HEALTH AND SPORT COMMITTEE

Monday 25 January 2010

Session 3

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HEALTH AND SPORT COMMITTEE
3rd 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:

Murdo Fraser (Mid Scotland and Fife) (Con)

THE FOLLOWING GAVE EVIDENCE:

Dick Barbor-Might (SOS Rannoch)
Keith Cameron (Scottish Ambulance Service)
Linda Entwistle
Tom Forrest (Wester Ross Medical Practices Community Representatives Out-of-hours Group)
Dr Michael Hall (NHS Highland)
Pauline Howie (Scottish Ambulance Service)
Dr Sheena MacDonald (NHS Borders)
Roy Macpherson (Wester Ross Medical Practices Community Representatives Out-of-hours Group)
Randolph Murray
Gerry Marr (NHS Tayside)
John Turner (NHS 24)

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Macdonald Loch Rannoch Hotel, Kinloch Rannoch

Scottish Parliament

Health and Sport Committee

Monday 25 January 2010

[THE DEPUTY CONVENER *opened the meeting at 10:00*]

Rural Out-of-hours Health Care Provision Inquiry

The Deputy Convener (Ross Finnie): Good morning. I welcome members, witnesses and the public to the third meeting of the Health and Sport Committee in 2010. I remind everyone to switch off mobile phones and any other electronic equipment that might interfere with proceedings.

This is the first occasion on which a formal meeting of a Scottish Parliament committee has taken place in Kinloch Rannoch. In order that a proper record of the event be made, the early part of proceedings may be slightly interrupted by the official photographer. I hope that that does not cause any disturbance. In a short while, a broadcaster will take some set-up shots, but they have been instructed not to interfere with proceedings. Everything that is said during today's proceedings will be formally recorded in the Parliament's *Official Report*. The audio feed from the meeting is being relayed back to the Parliament's broadcasting system and is being webcast live on our internet site.

This is a formal meeting of a parliamentary committee in public session. That is different from a public meeting, in that only members of the Scottish Parliament and witnesses who have been formally invited to give evidence are able to speak. Although the focus of the inquiry is national, the committee appreciates that the local residents, many of whom have turned up, have views and concerns about out-of-hours health care provision that they may wish to express. We have, therefore, arranged for an opportunity for everybody present who wants to speak to members to do so over tea and coffee after the formal meeting has closed.

Apologies have been received from Michael Matheson, Richard Simpson and, unfortunately, our convener, Christine Grahame. She was involved in a minor incident last night on her way here. No parties were injured but, as everyone will appreciate, such things cause a little upset and she was advised that it would be better if she returned home instead of carrying on to be with us. She is very sorry indeed not to be present. We are joined by Murdo Fraser, who has a constituency interest and will participate fully in proceedings. I have also received an apology from the Cabinet Secretary for Finance and Sustainable Growth, John Swinney, who is hugely involved and engaged in the Government's budget process, which precludes his taking time out of his diary. As many here will be aware, he has been actively engaged in this matter as the constituency MSP. He is very sorry indeed not to be able to be present this morning.

The only item of business today is an oral evidence session on the committee's inquiry into out-of-hours health care provision in rural areas. This is the second of three oral evidence-taking sessions that the committee is holding as part of its inquiry. The committee's call for written evidence for the inquiry closed on 6 November 2009 and written submissions have been published on the committee's website. In the light of the evidence that was 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 and from the Cabinet Secretary for Health and Wellbeing.

The first evidence session was held in the Parliament last Wednesday, 20 January, with Audit Scotland, NHS Quality Improvement Scotland, the centre for rural health, the centre for international public health policy in Edinburgh, the British Medical Association, the Royal College of General Practitioners Scotland, the Royal College of Nursing Scotland, the Scottish Ambulance Service committee of Unison, the Remote Practitioners Association of Scotland and the British Association for Immediate Care Scotland.

This morning, we have two panels, and I welcome the witnesses on the first panel: Keith Cameron, communities resuscitation development officer with the Scottish Ambulance Service; Dick Barbor-Might and Randolph Murray of SOS Rannoch; Linda Entwistle, first responder from the Kinloch Rannoch area; and Tom Forrest and Roy Macpherson from the Wester Ross medical practices community representatives out-of-hours group. I welcome you all.

The committee has found that we make more progress in the exchange of questions and answers and getting to the bottom of the issue if, rather than dwelling on opening statements, we proceed straight to questions based on evidence that we have received and, specifically, on the written submissions.

Helen Eadie (Dunfermline East) (Lab): I am glad to be here today. It is a great location. Thank you for having the committee here.

Will the Scottish Ambulance Service witnesses elaborate on the point in their paper about the

increased use of technology to facilitate better co-ordination? Are barriers to that developing already? Telemedicine and much better use of new technology for co-ordination seem to be a positive and progressive way forward. Why is that not already happening?

