

"primarily because no sustainable alternative arrangements could be put in place."

However, the evidence from the Royal College of General Practitioners includes many statements from GPs providing out-of-hours cover in rural areas who seem strongly in favour of doing so. They are not people who just could not find any alternative arrangements. The thread that runs through the evidence seems to be that continuity is an important factor in the provision of care. Those people seem to have gone into general practice because they wanted to provide continuity of care to their patient group. It is a bit difficult to see how they would do that by closing the door at 6 o'clock and leaving the provision of care to another arrangement, whatever that might be.

Will someone explain the situation to me? Are those practices providing out-of-hours care for a positive reason, which we should perhaps reinforce in other areas, or are they providing it

only because we have not provided arrangements that enable them to shut their door at 6 o'clock?

Dr Buist: In some cases it is because they see absolutely no alternative. Clearly, on an island such as Islay, which has three or four doctors, it would be impractical to do anything else.

Your question might be better addressed to the witnesses in the second evidence session, who include a doctor from the Remote Practitioners Association of Scotland. Susan Taylor works in the way that you describe.

I have full respect for the doctors who continue to provide out-of-hours cover, which is wonderful for their patients. That is the ideal. The question is whether it will be going on 10 or 20 years from now. My impression is that the younger doctors who are coming through will be less willing to replace the doctors who have always worked in that way.

Ian McKee: I ask the question now because the point was raised in the written evidence that was submitted by the people who are present giving evidence. It seems reasonable to ask the question of the people who made the statements in the first place.

Dr Buist: I think that the geographical situation makes it extremely difficult to do anything else.

Professor Pollock: Things have moved on since 1995, when there was a major shortage of GPs. Our medical schools and, indeed, medical recruitment in general have expanded enormously, with many hundreds of GPs now applying for every principal or salaried post right across the board. As a result, competition for such posts is very great. For example, when the community in Kinloch Rannoch advertised for GPs, there was an extraordinary amount of interest. Of course, you can talk to them about that next Monday. The introduction of the GMS contract might well have been driven by the GP shortage back in 1995 but, even then, I believe that that is only partly the case, as it has all fed into the UK Department of Health's market-oriented reforms.

As I say, things have changed. Given the current surplus, doctors—and, indeed, nurses—could very well be recruited. There is no evidence that young people nowadays are any less inspired or motivated than they were 30 or 40 years ago, and I certainly think that local solutions can be found.

Ian McKee: We are talking about rural practices throughout Scotland, not just in Kinloch Rannoch. According to NHS Tayside's evidence, which I think has been signed by Dr Buist, it would cost £150,000 a year to provide all-round GP cover in Kinloch Rannoch. How was that figure reached?

Dr Buist: This links back to Alyson Pollock's earlier point. An advertisement was placed in the papers just to test the waters and see how much provision would cost.

NHS Tayside disagrees with that £150,000 figure, suggesting that it could cost as much as £500,000. I suspect that the truth lies somewhere between the two. The £150,000 roughly represents two salaried posts sharing the out-of-hours service, but that is still quite a lot of money for what is quite a low level of demand. When we consider that, as I said, only 19 home visits were required in a year, the whole thing becomes rather expensive. According to figures produced by Audit Scotland, the cost of out-of-hours service from health board to health board varies from under £8 a patient in Glasgow to about £43 a patient in Argyll. Even if the cost of provision in Kinloch Rannoch turns out to be nearer the £150,000 estimate, for a population of 600 that still works out at £400 a patient or 50 times more than we are spending in urban areas. I question whether that is affordable.

The Convener: I see that Allyson Pollock wants to respond. This is turning into something of a match, but I guess that that is how it is.

Professor Pollock: I question the £150,000 and £500,000 figures but, in any case, the cost per capita is something of a red herring. After all, costs will always be higher in remote and rural areas. Indeed, that is an aspect of the Barnett formula and why health care costs more in Scotland than it does in England.

The same arguments would not be used to withdraw water, electricity or transport services—although I admit they might have been with regard to post offices. We are talking about a universal entitlement to GP services. The GP, in his or her role as the family doctor and in the part that they play in integrated health care, is and has always been the bedrock of the NHS.

The cost argument is very divisive, especially given that the resource allocation formula for health boards recognises remoteness and rurality and the need to compensate remote and rural areas. It is even more divisive to suggest—as Dr Buist has done—that the money would be better spent on the poor of Dundee. First, he would have to demonstrate the opportunity costs and the cost benefit of withdrawing such services from those areas and then show whether such a move would even benefit the population of Dundee. It is not a logical consequence.

I am seriously concerned that the cost per capita is being used at a time when we should be going back to the core principles of risk pooling and integration. You do not talk about cost per capita if you are keen to ensure that you have a risk pool.

Indeed, some of the high costs can be attributed to the very fragmentation of out-of-hours services that we have just been discussing.

The Convener: I am glad that you have nominated yourselves, but I wish to broaden out the discussion to bring in the rest of the panel. Kinloch Rannoch is very important, but the discussion concerns service delivery in all of Scotland's remote and rural areas, which are diverse, as we know from the rural areas in our various constituencies.

10:45

Barbara Hurst: I am slightly reluctant to launch myself into the dialogue.

Although our report was published in 2007, it still contains some relevant messages. One of the clear messages is that, without doubt, it is more expensive to provide services in remote areas.

The other clear message is that there are questions about sustainability in the future. I do not have up-to-date data, so the committee might wish to get hold of something a bit more current but, when we carried out the work, we identified a small drop in the number of GPs reproviding out-of-hours services—I am not talking about the number of GPs providing their own out-of-hours cover. In 2004-05, there were 1,696 GPs reproviding out-of-hours services. In 2006-07, that had dropped to 1,440. If that trend continues, it will become even more difficult for boards to provide out-of-hours services without considering other innovative and creative approaches. It is good that the committee will be talking to representatives of individual boards, who will speak about how they are dealing with that.

This is not a matter of services being cost driven; it is a matter of people choosing whether they will reprovide services. The evidence at the time when we carried out our work was that there was a drop in provision.

Ian McKee: Is it not possible, contractually, to devise terms and conditions of service for new entrants so that people applying for jobs might wish to provide out-of-hours services?

Barbara Hurst: Yes. In the Borders, for example, more salaried GPs have been introduced to provide that sort of cover. It is a complex situation, as the committee knows—you all have constituents living in rural areas—and it is not as straightforward as simply continuing with what has gone before. The service is very different now.

Dr Elliot: It would be helpful to wind back the discussion and think about issues to do with quality. We should consider both the patient perspective and the provider perspective. There are some key dimensions to delivering a high quality of service. Safety is paramount, as is the evidence on which clinical effectiveness is based. There is also the timeliness with which a service can be provided. It must be equitable.

Services must be patient centred, as they must take into account the preferences, wishes and choices of patients. They should be efficient when they are delivered, as we have to take cost and cost-effectiveness into account. It should be possible to look at the models that are being used around Scotland and to consider how a piece of work could be undertaken to show patient pathways, as measured against the dimensions that I have mentioned, and to consider which models will deliver what patients, and indeed practitioners, are looking for. Practitioners want to deliver a good service to patients, although they, too, have rights as individual human beings to pursue other activities in life as well as delivering care. It should be possible to bear those dimensions in mind and build on some of the work that has been referred to today as we consider how care should be delivered into the future.

David Heaney: We need to maintain an open mind. I challenge Andrew Buist's suggestion that the remote or rural GP delivering care 24 hours a day, seven days a week, all year, is the ideal. It might not be so. Our experience suggests that that is how things used to be done, and it worked, but that model will not necessarily offer the solution for the future. There is little evidence to support any particular model, whether that be community first responders or general practitioners. We have a lot of experience that suggests that using general practitioners to provide such services is a good model but, on the whole, over the past 10 years, general practitioners have shifted towards dealing with chronic health problems. Many GPs do not see acute problems in their day-to-day work, although that might be slightly less the case in rural areas.

It is important that we look at all the models rather than just assume what the ideal is. In many areas of Scotland, such as in Grampian, the out-of-hours service uses different practitioners to deliver care according to the circumstances. For example, in remote areas in Grampian such services are supported by a team. We should look at all the models and ensure that we pick services that are appropriate for patients, rather than just assuming that the previous service-delivery model is the only one to be thought about.

The Convener: We will hear from Professor Pollock and then from Dr Buist.

Professor Pollock: I do not mind allowing Dr Buist to go first.