Keith Cameron (Scottish Ambulance Service): That is already happening. In the developments that we are looking at—primarily the first responder schemes within rural areas—part of the problem is mobile phone signal deficiencies. Kinloch Rannoch is one of the problem areas. We are also looking at the development of co-ordination processes within the control room. We are looking at first responders, what they get called out to, and how they are designated and dispatched, and therefore controlled. The technology for that is developing. We hope that we will get new radio networks this year. We are also considering new developments in smart phones, which we hope will benefit the facilitation of the community resuscitation schemes that we run.

In the two areas that I deal with, the issues are communication and collaboration. The biggest issue on the community resuscitation side is communication—either with the control or the dispatch—and maintaining contact with the individuals involved. Without that, they do not have the support or the requirements that we, as ambulance staff, would need. That is a developing area. Our information technology department is heavily involved in that at the moment.

Helen Eadie: Is that more to do with the capabilities of radio signals and so on? On my way here yesterday, I used my hands-free mobile phone and lost the signal two or three times. Is that the issue?

Keith Cameron: I am directly involved in community resuscitation and that is one of the biggest issues that we are looking into, simply because we sometimes struggle to dispatch the first responders—they might be using their own phones—and to keep in contact with them. In certain areas, if the mobile phone system goes down, it is a bit hard to overcome the issue directly or quickly enough. We are considering many further ways in which we can overcome the problem.

Helen Eadie: How might the problem be overcome? Is it a question of more investment from the mobile phone companies? What would help?

Keith Cameron: First, we are looking at different networks in different areas, so that we have more cover. Also, community resuscitation development officers—I am one—are looking at new smart phone technology, which has recently been investigated and is being assessed; it will allow us directly to supervise, manage and have locations for every first responder who has such a phone. That technology is being developed and we are currently investigating it with a view to having it run out nationwide, if finances permit.

Helen Eadie: Does it have a big price tag?

Keith Cameron: I think that each unit costs approximately £1,000.

Helen Eadie: That is not so bad.

Keith Cameron: That depends on how you look at it. We are looking at having one or two per scheme, which becomes quite expensive.

Helen Eadie: What would the figure be?

Keith Cameron: I am involved in east central and I have 14 schemes. At any one time, there is a minimum of 50 to 60 first responders.

The Deputy Convener: Does anyone else want to comment on the lack of telecommunications before I move to the second question?

Roy Macpherson (Wester Ross Medical Practices Community Representatives Out-of-hours Group): It is worth adding that broadband coverage links in in the same way. With the probable introduction of telemedicine in the near future, the sooner that broadband coverage improves, the sooner telemedicine will progress. That ties in with coverage for mobile phones and so on.

Tom Forrest (Wester Ross Medical Practices Community Representatives Out-of-hours Group): Is the Scottish Ambulance Service going on to the new Airwave system that is being run out across the country?

Keith Cameron: All the ambulances have been fitted with Airwave technology; it should be going live this year. A few technical issues are cropping up, but it is coming in.

Tom Forrest: When that comes in there will be a much better system overall.

Keith Cameron: It will help with the dispatch of ambulances. It is a bit more difficult with regard to first responder communications.

Rhoda Grant (Highlands and Islands) (Lab): Can someone explain what Airwave technology is?

Tom Forrest: It is apparently a telephone-led system. I believe that Vodafone has been tasked with making progress on its implementation; it is putting masts up all over the place—four or five have been put in our area recently. From what I can gather, it is taking over from the radio system. It will be a mobile-telephone based system.

Keith Cameron: That is right. It is to be a telephone-based system. It is the same system as the hand-held one that the police currently use. We are looking at altering it a wee bit for our use.

Randolph Murray: I want to mention that, at our house at Camghouran, which is on the south side of the loch, eight miles along from the village, there is no mobile phone coverage at all. Recently, and previously, ambulances have had great trouble finding people. The global positioning system does not seem to work and there has been a lot of misdirection as a result. That is certainly still a problem.

Mary Scanlon (Highlands and Islands) (Con): I, too, thank the petitioners for bringing us here. What we are uncovering is certainly helpful in examining out-of-hours services in rural areas throughout Scotland.

I would like to ask the two panel members from Kinloch Rannoch about the situation. NHS Tayside's submission states that its provision of GP out-of-hours

"cover to Kinloch Rannoch is within a framework that meets and exceeds the legal, regulatory and inspectorate requirements and standards".

According to NHS Tayside, you have a service that is not only adequate but which exceeds expectations. That seems to me to be at odds with the community's experience. Do representatives of the community agree with NHS Tayside's submission?