The Convener: A tactical move, perhaps.

Dr Buist: Let me clarify something in response to David Heaney's comments. I am not suggesting that the ideal model for the future is that everyone should have a personal GP who is always available. I am just saying that individuals perhaps previously felt that way. For example, if the Queen was at Balmoral, she had her doctor available in Ballater who was just her doctor. That was the ideal. However, I agree with everything else that David Heaney said about services in the future.

In her evidence, Allyson Pollock has suggested that GP care is being denied in places such as Kinloch Rannoch. I stress that that is not the case.

Another point is that we need to consider health care inequalities. Both this Government and its predecessor put health care inequalities at the top of the agenda. We cannot ignore the fact that we currently have an inverse care law in existence in Scotland, whereby the gap between the life expectancy of the best-off and that of the least well-off is widening. Giving unlimited resources to out-of-hours provision could just exacerbate that problem.

Professor Pollock: As members might expect, I take issue with a lot of what has been said. As a public health physician, I take issue with the link that has been made between moving GP resources from Kinloch Rannoch and providing services to the poor people of Dundee.

I come back to the whole idea of a model. We are talking about the withdrawal of the universal right and entitlement to out-of-hours GP care. It is not quite right to say that the people of Kinloch Rannoch have access to out-of-hours GP care. They have that access only if they can travel the necessary hour or hour and a half, on which I think the committee will hear more evidence. We are talking about fairness of distribution and access to provision. Once we have established that access to out-of-hours GP care is an important principle, a whole variety of models can be devised to deliver such care, which might involve salaried GP services or co-operatives and all the other add-ons. I would hate us to lose sight of the principle of universal entitlement to GP care, which is the bedrock.

It is not quite true to say that GP provision of such services has not been shown to be efficient. We might not have wonderful randomised control trials of such provision, but we have had more than 60 years of it in the NHS as well as long before that. Having the GP as gatekeeper to the rest of the service has been the model for the rest of the world. The GP is the only person who is trained to make a medical diagnosis. I suggest that, between the hours of 6 at night and 8 in the morning, committee members would want a physician rather than a community first responder to make their medical diagnosis.

The Convener: I think that we have aired this debate about a principled versus a pragmatic approach, if I may put it like that. Let me bring in the MSP for Dundee West, who has been stung into action by some of those comments.

Joe FitzPatrick (Dundee West) (SNP): As probably the only member around the table who represents an exclusively urban location, I think that it is important that we do not let the issue become an urban versus rural argument. The issue should really not be about that but be about ensuring that people get a fair provision of service. My constituents in Dundee would love to have a 24-hours-a-day, seven-days-a-week service provided by their nominated GP, but they do not have that.

In today's modern society, I do not think that anybody can expect to see their particular doctor 24 hours a day, seven days a week. People in Dundee have come to accept that they will see a doctor, which is the most important thing. If somebody needs a doctor—whether they are in a city or a rural location—they should be able to access a doctor, although that might not be their personal doctor. We must not say that, if people live in a rural location, they are somehow in a special situation of having roune-the-clock access to their village doctor, in effect. That would be great—we would all love that, and we would love to have such access in Dundee, too—but that is not where we are at. We must be careful not to create an urban versus rural—

Professor Pollock: Joe FitzPatrick is misrepresenting me.

The Convener: I know—that was more of a statement than a question. Your point was not about accessing a particular doctor; I appreciate that your line was about access to a GP—any GP.

Professor Pollock: Joe FitzPatrick misrepresented me.

The Convener: I do not think that he did. We know your point, which is fully on the record. I just felt that Joe FitzPatrick had to speak about the urban issue.

Rhoda Grant (Highlands and Islands) (Lab): The evidence that we have received does not make questioning easy, because it comes from different viewpoints.

I will ask about the GP contract, which has caused rather than solved a problem. A GP loses £6,000 a year by opting out of out-of-hours care but can make up that loss by providing out-of-hours care for one night a month, so why would they provide more? Unless GPs wanted an income that was way above any of our aspirations, they would not work more than one night a month out of hours. Does the contract need to be torn up and started again?

Dr Buist talked about the responsibility of the Scottish Ambulance Service and the like. I could not help thinking that a GP receives £50 an hour for out-of-hours care, whereas an Ambulance Service technician probably does not receive that for a night on call. The system has a huge imbalance. Do we need to consider that as well as people's right to care?

Professor Pollock: I could not agree more. The GP contract is UK-wide. We have submitted two separate pieces of evidence to the Parliament, which we can provide again, to advocate why the UK GP contract needs to be re-explored and why a new contract needs to be drawn up for Scotland. That is for several reasons, which include the prevention of deregulation, of privatisation and of the involvement of multinationals, which is happening south of the border. Much would be gained by revisiting the idea of a Scottish GP contract.

Dr Buist: This Parliament is in the process of passing legislation to prevent the privatisation of general practice.

Allyson Pollock quoted the figure of £6,000 in her submission, which showed that she did not understand how that was calculated. That was the figure that newspapers presented, but the amount was not £6,000 per GP. The amount was calculated as 6 per cent of the global sum, which is a pool of money for the whole of Scotland that is divided among practices according to the age and characteristics of their patients. The figure of £6,000 was an average.

Rhoda Grant: What are the correct figures as you see them?

Dr Buist: The average figure is £6,000, but behind any average lies a wide range. In Kinloch Rannoch—if we are focusing on it—the global sum is quite small, and I suspect that 6 per cent of that small number would be less than £6,000.

Rhoda Grant is right—the total amount of money that would be gained from 6 per cent of the global sum for Scotland is much less than the cost of the reprovision of out-of-hours care. Audit Scotland will tell me the cost to Scotland of providing an out-of-hours service, which has probably increased by £30 million or £40 million—it might have doubled. I believe that that represents the fact that out-of-hours care was grossly underresourced under the pre-2004 arrangements. If London or Edinburgh had decided to resource the arrangements properly, we might not be sitting here now. The Government did not appreciate how demanding and difficult out-of-hours care can be, particularly in rural areas, or how expensive it can be.

I have no idea how much an ambulance technician gets paid, so I cannot tell you whether it is more or less than the £50 you quote, which is for a GP working at 11 o'clock at night. I do not think that that is an exceptional amount of money for a highly trained professional person. If someone had to call out a lawyer to represent them at that time of night, I suspect that that rate of pay would not be unreasonable.

The Convener: I will let others in, Rhoda, and come back to you later. Your question is running along.

I do not know why lawyers always get hit like that. Thank goodness I gave up that profession and am now a very popular professional called a politician.

11:00

Barbara Hurst: To go back to Rhoda Grant's original question, no one thought that the £6,000 or the 6 per cent would cover the cost of out-of-hours care. My understanding is that that was a way of negotiating an agreed contract. We have to remember that out-of-hours care is only one element of the contract; other elements are being used to improve in-hours services, for example.

The difficulty with ripping up the contract and starting again in Scotland is that we would not have a UK-wide contract, which could mean losing GPs from Scotland. I will leave it to my BMA colleague to be more forceful about that. It is a judgment call whether that would happen, but there is a real risk of it.

David Heaney: The out-of-hours issue was an element in negotiations on the GP contract that was negotiated in 2004. There is not so much an England-Scotland divide as an urban-rural divide in that GPs in urban areas, and probably in reasonably-sized small towns, had largely gone a long way towards solving their own out-of-hours care issues by forming co-operatives. The transition from pre-contract to contract out-of-hours care arrangements in Glasgow, Edinburgh and Dundee was smooth and patients probably did not notice much at all; the change had already happened.

The difference in rural areas was the fact that solutions had not already been put in place, because GPs in remote areas could not form co-operatives. Rural patients were suddenly faced with a very different service when they woke up the next day and the new contract was in place with NHS 24, rather than their local GP, answering their calls. To patients in remote locations, the NHS 24 person in Aberdeen or Glasgow did not understand their geography, so the change was much more noticeable. Three years later, we are here again, and the problem still has not been resolved for many patients.

We might not need to rip up the GP contract and start again with a new one, but it might be that different contractual forms could be brought into play to provide the correct solutions for the most remote locations in Scotland. That would be no mean undertaking, however.

Professor Pollock: I suppose that I would answer the question by saying that Scotland has its own NHS, which was devolved to it, so it could start to devolve its own GP or consultant contract. South of the border, the BMA has launched a massive petition against the privatisation of primary care, where GPs are waking up to find themselves employed by large multinationals such as Take Care Now Ltd. There is an increasing amount of dissatisfaction and unhappiness so, if anything, there will be a flow of GPs and other medics from south of the border to the north.