10:15

Randolph Murray: We do not. The interesting evidence that was given on the NHS Quality Improvement Scotland standards at your last meeting made perfectly clear the fact that NHS QIS deals not with the receipt of quality service on the ground but with systems and processes.

QIS standard 1(a)4 refers to geography, among other things. However, QIS reports on accessibility consider, for example, whether disabled people can access a service. They do not take account of geography or terrain. That means that the QIS standard is meaningless with regard to Rannoch, because it does not take into account our remoteness and the geographical situation here.

Dick Barbor-Might (SOS Rannoch): I echo Randolph Murray, but would add a couple of points. At your meeting last week, Professor Pollock drew attention to problems around the collection of data. There are also problems in relation to the cost of these services, which we might discuss later.

As a lay person, it struck me, from reading the NHS 24 documentation as well as what NHS Tayside has said and the letter of 11 October from the Cabinet Secretary for Health and Wellbeing, that there is a worrying reliance on the notion of quality standards that, as Professor Pollock was saying, are not fit for purpose. I am not absolutely sure about this but, on the face of it, the quality standards quite rightly cover various criteria that are to do with equity, fairness and quality but they do not seem to cover geographical inequality. That is the nub of the issue. Kinloch Rannoch used to have a 24/7 general practitioner service but no longer has one. Places such as Gairloch, other places in the Highlands, Grampian and the islands—probably 50 or so practices altogether—are also remote. It seems that the system allows rather arbitrary decisions to be made about who is and who is not included in the local GP out-of-hours service and will, therefore, have to rely on NHS 24.

Friends and neighbours of mine have carried out research, or unofficial monitoring—which is outlined in Mr Murray's submission—that shows that there have been quite distinct failures locally. That record of failures and of things that simply have not happened when they should have—which is not the fault of the NHS 24 staff, who are dedicated people—is absolutely at variance with the claims that are being made on behalf of NHS 24 on the basis of the official record, which we know for systemic reasons is highly problematic and insufficient. We have ended up with what some of us feel is an almost systemic failure, which is attributed to the loss of the GP out-of-hours service and the over-reliance on NHS 24. I suspect that that is down to the problems with this area that were highlighted last week by Professor Pollock, Mr Heaney and others. The result is a tremendous amount of distress. Such cases keep on cropping up—perhaps we will be able to talk about that later. The last one that I heard about occurred on 27 December, I think, when Kinloch Rannoch was pretty snow bound. There is a big discrepancy between what local people know and what is officially stated in the records.

The Deputy Convener: Does any other witness wish to add to that before Mary Scanlon asks her supplementary?

Tom Forrest: I cannot quite work out what we consider to be remote. I consider our area in Wester Ross to be remote. From driving down to Kinloch Rannoch yesterday and from the research that I carried out before coming here, I note that there is a hospital in Pitlochry and another in Aberfeldy. Although they are both partly part-time manned, 24-hour cover is provided in Pitlochry and I believe that Aberfeldy is covered in the evenings. There are two rapid-response vehicles, one in Pitlochry and one in Aberfeldy.

The situation with us, in what I consider to be a remote area, is that we do not have a rapid-

response vehicle. Our nearest hospital is in Inverness, which is 100 miles from some parts of our area and 50 miles from Kinlochewe, which is about the closest location in our working group patch. At night, our nearest GP is 37 miles away. From looking at the provision in Kinloch Rannoch it seems that it is very well served.

The Deputy Convener: Last week, the committee was conscious that different communities, whether rural, remote rural or island, have different characteristics. We are trying hard not to play one community off against another but to discern, through evidence and questioning, what an adequate standard of provision might be. As has been mentioned, Tayside NHS Board claims that Kinloch Rannoch's provision is in excess of what is required, whereas the witnesses take a different view, to put it politely. That is what today's meeting is about. We accept that different areas have different degrees of rurality and that greater rurality accentuates the problem.

Mary Scanlon: A good point has been made about Wester Ross but, as a Highland MSP, I know that it is fair to say that the area has not been without its problems in the past—it has had single-manned ambulances, for example—but its residents have been listened to by NHS Highland and a good working relationship now exists, which is highly valued.

We have an excellent submission from the Scottish Ambulance Service. I do not wish to read the whole thing out, but it states that

"decision-making around the appropriateness of referral route ... is inconsistent",

that

"the Ambulance Service is filling 'gaps'",

and that

"Provision is inconsistent ... across Scotland."

Dick Barbor-Might's point about standards relates to my questioning at last week's meeting. NHS QIS and Audit Scotland are now to review out-of-hours provision because there are no standards for patient care—there are standards only for processes. If nothing else, the committee's inquiry has moved that issue on.

Given that the impetus for our being here is the petition on provision in Kinloch Rannoch, why do local people think that the current out-of-hours service is inadequate to serve the needs of the population?

Randolph Murray: Because there have been numerous cases of distress as a result of the system not working. We have been told that an ambulance can get here from Pitlochry or Aberfeldy in 31 minutes. That is ludicrous—the experience of people in Kinloch Rannoch who have had to call an ambulance is that it has regularly been two to three hours before one could come. There have been cases in which people have had to drive their sick relatives to hospital because that has been preferable to waiting for an ambulance to come.

As a result of those mishaps and the unsafe system that we have through not having a doctor, people in the area bypass NHS 24—we do not use it. I can speak personally on the matter. Three times in the four-year period since opt-out was allowed, I have needed medical attention. The first time, I used NHS 24 and it did not work. We were supposed to be directed to the local doctor, but the system did not recognise that. My wife drove me to Pitlochry. A doctor had to come from Perth to Pitlochry to see me and was furious at having been brought there. The fault in the system was that the local doctor should have been contacted but was not. That was under early NHS 24 arrangements.

It is interesting that the hub system specifically recognises the rurality of our area, but that was the system that let us down. The definition of the hub states:

"Patients in Kinloch Rannoch and surrounding areas are covered by Kinloch Rannoch Medical Practice who provides services for these patients due to the remote location and the length time and mileage to the nearest PCEC."

Remember that that was in the interim period after opt-out was allowed, but when Dr Simmons was still providing cover.

At this stage, there is no local confidence in NHS 24. Time and again, people will either get neighbours to attend to them or drive their relatives to hospital or take their own measures, because of the inadequacies of the service. That is the situation here. The statistics that NHS Tayside produces are totally unreliable and unrealistic in relation to Rannoch—they are phantom statistics. For every case that is recorded by NHS Tayside, there is probably another one that is not recorded. It is as bad as that.

Roy Macpherson: I accept that comparisons are invidious. The report on the Wester Ross out-of-hours service shows a positive improvement in the service since it started. Like the previous speaker, I have been unfortunate enough to have to use NHS 24 on three occasions. As Liz Pritchard said in a report to the committee, the improvement has been positive throughout.

At the beginning, NHS 24 provided agency doctors at weekends, but positive attempts have been made to get doctors who are familiar with the NHS Highland area. Many of the original complaints about OOH services through NHS 24 were a result of agency doctors—they were not

medically unable to deal with the emergencies, but they were unfamiliar with issues such as the distances, the terrain and getting to patients. Personally, I had no problems, but that was because I live in Ullapool, which is the hub for our practice area.

I did not realise that the Ambulance Service would be mentioned, although I suppose that it is an integral part of NHS 24. A public meeting was held in Ullapool about three or four months ago at which the Ambulance Service was represented. It strikes me, and it struck people at that meeting, that the number of ambulances that are based in Inverness to cover the west Highlands and the Inverness area is too small. That comes down to finance. There was an incident in Ullapool the week after new year. As I said, there has been a distinct improvement in the public conception and understanding of NHS 24, but a non-Highland agency doctor was on duty the week after new year. An ambulance was needed and although an ambulance is based in Ullapool, it was not available and the patient had to wait over an hour before being taken by car to Raigmore. It is unfortunate that that might somehow blight the improvements to NHS 24 that have been made in our area. The ambulance service is doing its best, but if there are no ambulances, it cannot provide cover.

10:30

Dick Barbor-Might: I would like to call in evidence from NHS Tayside, which is in my submission to the committee. It is important to note that from April 2004, when the new general medical services contract began and 95 per cent of GPs in Scotland or the United Kingdom opted out, NHS Tayside had to consider its responsibilities as a health board. It made a clear decision based on the geographical fact of remoteness that local GP out-of-hours services had to be maintained—that was its definite and considered view.

Dr Russell is the current medical director of NHS Tayside, but back then Dr Russell and Dr Meikle wrote an interesting and, I think, very good, memorandum in which they argued that, for reasons of geography and because of the familiarity of patients with local GPs, but mostly because of geography, the 24/7 service had to be maintained. They were opposed in that by Dr Simmons, the then incumbent, who was strongly supported by Dr Buist, from whom you heard last Wednesday, who represented the BMA and Dr Simmons at that point. The assessments panel decided in favour of Dr Buist and Dr Simmons and against Tayside. However, the Tayside health board continued to take the view, despite Dr Simmons's opting out, that the area is remote enough to require a 24/7 GP service. The medical practice vacancy notice advertising for Dr Simmons's successor that was issued while Peter Bates was still chair made it clear that maintaining out-of-hours provision was a core element of the post. Vacancy notices also said that it was a requirement that GPs should reside in or in the immediate vicinity of the village. In the event, however, just after Peter Bates, who was very ill, stepped down, and Mr Sandy Watson took over—perhaps that is or is not the explanation—the panel, which was made up largely of Tayside people, trashed its own specification and appointed the one candidate on the shortlist who refused to provide any out-of-hours service.