Rhoda Grant: I just want to make a short observation on that point. As Dr Buist said, we are passing legislation that will prevent multinationals from becoming involved in providing GP services in Scotland. It is interesting that the BMA has suggested that it should have a monopoly on GP services but obviously not on out-of-hours services.

The Convener: Oh, well, you managed to get that in—this is supposed to be questions but occasionally political statements are made in passing.

Helen Eadie (Dunfermline East) (Lab): Patients are at the heart of everything that we are trying to achieve. We all know about the golden hour, the requirement for stroke victims to be treated within three hours and so on. When I meet my constituents in Fife—I will get the area that I represent on record, as usual—

The Convener: I can never stop you, Helen. Mary Scanlon mentions the Highlands and you mention Fife.

Helen Eadie: Fife might not be remote, but many parts of it are certainly rural. At the heart of my constituents' concerns is the issue of access to a trained doctor who can diagnose a stroke, for example. My mother died of a stroke, so I know how that can affect a family. It was the morning after she had a stroke that the doctor made the correct diagnosis, which made the difference between her recovering and her not recovering.

Audit Scotland's evidence shows that 52 per cent of GPs say that patient access and the availability of out-of-hours care services has not improved. All of the evidence before us suggests that we should be concerned about the situation, given that we are moving towards the use of volunteer first responders, which is very alarming. Patients and politicians need to hear some answers in that regard; I invite you to reassure me that something is being done.

David Heaney: I am a community first responder. I live 45 minutes away from the nearest general practice. We have had a first responder scheme in place for two years and in no way would any of the people who are involved in it see themselves as a substitute for a general practitioner. However, with the best will in the world, the general practitioner is not going to be able to get to someone in the area in the time that is required in certain circumstances, such as cases involving heart attacks or strokes. On one of our call-outs, which involved a person complaining of chest pains, the first responders were well enough trained in basic knowledge to realise that the person was having a stroke and they contacted the services to say that urgent action was required. Community first responders have a role to play.

I agree that there is little evidence—

The Convener: Sorry, can you just tell me what a community first responder does, and what training they receive?

David Heaney: I can tell you about my personal experience. There are about 60 first responder schemes in Scotland—it is not a radical or new idea, although it remains unevaluated. First responders are trained by the Scottish Ambulance Service, which gives them two weekends of intensive training followed by an assessment. Following that, there are monthly self-training sessions that we run ourselves.

We respond only to 999 calls, so we are not a replacement for GP out-of-hours services. People in the local community can respond more quickly than the services can. However, as soon as we are called out, an ambulance is on its way. We are not replacing anyone; we are getting to the person more quickly.

I am not a medic or a nurse—the training that I have described is the only training that I have received. I have focused on some basic things that I have to remember when I get to the person.

The Convener: What are they?

David Heaney: They are to assess the situation when we arrive and to deliver, if necessary, basic life-saving techniques, such as resuscitation. We have a defibrillator so, if one is required, we can use it. More simply than that, we can ensure that, if the person is still conscious, they are in the recovery position. There are some basic things that we can do: we have been taught how to deal with someone who is choking, and we can administer oxygen to calm the situation down and give the person some help until emergency services arrive.

Much of the time, we are probably simply being there for the person. We are organised and not doing much more than settling the relatives down and being able to report back that the ambulance is coming. We are in contact with the ambulance service and the ambulance desk. We can ask for advice from a paramedic and, if we are very concerned about the situation, we can lobby for an upgrade of the response—we can say that we think that a helicopter is needed—but we cannot downgrade it. When the ambulance comes, the ambulance crew takes over.

I make it clear that our scheme is an addition to service and that we are community volunteers. We have been trained enough to be able to help. We may not be able to help in some circumstances, but we can provide support. That is often what it happens to be.

Helen Eadie: Would you stand down an ambulance that was on its way?

David Heaney: No. There are circumstances in which common sense would say that the situation does not require an ambulance, but we still wait for it to come and the ambulance crew then deals with the situation. We cannot stand down an ambulance—it would not be right, because the situation could be more complicated than we think it is.

The Convener: How long have you been doing first response and how often have you been called out in that time? You say that you do it for 999 calls only.

David Heaney: Yes. I live in Achiltibuie, which is a small community of 300 people, so we do not have a great demand. Our service has been running for two years and we have had approximately 20 call-outs in that period.

Professor Pollock: On 14 July 2009, we wrote a paper reviewing all the evidence on community responders. As David Heaney says, they can deal with almost no medical emergencies. Indeed, they do not see most of the common things for which out-of-hours calls are made, which include suicide, diabetes, road traffic accidents, cancer and asthma.

We need to think about whether training up first responders involves serious opportunity costs. It is often done by the health board, and it costs a lot of money to get the community trained up in something that will be of very little benefit to it. Perhaps the benefits would be realised in meals on wheels or other ways that we have not thought about. Providing first responders uses up a community resource and energy, perhaps needlessly. That might be a provocative statement, but we need to think about it seriously.

I would be concerned if it was possible for a community first responder to upgrade an ambulance to a helicopter because the costs of calling in a helicopter are probably in the tens or twenties of thousands of pounds. At one fell swoop, that would offset the cost of having a proper, local, accessible out-of-hours GP service.

I will send the committee the paper on community responders.

Dr Buist: I will pick up on two of Helen Eadie's points. She quoted GPs as being less happy with the out-of-hours service. I strongly suspect that that represents unhappiness with the first element of patient contact: NHS 24. Many patients tell me that they are concerned about the time that it takes to be triaged. There were problems with call-back prior to the NHS 24 review in 2005, but they have largely been improved. The average call takes 10 or 11 minutes, but I think that people are reasonably happy with what happens next.

I will also answer the golden hour issue. Some clinical situations are so urgent that the patient does not simply want a doctor but wants to be in hospital. Ambulance is the way to get there. For my letter to the chairman of NHS Tayside, I looked at all the home visit requests to Kinloch Rannoch during a whole year period. There were 19—I have the print-out here. Several were triaged by NHS 24 as requiring a one-hour response—the call handler said that the patient needed to be seen within an hour of their call. The times for the doctor arriving at the scene were: one hour and 22 minutes; one hour and 11 minutes; 48 minutes; 58 minutes; 45 minutes; and 53 minutes. On those occasions, a doctor came from Aberfeldy to Kinloch Rannoch to someone's house to see a patient. On the golden hour, patients are covered, because things are working now.

11:15

David Heaney: I want to address some of the points that have been made. I agree with Allyson Pollock that there is very little evidence on the role of community first responders in Scotland. The centre for rural health is doing some work on the first responder model in Kinloch Rannoch, and we have been awarded a grant to look at similar schemes throughout Scotland. I am pleased that we will be doing that important work during the next year.

There is evidence in work that has been done in America and Australia that a community first responder can be useful. We understand that the context is different here and we intend to look at that. I stress that I am neutral about the role of community first responders. I decided that we needed them in my community, but lots of issues need to be addressed to ensure that they deliver

what we want. They have the potential to intervene in cases where a fast response by someone with some basic knowledge could help. That is what I like about the model, but it is important that we remain neutral, test it properly and ensure that it is delivered with support. The model is not seen as a substitute for services: the statement that a community can take over from a general practitioner is wrong. The community first responder has to be an addition to services.

The decision on the call-out of a helicopter remains with the paramedic in charge at the call centre. However, if someone has identified that something is wrong, such as in the example that I gave—when the community first responder identified correctly that the person was having a stroke—the cost of bringing an ambulance that is already out on duty to get that person to hospital within three hours is more than offset by the saved cost of their not getting there in time and having to go into rehabilitation for the rest of their life.

The Convener: I am going to move on, because we have to stick to our time. We have first responders in next week at Kinloch Rannoch, Helen, so perhaps you can ask your question then.

Helen Eadie: I have a separate question on the costs and fees, which are set out in our briefing paper.

The Convener: Next week, come in early with your first responder question—you will get longer to ask it when we are not so pressed for time.

Helen Eadie: Our briefing paper, which was prepared by the Scottish Parliament information centre, states that the fees that are paid to GPs for the provision of out-of-hours services are negotiated locally and vary a great deal throughout Scotland, which made me raise my eyebrows. For example, £50 per hour is paid to GPs in most areas, but in some the fee is £80 per hour. Over Christmas and new year, there is an even bigger variation—the fee ranges from just under £81 per hour in NHS Tayside to £150 per hour in NHS Highland and NHS Grampian. It is a cause for concern that we have such a fragmented approach. What do the witnesses think about that?