Under Peter Bates's chairmanship, with Dr Meikle and Dr Russell stressing geography, NHS Tayside had a proper understanding of the situation. With reference to what Roy Macpherson from Wester Ross said, it seems to me that there are degrees of remoteness, but just because one place is very much more remote than another is not a reason to deny us some sense of justice. NHS Tayside originally had a clear understanding of geography and then it trashed it. That is an example of a dreadful incoherence in policy. With respect, it should not be possible, because of a change of chairmanship or for some other reason, for the geographical consideration, which is about equity, simply to be thrust to one side. That is what happened in our case.

Mary Scanlon: Apart from the remoteness issue, Tayside health board and its community work together to address their difficulties. I am sad to hear that trust and confidence in the out-of-hours service has been lost. I hope that, as a result of this inquiry, we get back on the road again.

Ian McKee (Lothians) (SNP): I was impressed by the small statement in the Wester Ross submission that we are dealing with "patients not parcels". One of the factors in the fog that surrounds the provision of medical care for remote and rural areas is the fact that any solution that makes the population we serve highly discomfited either is not the correct solution or has not been presented in the right way.

The last time that the committee took evidence, we all seemed to agree that the ideal, which might be impossible to realise, is to have our own GP on 24 hours a day, 365 days a year. It was accepted that that is no longer possible, because people have different standards for living their lives, and so on. NHS Tayside told us that, when it advertised for a GP for Kinloch Rannoch, no person who applied offered to give the service and, in the end, the health board came to the solution that you know about.

On the other hand, the Wester Ross submission showed that there are ways of getting more local GP input, which has the advantage of providing continuity and of allowing people to get their prescriptions when they want them instead of having to go to a town—to Pitlochry, as it would be in this area. Could Tom Forrest and Roy Macpherson say a bit more about how their areas manage to have a local GP providing a service most of the time? It seems that you might get cover for the weekend, but the local GP provides 24-hour cover from Monday to Thursday. Does that model appeal to the people from Kinloch Rannoch?

Tom Forrest: Ian McKee is correct. Our local GPs provide 24-hour cover from Monday to Thursday. For the past eight to 10 years, we have operated a system whereby the two practices, Torridon and Lochcarron, work together. One night, a nurse will be on in the Torridon practice and a GP will be on in the Lochcarron practice, and the next night a GP will be on in Torridon and a nurse will be on in Lochcarron; they alternate nights. That has been happening for a number of years, and it is a very successful and safe solution to the problem. We are encouraging the other practices along the west coast to carry out a similar process. I believe that they are looking at that at the moment.

Ian McKee: District nurses in rural areas are highly skilled people, are they not?

Tom Forrest: Indeed, they are very professional. We now have a number of first responders. During the recent snowy period, we had a bit of a problem with that because the first responders were snowed in and unable to get out, so one first responder covered the entire area for four days—successfully, I might add.

Roy Macpherson: Ullapool is a centre of population. There are 2,500 people on the practice's roll but, in summer, the practice's population goes up to about 24,000 to 25,000 because the hotel beds and holiday homes are full. The winter service and the summer service are chalk and cheese. Also, the Ullapool practice is in a centre with a pharmacy and all the support services.

Elsewhere, Scoraig now has a population of 89, and it can be approached only by boat, so someone from the Ullapool practice has to go about 26 miles by road, take a small boat and then walk in to Scoraig. With the population now being 89, that puts a bit of a strain on the local practice.

Most things are now settling down and a lot can be done. Any diminution of service would be a dreadful blow to the community. Given the way in which we are now heading, I hope that the service will gradually improve.

The Deputy Convener: Who would like to pick up on those points? I am conscious that I have not afforded Linda Entwistle an opportunity. I am not pressing you, however.

Ian McKee: I was about to ask Linda Entwistle about first responders.

Linda Entwistle: Tom Forrest said that in Wester Ross they rotate between having a nurse on in Lochcarron and a doctor on in Torridon, and a doctor on in Lochcarron and a nurse on in Torridon. What is the mileage between the two places?

Tom Forrest: Thirty-seven miles, but we cover quite a considerable area beyond that. Applecross still has its own 24/7 cover from its GPs, but it will become a problem shortly, because one of the GPs is about to retire and, under the legislation, the other one will not be allowed to work 24/7.

Linda Entwistle: You have first responders, GPs and nurses and they all seem to work together well. Do you feel that the model is successful?

Tom Forrest: Indeed, yes. We have now been going for eight years—for six years as the group. We have found that, all along the way, we have consulted, not confronted. Consultation, rather than confrontation, is the key word. If there is a problem, we speak to the local health board, the local ambulance service or whatever. We have a good relationship with all the medical services in the area.

Dick Barbor-Might: The original question was what we in Kinloch Rannoch would make of that and other models. They are enormously interesting to us. Although I have not done any travelling, I have talked to a number of people, including Dr Helen Stewart and Dr David Murray of Lochcarron and Torridon, and Randolph Murray and others have been to Applecross to talk to people there. We are enormously interested in the model. I talked to Dr Paul Kettle, who gave evidence last Wednesday, which was fantastic and very interesting. We are very interested in either successful models or models that are struggling into existence. For us, the fundamental entitlement to good-quality health care translates into 24/7 GP cover plus whatever else—first responders, for example. We are very interested in what happens to meet that entitlement successfully in other places.

I was struck by something that the local GPs, Dr Murray and Dr Stewart, said. They are sort of like Box and Cox—they support each other. David Murray said that, in making the necessary calculations as to costs, people tend not to look at the financial savings that can be made in secondary care by having a GP locally. That might happen in NHS Highland, but it certainly is not

happening with us. We are also struck by the history. The Highlands and Islands medical service started in 1913 and brought doctors and nurses to the crofting counties. It worries us when that service is given up in favour of some other model in remote places. The model of 24/7 GPs plus others seems dynamic and progressive. It is not, as Dr Buist suggested, something impossible from the past—lovely but hopeless and a sort of golden ideal; it is being worked on as we speak. There are 50 or so practices in the Highlands and Islands. We think that it is a very good model. It is developing. There are problems and difficulties, but we think that that is where to look.

Randolph Murray: I want to correct Dr McKee. When the job was readvertised by NHS Tayside, it was made plain to us that the return of 24/7 out-of-hours responsibility was part of the deal. In fact, we had a note from Shona Robison, which was sent to our MSP, John Swinney, which said that it was

"understood that the current post holder in Kinloch Rannoch had indicated that he would be retiring. He also understood that NHS Tayside were committed to striving to attract a new principal practitioner who would take back the responsibility for providing out-of-hours cover."

Of course that was reflected in the specification in which three items were very important. First, on the area of residence, it said:

"The successful applicant(s) will be required to reside in or in the immediate vicinity of Kinloch Rannoch."

The second was that out-of-hours care

"will be a core component of the specification. NHS Tayside will work in close partnership with the successful applicant with a view to seeking innovative solutions to the provision of out of hours care."

The third aspect was that funding would be in place for that to happen—that comes under item 7 of the specification, according to which,

"Entitlements under the 'Payments for Specific Purposes' section of the Statement of Financial Entitlements (e.g. Seniority Payments, Golden Hello Scheme), will be made based on individual circumstances and are over and above the payments"

for out-of-hours cover. And if there—

10:45

The Deputy Convener: Mr Murray, if you wish to correct Mr McKee, what he said was that no one applied in relation to that specification. Mr McKee did not suggest that that was not the specification; he was suggesting that no one applied, in the end.

Randolph Murray: But that is not the case.

The Deputy Convener: I ask you to correct that, then. The earlier bit was not contested by Mr McKee.

Randolph Murray: That is what was in the spec.

The community was pressing for the restoration of 24/7 cover and we were told at the time that there was substantial interest in the post. Eventually, three people on the short leet were interviewed—we have the working papers following a freedom of information request. Two of the people were offering out-of-hours cover, albeit not total cover. One of them was offering total out-of-hours cover during the week; the other lady was prepared to go into a co-operative to offer out-of-hours cover. The question is whether a co-operative arrangement would have been appropriate, given the remoteness of Rannoch, although that is a separate matter. In any case, those two applicants were both offering a degree of out-of-hours cover. Remember that "core component" might mean a substantial, essential element of cover rather than comprehensive cover.

Despite all that, NHS Tayside decided to appoint the one practice that offered no cover whatever. The practitioners said that they would not be prepared to offer it on ethical grounds, because they did not give it to their patients in Glen Lyon. That was stated specifically. In a way, that practice should have been disqualified at the outset.

The Deputy Convener: The committee is very sympathetic regarding the difficulties that have arisen as a consequence of all that, but I am bound to say that we are where we are, and our purpose in this inquiry is to find out how to progress, following what happened. We are anxious to discover what type of solution might be capable of being taken up, both here in Kinloch Rannoch and throughout remote rural and island Scotland. We are very conscious of the difficulties that have arisen, including the one that you have just eloquently described. However, we are not here to be the judges of what NHS Tayside did or did not do. This parliamentary committee is here to look forward and to establish, based on experience, how we might take things forward. I hope that you understand that.

Randolph Murray: I do.

Ian McKee: Without going further into the matter, I have been quoting from the evidence that we have received—it is somewhere in this sheaf of papers from NHS Tayside. Whether or not the information that we have been given is correct is perhaps a matter to be decided at another forum.