The Convener: I will let Dr Buist answer that, as it is a factual question that he should be able to answer. I then want to move on to Ross Finnie.

Dr Buist: I do not have up-to-date figures other than those that Helen Eadie has presented, but I have no reason to doubt that they are fairly accurate. There will be a standard rate, which will be about £50, but the rate will be higher on certain public holidays such as Christmas day. Undoubtedly, market forces play a large part in the rates. The briefing paper suggests that, when the contract was set up, the boards made an attempt to make the rates uniform but, inevitably, market forces will have a part to play.

The Convener: Perhaps Barbara Hurst can explain.

Barbara Hurst: In preparing our report, it was clear that each board has had to conduct its own negotiations because there was not a central drive for that. Therefore, there is variation.

The variation is less marked in the evenings than it is from midnight to 8 o'clock, at weekends and on public holidays, which Dr Buist mentioned. In advance of the meeting, we examined some rates in boards and found that they still seem to be at about the same levels that we reported back in 2007.

Ross Finnie: To be honest, I am finding the process difficult, because I do not see a logical progression. There does not seem to be agreement among the panel even on what a basic out-of-hours service might be, whether it is rural or urban. There are real distinctions in rural provision. That is self-evident because of its very nature—there are issues of rurality, the sparsity of the population and the different time zones—but I am not sure that I have clear in my mind what the model is that needs to be adjusted and amended to take account of those rural issues. We almost seem to be trying to invent a different model for every area.

I live in an urban area, and I do not necessarily agree that all was sweetness and light after the new GP contract was introduced. Where I live, one day we had an absolutely smashing co-operative service and the next day it was gone. It was not easy to phone up and find that it had gone, even in an urban area, but there we are.

With respect, Dr Buist, you keep harping on about the perfect model, which you say is to have a GP everywhere. As a member of the BMA, can you say whether you are offering that? I do not think that you are. I do not mean you personally—you probably are offering an out-of-hours service, because you believe passionately in that. My difficulty is that the BMA is not offering that. Your contract does not offer it, although perhaps the BMA is now saying that it wants changes. I am interested in that but, at the moment, GPs are not into out-of-hours care—95 per cent of practices are no longer responsible for it, and that covers vast rural areas—and I have difficulties with that.

The universal service might well be needed, but nobody seems to be telling me what the patient needs. Care is now delivered differently in-hours, so the out-of-hours requirements have changed, too. There seems to be no agreement about what a very much changed NHS 24 should provide. Right at the outset, we talked about trying to integrate, yet here we are, an hour into the

evidence, and we are hearing a more disparaging view of NHS 24. The Scottish Ambulance Service is generally accepted, but I am not clear about how it is integrated.

I would like clarity about what the bodies that the witnesses represent can offer. I am not talking about going back to where we were; I am talking about dealing with the reality of where we are now. If the BMA is offering something different, that is great, but I am not clear about that.

The Convener: Dr Buist is champing at the bit.

Dr Buist: I think that Ross Finnie has misunderstood me, as David Heaney did earlier. I was not saying that we should go back to the arrangement in which a person's own GP was on call. In an ideal world, we would all want that, but in reality we cannot go back to such a situation.

Ross Finnie said that GPs are not into out-of-hours care, which is not true. As Barbara Hurst pointed out, many thousands of GPs provide out-of-hours care in addition to daytime services. The difference now is that they do not hold that responsibility, so they can provide that care when it suits them. Previously, if Dr Simmons in Kinloch Rannoch, for example, became ill, he still held that responsibility. He could not phone in sick—it was down to him to provide that service, as he was the only person who could do it. Under the new arrangements, if a doctor says that they will work on Saturday night and they become ill, the health board is responsible for bringing in someone else.

We need an integrated system, and we believe that NHS 24—which has come in for a lot of criticism—is here to stay. We do not see any point in throwing the baby out with the bath water; NHS 24 will play a key part in the out-of-hours service in the future. However, we need to integrate all the components: the GP visiting service, which is run by the boards; the ambulance service; NHS 24; the hospital service; and the social services.

I am passionate about patient pathways. We need to consider the patient journey, from when someone first thinks that there is something wrong with them to when they get care and go back home. We need to think about how different parts of the health service communicate, share information and work together. We need to get local GPs involved in local groups to look at the patient pathways and how patients receive care out of hours.

We have touched on the quality standards, which I believe we need to review. Frances Elliot pointed out the key components of the quality strategy that has been issued; it is a useful way to consider how we develop out-of-hours care.

Mr Finnie misunderstands me if he thinks that I am suggesting that we go back to where we were.

Ross Finnie: I was not suggesting that; I was just saying that I found the reference unhelpful, as that option is not on the table.

The Convener: We are all clear about what we have said now.

David Heaney: It is possible that I made the mistake of generalising about urban areas, which I am trying to ensure does not happen in relation to rural areas.

I will focus on the question of what the patient needs. With regard to out-of-hours care, the most important issue is the emergency situation. The patient needs the most rapid response that they can get from the best-trained person possible who is there at the scene as quickly as possible. In urgent out-of-hours situations, patients need a response that enables them to travel to the services or vice versa.

Non-urgent situations that arise out of hours need to be triaged to daytime services on a much greater scale than they currently are, in order to relieve pressure all round. Patients need the services to concentrate on the emergency situation. That is the most important issue for rural communities and the thing that makes them feel uncomfortable.

Professor Pollock: Ross Finnie asked where we need to be, and he mentioned GP co-operatives. We need to ensure that all patients in Scotland still have universal entitlement and access to GP care and that the services that are provided allow that. Patients want a medical diagnosis quickly, but there has been enormous fragmentation between NHS 24, community responders and all the other services that have been introduced. Health boards need to go back to doing proper strategic planning. They must think about their patients' needs and entitlements and about how to ensure fair distribution and integration of services.

The evidence on NHS 24 is very mixed indeed. Patients have had confusing experiences, as Audit Scotland has commented. Patients give their history two, three or four times and, even after all that, often do not get the care that they need. The issue is problematic.

11:30

Barbara Hurst: An exhibit in our report, "Primary care out-of-hours services", shows the typical model of care before the introduction of the GMS contract and NHS 24. It is about more than just the GP's visit to the home. Perhaps this is an oversimplistic offering, but it might be helpful if I sent the committee the exhibit. In a sense, the issue brings us back to Dr Simpson's questions and observations on the need for an integrated

system, which is about not just better working but better information technology systems and better planning at local level.

Dr Elliot: QIS acknowledges that the standards that were set in 2004 are past their useful life. If there are to be further discussions about future models of primary care and integrated out-of-hours care, our responsibility will be to respond by considering the standards and ensuring that we have something that is fit for purpose in future.

The Convener: I see that Mary Scanlon has a question. Please make it short; I want to keep to time.

Mary Scanlon: I will be brief. I am glad that the discussion has been brought back to standards. I want to put on record that Barbara Hurst is talking about a 40 per cent reduction over three years in GP provision of out-of-hours services, which is a concern. Because GPs are unwilling to provide a service, NHS Highland regularly flies in GPs from eastern Europe, who are paid £1,000 per shift. That issue has not been mentioned.

We have not had a proper answer to the final question in our consultation paper. Pretty well everyone who gave evidence—I will not go through them all—expressed concern about the Scottish Ambulance Service and NHS 24. Is there a suggestion that the two bodies be merged? Is there a suggestion that the ambulance service is too detached from the NHS? Before we conclude our discussion we must put on record people's serious concerns about the ambulance service.

The Convener: I am mindful that you have opened up a substantial new discussion, Mary. We will take evidence on the issue next week and it would be useful if the witnesses could provide supplementary written evidence. With the committee's leave, I will move on.

Dr Buist: May I take up 30 seconds on a point of information that might be of help to Mary Scanlon? I had a meeting—

The Convener: I never said yes or no. You are a tough negotiator. Go for it.

Dr Buist: Yesterday, I met George Crooks, who is clinical director at NHS 24 and the Scottish Ambulance Service. He is piloting arrangements in which there will be one call operator for both services when a patient phones up. The operator will use the arrangements to determine whether the person is directed to the ambulance service or to NHS 24—

Mary Scanlon: Is that potentially a move towards a merger?

Dr Buist: They are moving in that direction.

The Convener: I knew that if we opened up the discussion it would start to grow legs—like an octopus, as someone said. Richard Simpson wants to comment—is your comment brief?

Dr Simpson: Yes. I wanted to ask for further written evidence on another topic. An elephant in the room is telecare, which we have not talked about, although IT got a mention. I also mention accident and emergency services, which are predominantly a problem in urban settings, where there is massive growth and there are concerns about patients' inappropriate use of A and E. We have not considered how telecare can be linked with A and E to use the 24/7 services that exist. If the witnesses have evidence on that, will they write to us?

The Convener: I cannot open up a discussion on telecare, which is a huge issue. I must use the guillotine. I thank all the witnesses for their evidence. When Dr Buist mentioned the Queen, I wondered whether Balmoral has ever phoned NHS 24—perhaps we will never find out.

11:35

Meeting suspended.

11:43

On resuming—

The Convener: We move to our second panel of witnesses. Dr Susan Taylor is the remote and rural lead for the Royal College of General Practitioners Scotland's membership liaison group; Linda Harper is lead nurse for G-MED—the Grampian out-of-hours medical service—with the Royal College of Nursing Scotland; David Forbes is regional organiser and secretary to the Scottish Ambulance Service committee of Unison; Dr Paul Kettle is an out-of-hours GP with the Remote Practitioners Association of Scotland; and Dr Ewen McLeod is vice-chair of the British Association for Immediate Care Scotland.

Thank you very much for coming. I think that you know how we work—just nominate yourselves to answer questions as they come along, and indicate to me, as convener. Thank you for your written submissions—they are always extremely helpful, and they allow us to go straight to our pertinent questions.

11:45

Ian McKee: The witnesses probably heard me ask this question to the previous panel. We have been told that there are still quite a lot of practices in rural areas that provide out-of-hours cover. The evidence from the BMA seemed to imply that that was because other arrangements could not be put in place. The evidence from the Royal College of General Practitioners, in particular, seemed to show that its members provide that service

because they think that that is the best way of providing out-of-hours care to their communities. Could you—especially Dr Taylor—give your perspectives on that? Is it thought that GPs simply cannot get out of doing out-of-hours work because there are no other arrangements? Do you think that continuity of care and service to the community are important, so long as they can be tied in with getting a reasonable amount of time off and a decent family life?

Dr Susan Taylor (Royal College of General Practitioners Scotland): Yes. I work as a GP in Morvern. I provide care out of hours for my own patients, of whom there are 300, and I do so because I cannot see an alternative way to provide such care. The new contract in 2004 marked the very beginning of the steps that had been happening in urban areas 20 years previously.

I am 30 miles from the centre of a neighbouring practice, by single-track roads; travelling times are double those of urban areas, so I am an hour from the centre of another practice. I am also isolated because of a limited ferry crossing. Most of the GPs who responded to the RCGP survey and who are still doing out-of-hours care are island based, or geography has in effect made their area an island; I am referring to the Bealach na Ba pass to Applecross, for example. As for my situation, there is a ferry crossing that does not run at night. Many GPs are in a similar situation.

Some practices have evolved more and have managed to join up with primary care centres. In Lochaber, people in Mallaig, Ballachulish and Kinlochleven can now receive out-of-hours calls from the centre, which they were not able to do before 2004. That is because of the expanded roles of GPs in providing out-of-hours services.

NHS 24 response times are a factor. If the GP responder cannot do home visits within the hour, that means that local GPs will conclude that they must carry on providing the service themselves. There are links with community nurses in some areas, but the amount of training that they have had varies. The GPs who provide the services will not withdraw from doing so until they feel that it is safe. Problems arise when a GP withdraws a service, thinking that it is safe to do so, but the community does not feel likewise, in which case a perception arises that something is wrong. If the GP works with their community, great steps forward can be taken to provide out-of-hours care.

I have an annual contract to provide out-of-hours care, but that is not very stable. Every year, I am told, “We’ll be thinking about it.” As some of the written submissions mention, some stability of contract would be helpful. The doctors who provide out-of-hours care believe passionately in it, in the main. There should be some division between what is provided by GP out-of-hours care on visits and by immediate care. We have not really expanded into that. Immediate care is the responsibility of the Scottish Ambulance Service, but we, too, want to be involved in that in remote and rural areas, where doctors have an extended training in BASICS. Some doctors who do not do out-of-hours work will provide immediate care, and we should bear that in mind.

Dr Paul Kettle (Remote Practitioners Association of Scotland): I am a GP on the island of Hoy in Orkney, and I provide my own out-of-hours care to the people of the island. I do not use NHS 24. We have an ambulance provided by the Scottish Ambulance Service. I do not have an alternative to providing that care, as it would take too long for a GP to get to the island from anywhere else. I am not looking for an alternative, because that is a good way to practise. It is good for the patients and it allows me to maintain a high quality of care.

However, in order to provide that service, I need support. I do not want to be stuck on the island 24/7 with no opportunity to do other work, undertake training and so on. From a governance point of view, it is essential that I am allowed to get off the island. Cover can be provided by nurses but only for a short period of time. Any longer than that and the risks become unacceptable to me, and I tend to look for a locum or part-time partner to fill the place.

My point is that any alternative to what I do at the moment would result in a service of much lesser quality. That is nothing to do with me and everything to do with the fact that I am there and can respond quickly.

I was about to talk about first responders, but perhaps I will not go into that.

The Convener: We will come back to that later. I should say, though, that it is good to have a picture of the situation.

By the way, I think that Hoy is a beautiful place. I should also say in passing that the clerk is originally from Orkney, so you have fans on the committee.

Linda Harper (Royal College of Nursing Scotland): There are particular issues in remote areas. For example, to deal with Grampian’s remote and rural areas, we have developed a team of advanced nurse practitioners, who have a lot of good skills and work well together. As far as the six dimensions of quality are concerned, we certainly provide safe, effective, efficient and person-centred care, which for patients is the most important thing. If the appropriate training is available for advanced nurse practitioners, paramedic practitioners and so on, they can be very supportive; indeed, Dr Kettle has already said

that he is sometimes covered by an advanced nurse practitioner. Given that some islands have only advanced nurse practitioners, the team approach that I have outlined is key.

Dr Kettle: I said that the cover was provided by nurses, not by advanced nurse practitioners. In fact, I am not all that clear about what an advanced nurse practitioner is, given the variability in the degree of training—or, should I say, extra training—that they have received. In Orkney, advanced nurse practitioners cover some of the smaller islands that—it has been decided rather arbitrarily—are not big enough to have their own GP. Although there are some problems with the approach, it can work.

As I say, I am not sure where you draw the line between the kind of nurses with whom I work at the moment and advanced nurse practitioners. I have worked with both and, as far as I can tell, there does not seem to be a lot of difference.

The Convener: Ms Harper, do you wish to explain—or retaliate?

Linda Harper: An advanced nurse practitioner has different key competencies. For example, I have not only done a bachelor of arts in professional nursing studies but gone through a nurse practitioner degree programme, the key competencies of which are clinically based. For example, you are taught how to take a patient's history and then how to examine, diagnose and treat them. I am not saying that advanced nurse practitioners are more autonomous, but their autonomy might be said to be different, and the way in which you examine and the outcome that you reach sit with you.

The Convener: The debate over nurses and advanced nurse practitioners can continue elsewhere. It sounds like a specialist subject for "Mastermind".

Dr Taylor: The RCGP's evidence consists of responses that it has received, mostly from GPs who provide out-of-hours care themselves or as part of a very small and limited co-op. Those doctors are not on the pay scales that have been set out in the SPICe briefing paper, because they are working within what are very often local service level agreements. NHS Highland, for example, has a wide variety of those agreements, all of which are very different. In some, GPs provide services from Monday to Thursday, with a locum service at weekends; in other areas—mine, for example—GPs provide the whole service. Rates of pay also vary. In some areas, no payment is made and doctors simply retain the 6 per cent that has been mentioned. I can certainly assure members that I am not getting £50 an hour.

It must be remembered that the communities that are served by doctors who provide their own out-of-hours service usually have fewer than 1,000 patients. We need to recognise that different workloads are involved in out-of-hours provision. In my practice, I am probably called on out of hours on average about once a month—although it might be slightly more often during the summer because of holidaymakers, which can be an issue in many remote places. We are not comparing the same things. Those doctors who provide out-of-hours services to just their own patients are dealing with small numbers of patients.