I will move on to the role of community nurses in so-called remote and rural areas. My experience of another remote and rural area that I know well is that, de facto, the community nurse is the first person who is consulted on everything. In that instance, the GP lives 20 miles away but the

community nurse lives in the village, and everyone contacts the community nurse first. Is there some mechanism whereby, to allow a GP time off on some occasions, the nurse could be the person whom people contact formally, and that nurse could use whatever backing arrangements exist in Pitlochry, for instance? Would that be acceptable, or is the idea of contacting a nurse rather than a doctor anathema?

Linda Entwistle: Kinloch Rannoch does not have a community nurse living in the area now, but there is a district nurse out-of-hours service. That service can come to Rannoch, but there is no community nurse residing in the village.

Ian McKee: But I am thinking of the principle in general terms, rather than whether or not there is a community nurse here.

Linda Entwistle: I beg your pardon.

Ian McKee: Would people be happy, or would they consider it a lesser service, if they contacted a very experienced nurse who knew everyone in the area?

Tom Forrest: Over the past eight to 10 years, our local nurse and doctor have worked together covering each area, and we have found that system to be very successful. As far as distances are concerned, the district nurse is 15 miles away from where I am located and has to travel along quite a narrow single-track road, which recently was blocked for about 36 hours and, indeed, can also get blocked if something decides to part company with the road. Unfortunately, such problems are a fact of life.

That said, the system could be expanded. We have discussed at length—I believe that Mary Scanlon attended the meeting—the knock-on effects of having doctors in Lochcarron, Gairloch and Ullapool and nurses in between; for example, there might be three doctors on at one point, two doctors and three nurses on at another and so on. However, one of the main problems with that approach is that Ullapool has quite a large population and needs a GP 24/7. I should add that first responders have also made a difference to cover.

Randolph Murray: It is very important to have a nurse as a back-up. As a generalist, our previous district nurse was extremely useful, but there is a tendency not to replace such people.

The three essentials are the ability to examine, the ability to diagnose and the ability to treat patients. The point that I really want to get across is that, as the doctors from Hoy and Lochaline made clear at last week's committee meeting, diagnosis is integral to that whole process and that what is really needed is a diagnostician. If the nurses are equal to doctors in their ability to diagnose, that is fine; if not, we need a doctor first and foremost for primary care, not a nurse.

Tom Forrest: The hope is that with telemedicine, on which we have been working for some time now, this problem with nurses and doctors can be overcome quite easily. When a nurse visits premises, all she will really need will be a phone line and an internet connection for her laptop and she will be able to get a doctor in whatever part of the country to carry out a consultation. It will be quite a good system if we can ever get it off the ground.

The Deputy Convener: You have the committee's backing for that. We continue to be very exercised about the lack of progress in introducing telemedicine. You say that it could happen; of course, you have mentioned three things, in particular the broadband connection, that might make that difficult.

Tom Forrest: When, in Wester Ross, we sent out six nurse practitioners to do their job, all but one of them said, "This is not for us," and simply gave up. You have to be very dedicated to get through the course.

I dare say that, in a lot of areas, another inherent problem is accommodation. We could probably support a few more nurses in our area but, because the health boards have sold off all their houses and so on, we simply do not have any accommodation for them. Doctors face similar problems. Our doctor in Torridon lives 27 miles away in Kishorn because she cannot get a house in Torridon.

Keith Cameron: I have a comment to add to the point about nurse practitioners. The ambulance service is incorporating paramedic practitioners who go through the same course and have the same skills set as other staff. They are also involved in the rapid response units. Not only can they do more diagnosis and telemedicine should it be required, they are also emergency drivers. They can get here from Pitlochry in less than half an hour. I have done that in my vehicle.

Ian McKee: The difference is that I was trying to find some way of keeping the continuity with the local community. A district nurse who works in a community knows the history of certainly all the chronically sick people there and has their confidence. Someone who comes from a long distance away, however well trained they are, does not have that knowledge and therefore does not have the same bond with the people whom they look after.

Roy Macpherson: Each area is different and has its own problems. We cannot compare what happens in Ullapool with what happens in other parts of Wester Ross, although we all have certain problems. The bottom line is that we all have to

get to Raigmore and the distances are considerable. People in Ullapool are well served by their practice, but there are four separate communities attached to it. Achiltibuie is at least 35 miles away. I have already mentioned Scoraig. Dundonnell is about 30 or 35 miles from Ullapool, and the lochside—that will not make sense to anybody here—is another community of about 250 people that is difficult to reach. Our practice and the NHS have to face up to the problems and cope with them.

The use of ambulances is one thing that could be improved. That is not the fault of the ambulance service. It is the fault of the number of ambulances that are available to serve our community, and of the road system, especially this winter, because it has been virtually impossible to get anywhere. Let us hope that it is an exception.