In considering who is the best person to provide an out-of-hours service, such GPs feel that they know their patients, with whom they work day to day, and that they are able to provide the out-of-hours service. If those GPs brought in someone from outside the area or a nurse practitioner to work solely out of hours, the out-of-hours person would not be able to retain skills from seeing just one or two patients a month. We need to be careful about comparing what a doctor such as myself provides out of hours with, say, the out-of-hours provision of the Lochaber primary care centre, where the doctors might do eight-hour shifts and see much larger numbers of patients.

Dr Simpson: The figure that we have been given is that about 100 GPs currently provide their own out-of-hours service and about 1,440 GPs across Scotland are involved in out-of-hours care. I want to tease out a little bit more a point that Dr McKee made. Might the number of GPs who would provide out-of-hours services in rural settings increase if it was possible to provide a sustainable contract, particularly if such GPs were given relief and support, as Dr Kettle mentioned, and additional telecare? In other words, could we amend the GP contract so as to develop a separate contractual package for remote areas and a separate package for rural areas, given that—although there is a continuum between remote and rural areas—those are different types of area?

I also want to ask my original question. What is the role of the other services in providing integrated care?

The Convener: We will deal with the contract question first. Perhaps David Forbes could then respond to the question on integrated care.

Dr Taylor: In a sense, the health boards are trying to do that through their contracts, but those contracts vary widely and have no standardisation. Whether it would be possible to force doctors into larger groups if they do not want to provide out-of-hours services is a difficult question—

The Convener: I think that Richard Simpson wants to explain his position.

Dr Simpson: I am not suggesting that health boards should try to force such GPs into larger

groups. There used to be a separate contract for rural practitioners, who were given enhanced payments and so on to recognise that we need their services in rural areas. Does the current GP contract appropriately reflect the nature of work in remote and rural communities, or does that contract need revisiting? That is a big question, but I am asking it in the context of out-of-hours services.

Dr Taylor: Actually, that question perhaps feeds into the whole question about what a doctor in remote and rural locations does and what competencies are needed for the role, which I think is a very specialist role. The contract is not good at rewarding what we do in remote and rural areas, where we have very small numbers of patients. The quality framework and so on does not work well. I am very well aware of the previous system of inducement practice; I feel passionately that that led to our having a great population of GP-led practices across the Highlands. Those must not be destroyed by destabilisation with out-of-hours contracts. Retaining doctors in those communities is absolutely key.

It is right to say that there are problems with how the new contract recognises remote and rural workloads. That is a big question. I think that, given training and support, doctors will still wish to do those kinds of jobs. I also think that it is important that doctors in training are introduced to that kind of work through, for example, the rural fellowship. I encourage medical students to come to my practice to let them have an early flavour of what happens in rural practice because I think that there are people who want to do those kinds of jobs. Such practices do not suit everyone—some people want to switch off at 6 o'clock and not see patients—but there are still small numbers of people who want to work in rural areas and who should be encouraged. I would like to see us getting those people trained and back in rural practices.

12:00

Dr Kettle: The answer to Dr Simpson's first question, on whether doctors would provide out-of-hours care if the constraints were addressed, is yes. I will give my reason for saying that. A scheme has been advertised on Orkney in the past month, and a large number of high-quality applicants have applied. For three of Orkney's north isles, resident GPs will be employed on a salaried contract that is linked to one of the mainland practices in Kirkwall for education, cross-cover and governance in general. Interviewing was on Monday, and the people have probably been appointed by now. That is promising.

We are not limited to the GMS contract. There are at least three different sorts of contract. The GMS contract is a national contract for GPs, independent contractors are contracted to the health board, there are section 17C contracts—in that case, the GP has a contract independent of the national contract drawn up with the particular health board—and GPs are employed directly on a salaried basis by health boards. There is probably a move towards salaried and section 17C contracts in remote and rural areas, because they are more flexible. I do not think that many people would disagree that the new contract was fairly disastrous for remote and rural practices—certainly remote practices.

David Forbes (Unison): If we are going to revisit the contract, I ask that that is not done in isolation. I am a huge admirer of the British Medical Association as a trade union negotiator; it has done exceptionally well for its members from that. However, there are ramifications for everybody else. If we are looking to integrate out-of-hours services and, indeed, the rest of the national health service, we need to consider all the packages that are involved for all the people who will deliver the service, not just one group in isolation.

The Convener: You speak like a good trade unionist. You are quite right: the BMA is quite impressive.

Mary Scanlon: I have a question that follows on from my previous question. Like Ross Finnie, I am struggling to find the way forward. As a Highlands and Islands MSP, I appreciate that one size does not fit all. Patient transport is a huge problem, and we have the ambulance service, NHS 24, GP practices, accident and emergency services, nurse practitioners, first responders and minor injuries units. In the Highlands, we have helicopters and mountain rescue services. NHS 24 has improved enormously in the past two or three years—I must put that on the record. It got off to a bad start, and members received many complaints about it, but it has improved.

We have here someone who deals with ambulances. I have been out with the ambulance service, and I think that the paramedics' training is underutilised at times. I was incredibly impressed by the training of the paramedics and technicians. Our briefing papers are generally fairly critical of the ambulance service, not because of its standard or quality, but because it seems to be detached. That concerns me. Out of the services that I mentioned, should the ambulance service be aligned to GPs in health centres or NHS 24? What is the way forward? The service is too fragmented.

The Convener: That is a call to arms for Mr Forbes.

David Forbes: That is a huge question. I would not necessarily say that the service should be

aligned to GPs. Greater alignment among all the people who provide the service is needed.

Mary Scanlon and Ross Finnie have asked where we are going. It is clear that we are going away from what we had 30 years ago. As part of that move, ambulance crews have improved and immensely increased the scope of their abilities. However, ambulance crews are not capable of doing everything that a GP can do. That means that we must work out the extent to which ambulance crews are able to see and treat—to use the current term. In the past, when an ambulance was called out, if the person insisted on being taken to hospital, they were taken to hospital—the crews had no discretion in that regard. There is an attempt to change that situation by enabling the crews to say that someone is fit enough to be left where they are. That is particularly important in rural areas, where there might be only one ambulance in 30 or 40 miles and, if it is occupied in driving someone to Raigmore, for example, it might be taken out of action for two hours or so.

We need to make greater use of people's skills and we need to integrate to a greater extent. The NHS Highland hub has been referred to consistently as an example of good practice. We have paramedic advisers who work with the out-of-hours doctors and NHS 24, which seems to work well.

There is no easy solution. The GP contracts were quite a shock. Almost as a direct result of them, our ambulance call-outs have increased by 25 per cent. I am not knocking the GP contracts; I am saying that they have forced things to move at a pace that the Scottish Ambulance Service and NHS 24 were not ready for.

Mary Scanlon: They have increased pressure on A and E departments as well.

The Convener: Could you clarify an issue that arose in my constituency? I understand that there must be a dedicated rest time for crews within a period of time in which they are on duty and that, even if a call is received from somewhere near the place where they are taking their break, they cannot respond, and another ambulance crew must attend the call. Is that correct, or have I misunderstood the situation?

David Forbes: That relates to the very big issue of paid and unpaid breaks, which goes back to the new terms and conditions under the agenda for change and the European working time directive.

A standard working shift of seven and a half hours is a lot harder to manage than a shift of eight hours, as there are 24 hours in a day. There are times when people want a rest and, if they are not getting paid for that time, it counts as downtime, which means that they do not get called out. It is the same as anyone else who has a job saying, "I'm just going down the shops to get my dinner."

The Convener: Am I right in saying that a crew that is on a break would not answer a call, even if they were close to the person, and that an ambulance from as far away as 20 miles would be called instead?

David Forbes: That is correct.

Dr Ewen McLeod (British Association for Immediate Care Scotland): That leads on to my point, which concerns the integration of services. BASICS is primarily an educational forum, although, in the past two or three years, it has become more involved in service provision, if I may use that term.

Before the GP contracts were introduced, we would train GPs, paramedics or even nurses on the islands to do the standard ABC resuscitation, which the first responders were alluding to earlier. We would then find that, although people had been trained to use the equipment, they did not have access to that equipment. Following the demise of a child in Canada, the Sandpiper Trust was set up to raise money to provide ABC equipment for BASICS-trained personnel.

For the past two years, we have been using a vehicle-locator system, which uses similar global positioning system technology to that which the ambulances use. We have 70 BASICS-trained GPs throughout Scotland who have been provided with equipment bags and have availed themselves of a vehicle locator. On a voluntary basis—that is, if they are going to be at home on a given night—they make themselves available through the system, which shows where they are on a control screen. If an ambulance crew is unavailable to deal with a 999 call for whatever reason, the control screen will show whether there is a BASICS-trained person—at the moment, they are primarily doctors—whom the ambulance service can send out to deal with the call.

Not all GPs want to rip off their ties at 6 o'clock; some of us are happy to do a bit of out-of-hours work over and above what we do in the out-of-hours co-operatives.

Dr Taylor: The RCGP's submission mentions the vehicle locator system that is coming in—some of our evidence came in pre-November. In my area, we are awaiting delivery of the vehicle locator system but, about six months ago, there was an improvement in the IT system that enabled me to be identified as being available. Prior to that, I had problems being called—many GPs have alluded to similar experiences. The new vehicle locator and IT systems that are in place are working. The last time I had a patient who had chest pains, I got to them before the ambulance

service had finished talking to them—I was there within four minutes. The ambulance is based 20 miles away, which takes at least 40 minutes to cover. I can get to patients within four minutes. That system is up and running in places.

The Convener: Were you able to do that just because it was known where your vehicle was?

Dr Taylor: No. The system is much simpler. There is a flag that says "Lochaline" and two phone numbers are given for the doctors who are on duty, one or other of which is tried. We do not have the vehicle locator system yet, but it would do the same thing.

Helen Eadie: My question is about the need for centralised co-ordination between NHS 24, out-of-hours providers and the Scottish Ambulance Service so that we can get better prioritisation. In its submission, the RCGP UK rural forum said that there were

"inappropriate diversions, prioritisation and misconceptions about community hospitals being regarded as places of safety."

We need to ensure that there is good co-ordination so that an appropriate response can be provided. Do members of the panel want to comment on those issues?

Dr Taylor: Different feedback was received from different areas of Scotland and some of the evidence may predate the introduction of the vehicle locator system.

There is another flaw with NHS 24's triaging of patients, which relates to misunderstandings of local geography, as a result of which patients with minor injuries are sometimes referred to distant A and E departments—they could be 50 or 100 miles away—when an on-call GP is available to provide minor injury services. We are supposed to feed back to the knowledge system. I regularly feed back the fact that Lochaline is not in Oban and that Oban is a very long drive away, especially when it is the middle of the night.

Another major problem is the fact that we have no way of knowing about visitors who call NHS 24 and who are misdirected to A and E units. I will take my practice in Lochaline as an example. If a visitor goes to an A and E department or contacts NHS 24, that information will go back to their own GP; we will know nothing about it. My perception is that that is less of a Scottish Ambulance Service issue and more of an NHS 24 issue.

Sometimes the mobile phone network directs people who make a 999 call on a mobile phone to the wrong control room. Even being directed to the nearest control room can be a problem for someone who is on an island, as the nearest control room may be Paisley. Historically, that was an issue, but I would have to ask the Scottish Ambulance Service whether that remains the case. Where there are co-locations—as is the case, for example, with NHS Highland's hub—the situation is better, but the RCGP rural forum's submission reflects evidence from across Scotland.

12:15

Linda Harper: We certainly have such episodes. It is important that individual health boards, NHS 24 and the Scottish Ambulance Service meet locally to discuss things that happen locally and that we fix them locally. We all have a responsibility to ensure that such episodes are discussed, significant events are held, and processes are put in place to try to ensure that they do not happen again.

David Forbes: I am not sure whether you are asking about the evidence that, occasionally, calls are bounced about a wee bit depending on who is the appropriate—

Helen Eadie: An example is given in the papers of a case in which a doctor near Inverness was available and could have dealt with the case locally, but the patient was sent miles and miles away. It was felt that that would not have happened if there was better central co-ordination. There is some evidence that that is beginning to happen, but it does not exist throughout Scotland. There is recognition that the links between the NHS, out-of-hours services, the ambulance services and the GPs are not working in every part of Scotland.

David Forbes: I agree that they need to be pulled together as a matter of some urgency.

If you remember, when NHS Argyll and Clyde was disbanded, some bits went to Glasgow and some bits went to Highland. That caused some confusion because there are now various controllers for the ambulance services. One is based in Cardonald and one is based in Inverness. The right controller is not always contacted, partly because of who is running the service in Argyll and Clyde, as opposed to who might otherwise have been doing so. People need to get things right by sitting down and thinking them through. We always say this, but it is a question of communication. The responsibility has to be taken on board to ensure that that communication takes place.

I said that general practitioners are sometimes not called and that there are inappropriate calls and so on, but one reason why crews are sometimes sent out instead of the GP being called is that some GPs—although far from the majority—are not particularly keen on coming out. As is the case with all sorts of professionals and

workers, there are problems with some individuals who are less keen to be called out than others are.

I apologise for our not providing a written submission. The submissions that the committee has are principally from the general practitioner's perspective. They imply that, basically, the ambulance service is doing daft things while the GPs are all ready and willing, but there are reasons why GPs are no longer called out at the same time as ambulance crews.

Dr McLeod: Helen Eadie mentioned the co-location of NHS 24 and the ambulance service in relation to out-of-hours services. You will see mention in some of the papers of a group that was actively formed by the Scottish Ambulance Service and Dr George Crooks, the medical director of NHS 24. It is made up of NHS 24, me and a colleague from BASICS, ambulance managers, and one or two A and E consultants. It exists primarily to consider ambulance responses to 999 calls.

At present, if a case is of a reasonable severity, the response will be blues and twos or slightly down from that. A proportion of calls do not necessitate that level of response. If a crew is sent out, it will be out of the running for a period of time. However, as I said, the ambulance service is aware of the issue, and a group is considering the ability of the ambulance service to triage calls more appropriately with NHS 24, which is shouldering the blame in the meantime. I hope that that work will bring us all together, make the response to 999 calls more appropriate and perhaps take the pressure off the crews.

The Convener: When will that group report, and to whom?

Dr McLeod: It is led by one of the directors of NHS 24 and I believe that one further meeting is to be held in the spring, so perhaps some paperwork will come from that after the summer.

The Convener: Will that be public?

Dr McLeod: I believe so. Dr George Crooks is leading on the matter just now.

The Convener: That is useful.

Helen Eadie: I have a question specifically for the ambulance service. I know from local experience that there are issues about the difference between sending out trained, fully qualified paramedics and resorting to the use of technicians. Do you want to comment on that? Why are we seeing an increase in the use of technicians instead of trained paramedics?

David Forbes: I would be surprised if there were such an increase, because the ambulance service now contains a higher proportion of paramedics than ever before. We tend to call technicians "trainee paramedics" because the jobs are seen as parts of a continuum.

There is an extra dimension to paramedics' training and competences, but for many of the bread-and-butter 999 calls, if I can use that expression, a technician is as good as anybody else, so I would not necessarily be concerned about that. We obviously want to upskill as much as possible, but I would not underestimate the skills of a technician.

Part of the difficulty is that, to some extent, there is risk aversion. We talked about the matrix that is used by NHS 24 and who gets called out. Because of the sheer volume of call-outs and the level of work that the Scottish Ambulance Service now faces, even when technicians want to train up to be paramedics there has not been the capacity in the service to release them and to train them. As far as possible, we would like all staff to move to paramedic level and beyond.

Helen Eadie: Is that an issue in the Scottish Ambulance Service?

David Forbes: It has been a bigger issue. The Scottish Ambulance Service has recognised that part of the problem is that the Barony, which is a site outside Peebles where most of its training is done, is no longer fit for purpose, so it is going to do much of the training in the big tertiary hospitals and in local hospitals throughout the health service. That makes a lot of sense, because what underpins much of this is the fact that GPs do not want to be on call 24 hours a day. In the same way, ambulance crews do not want to be away from their families doing training for six weeks. We also do on-call duty and do not particularly like that either. Changes are happening for all sorts of reasons—not necessarily for those reasons—that I think will improve the training of ambulance crews and their integration with the rest of the NHS.

Helen Eadie: That is important. In Fife an epileptic patient who was under the care of technicians died while travelling in an ambulance. That incident pointed to training being a key issue, so I am interested in your comment. The point about training being a key issue is not my comment but a point highlighted in the chief executive of the Scottish Ambulance Service's report on the investigation.

The Convener: We do not want to go into specific cases, because there may be all kinds of ramifications.

Dr Taylor: Helen Eadie asked about the comment in the RCGP's submission on problems with response times. Some GPs said that if a patient was in a health centre or a community hospital, the response was not immediate. They have perceived delays in the service and feel that it is not treated as a 999 call. The ambulance

service may perceive that there is less urgency because someone is with the patient but, in fact, if the patient is having a heart attack, they definitely need to be 999ed out of there. There are some tensions, and colleagues have reported that the ambulance service seems to feel that there is less urgency. There have also been issues about air ambulance prioritisation. For example, the helicopter has gone to a road traffic accident because that is not assessed, while you have an assessed patient who is definitely diagnosed as needing urgent care.

Rhoda Grant: We have heard different evidence from different people. We have heard evidence about financial constraints and constraints because of the hours that staff want or do not want to work, working patterns and the like. It would be useful to know what a safe level of service is. Taking out of the equation issues such as when staff wish to work, issues about being on call and so on, and issues about costs, what do panel members think is a safe level of service out of hours?

Linda Harper: The integrated team, which is a mix of GPs, advanced nurse practitioners and paramedic practitioners, is a safe way to provide the service, provided that training and support is delivered initially in health boards. NHS Education for Scotland has supported health boards, both in respect of competences and financially, to develop others within the team. I am here to represent the RCN but I keep talking about NHS Grampian because that is where I work. Practitioners see patients as they come in. We have been audited by the Scottish Government and internal audit. We have been involved in a workforce study with the University of Southampton and the University of Aberdeen. It was commissioned by the Department of Health to look at workforce issues. The study has not been released yet, but the Department of Health has it. It shows that a multiprofessional team is a good way to see, treat and discharge approximately 70 per cent of patients. We need the support of GPs and telemedicine. The service is safe, efficient and cost-effective, and the patients seem to like it. Since 2004, I have had one patient who said that they would prefer to see a doctor, and we will get a doctor if that is what the patient prefers.

Dr Kettle: We all work in multidisciplinary teams as part of our everyday in-hours practice. In many contexts it is appropriate to do that, as happens with NHS 24 and so on, and what Linda Harper has just described sounds like a very interesting scheme.

To step back for a moment, one of the key factors is that the local context needs to be taken into consideration. The further out we get along the remoteness axis, the more variation there is in that local context, and the less easy it is to apply a model that has been produced in advance. In the more remote areas—as well as in less remote areas—it is important to apply a solution that is responsive to historical and geographical contexts. We need to take into consideration who is already in the area and providing services that can be used, because we do not want to reinvent the wheel. Also, if in doubt about a particular area, which might be a whole health board or one small community, we need to look at its context and work out a solution using the different facilities that are available. It might be appropriate to use ambulance personnel in more innovative ways than they have been used in the past, and it might be appropriate not to, depending on the context.

Some of the confusion might be caused by the fact that the further out into the more remote areas we get, the more different are the problems and the more difficult it is to get our heads around what is actually needed. We talk about equality, but we cannot actually achieve it. The concept of equity is more to do with the fairness and justice that are needed to drive the decisions. Often the problem is political and it will have a local political solution. We cannot take something off the shelf and apply it to an area; we have to discuss it with the communities, stakeholders, local authorities and so on. The local context drives the determination of a solution to the problem of providing out-of-hours care. I do not know whether that helps or not.

The Convener: That was a very thoughtful answer. I think that we take the view that there is no one-size-fits-all solution. We are looking for equality of care, but it will be delivered in different ways, depending on where it is being delivered. The committee is aware of the differences between someone who lives in Hoy and someone who lives in the Scottish Borders and has reasonable access to the Borders general hospital, for example. The situations are very different.

12:30

Dr Taylor: I echo what Paul Kettle said. There is the core area and then completely different population densities. Rural Aberdeenshire has isolated areas, but it also has roads that interconnect. On the west coast, there are a lot of single-track roads down to dead ends where the communities live. What is isolation? Does it mean not having access to supermarkets within an hour? If we do not have equity of access to supermarkets, we will not have equity of access to out-of-hours services.

One change with the new contract is to do with the NHS 24 standards, such as the standard that, on non-urgent issues, there should be a call back

within two hours. That might seem appropriate, but if an initial call comes in at 9 o'clock from a rural area and a definitive decision to call the rural doctor is not made until midnight, that doctor might have been available earlier. That is actually worse than the previous service for remote areas. Sorry, I am digressing slightly.

There are different solutions. Other partners are involved in some areas. The coastguard and lifeboat services are involved and perhaps our retained firemen could be more involved to add to existing services. The inducement system populated most communities with GPs, although not every offshore island community, so there are probably more remote and rural GPs than any other type of practitioner. Where there are nurses, that is an addition. We have that level of population, but we probably all need to work together smarter. However, there is not a single answer.

David Forbes: Telemedicine is the key to a large extent in the remote and rural areas. I do not mean to underplay the value of paramedics, as I am a huge fan of them—indeed, in many instances I would far rather see a paramedic at my door than anybody else. However, greater access via telemedicine to a consultant in a tertiary hospital, for example, would instil confidence. Certainly, paramedics see the police out on calls with their wee helmets and things that instantly relay information. It sounds as though the technology is there; the issue is finding the best and most appropriate use for it.

Mary Scanlon: My question is related to Rhoda Grant's point about the safe level of service. Perhaps I am wrong, but I have listened carefully to the responses and there seems to be an assumption that all patients have physical and medical needs—no one has mentioned the needs of patients with mental health problems. In all fairness, despite my huge admiration for paramedics, it would be unfair to send a paramedic to such a patient's door. The meeting is wearing on, but nobody has mentioned mental health patients. Can we have a comment on how out-of-hours services cope with mental health patients who are in crisis?

Linda Harper: In remote areas, that is probably more difficult, but in many rural and other areas community psychiatric nurses work alongside GP and nurse practitioner colleagues. Certainly, in my health board area, advanced nurse practitioners do not visit acutely unwell people with mental health issues. GPs do those visits.

Dr Kettle: Mental health problems are always challenging and difficult, but GPs are qualified to deal with those situations. The problems are particularly difficult when a person is dangerous and there is only one GP and no police officers. Dealing with those situations requires innovation. Part of the advantage of GPs is that they have a broad and deep training in mental health and all other aspects of medicine. They can fall back on that knowledge and work things out from first principles to deal with situations as they arise and develop. Somebody who works on the basis of protocol cannot do that. It is appropriate for GPs to deal with such cases. The nurse that supports me is invaluable in mental health cases, but I would not expect her to be responsible for managing such situations.

Dr Taylor: A mental health emergency in a remote and rural area is probably one of the hardest things to deal with—I can picture it happening. Page 3 of the RCGP submission mentions the generalist nature of GPs and the multiple skills that they have, which allow them to cope with a mental health emergency. If they have basic training, they will be equivalent to a paramedic turning up on the doorstep. In peripheral areas where very few calls are made, you need the best person on the ground right now, which is the multiskilled GP. We talk about skill mix, but I would say that, when it matters, the best person is probably a GP with the specialist skills that they should have got in training.

The simplest form of telemedicine is phoning for back-up, perhaps from a mental health officer, who might be distant if they cannot come. That at least provides someone with whom to talk through the issues. However, we also need access with specialist teams should a mental health retrieval be necessary—I know that the Scottish Ambulance Service is trying to improve that. We need a first line, but we also need speedier back-up. Some emergencies can continue for eight to 10 hours while you wait for an evacuation.

Mary Scanlon: In the past in the Highlands, mental health patients have been locked in police cells. Have things moved on now and are there sufficient places of safety? Dr Kettle talked about a person who is dangerous, perhaps to themselves and others. Are there sufficient places of safety for such people, whether that is a community hospital or otherwise?

The Convener: I do not know whether Dr Taylor can answer that.

Dr Taylor: I do not think that I can. I do not have enough information.

The Convener: Representatives from NHS Highland will be at our next meeting, so they can answer it.

I will close the meeting soon, but first I ask the witnesses whether there is anything that we have missed.

Linda Harper: NHS Education for Scotland has supported boards in providing training in mental health first aid for all practitioners, which is GPs and other practitioners. Health boards are making progress on that. It is correct that the right person needs to be in the right place at the right time. For mental health cases, the GP is the right person, but that is not the case for everything.

The Convener: Why did I know that that was coming? I hope that we have a love-in for the witnesses after the meeting.

That concludes the evidence. I thank our witnesses.

Meeting closed at 12:37.

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