Dick Barbor-Might: Murdo Fraser MSP has raised an interesting point. I apologise for my partial-sightedness, but is he here?

Murdo Fraser (Mid Scotland and Fife) (Con): Yes, I am here.

Dick Barbor-Might: As a local MSP, you have drawn attention to problems with the ambulance service here. Again, I mean no criticism of the staff, but there has been something of a reduction in the service. The problem of not having a GP available out of hours cannot be looked at in isolation from the level of the ambulance service. It is perhaps worth putting that on the record.

It is a tremendous thing to have a community nurse. We have lost our local nurse. Somebody made the point that it is helpful to have a nurse who has direct personal knowledge of their patients so that there is continuity of care. That is absolutely right, and the same thing applies to local GPs. The problem is that they are not available 24/7. The practice here provides an excellent daytime service. It has excellent, committed GPs and it cannot be criticised. However, when the doors of our dispensing surgery close at 6 o'clock, or whenever it is, on a Friday, the nearest pharmacists are in Aberfeldy and Pitlochry, which is the other small country town. Over long periods at weekends and overnight, we lose the direct understanding and sympathy with the patients that the diagnosing GP has, and we also lose their knowledge of every last little track, which even satellite navigation cannot always master. Continuity of care through locally based nurses and GPs is critical.

11:00

Rhoda Grant: In evidence last week, the Royal College of General Practitioners stated clearly that the only safe out-of-hours service is one delivered by GPs. We have received other evidence that gives a different view. We have also received evidence on the service that the Scottish Ambulance Service provides. Some health boards say that the out-of-hours service does not need to respond as quickly as people would wish because the Scottish Ambulance Service should respond to emergencies. I am keen to find out what you think is the best minimum service, based on outcomes rather than what is in place at the moment. People see what is in place in their community and try to work around what they already have, but I am keen to know what you see as a minimum standard for response levels, both out of hours and in emergencies.

Tom Forrest: In our part of the country, three ambulances are based around the county at great distances—about 57 miles—from one another. If one goes, we have big problems and, in an emergency, must wait for another to come from outside the area. In my view, we should go back to the idea of the old district nurse. With the best will in the world, GPs cannot work 24/7. GPs are human beings and must have time off. If a practice has only one GP, there is no way that that person can be expected to work 24/7, 365 days a year. It is inevitable that people will have to come in from outside to provide cover. Having more nurses on the ground—nurse practitioners with dispensing capabilities—would probably be a solution to the problem.

Dick Barbor-Might: Minimum standards come down to geography, which is my deep motif. One size does not fit all—degrees of remoteness are critical in working out what kind of service is required. A great friend of mine, Dr David Player, who is now quite elderly and used to be a director of public health and a GP in places such as Banff and Islay, has submitted a comment on the e-petition, which is among the committee's papers. I have sat at David's feet, so to speak, and he has told me about the ideal situation—the combination of the doctor and the nurse, which works so well in the Highlands and Islands medical service. It would be unfortunate to exclude one in favour of the other.

I echo Randolph Murray's point that, although it is invidious to make a choice, doctors have years of training. Rural doctors have training as GPs; I understand that nowadays they are also being trained specifically as rural GPs. As Allyson Pollock said last week, a significant minority of GPs, including quite young people, are prepared to take a bit of rough with the smooth. The rough is being bound to the job to some extent 24/7, but the smooth is enormous—for all sorts of people. In Applecross, when an associate GP was needed to back up the principal GP, the post was advertised imaginatively in places such as outward bound, rock climbing and sailing magazines. A considerable number of high-quality candidates

responded, and a doctor called Mark something, who is in his early 30s and has been in places such as Borneo with the Army, was delighted to be appointed.

Here in Kinloch Rannoch, as in Braemar—I have talked to the Braemar GPs—we had a principal and an associate GP, who could Box and Cox. It is important to make that point because of what Dr Buist said last week. Although the work was demanding, the GPs had time off. When Dr Simmons and the associate GP were at the assessments panel hearing, at which Dr Buist was also present, a locum was brought in—far from Dr Simmons being utterly tied down in a dreadful way. It simply is not the case that a GP never gets time off; there is the rather good model of the principal and the associate.

We have heard about other models, of which committee members will be aware. For instance, in Durness and the Kyle of Tongue area in the north of Scotland—I talked to a GP there—three GPs work between two practices, meaning that each practice has 1.5 GPs. They cover for each other 24/7. That is not ideal, but it is an imaginative, sensible and intelligent use of resources. There are innovative and excellent solutions, some of the best of which were probably being worked 50 or 60 years ago or 20 years ago. There is not a closed book on having 24/7 cover; it is an excellent and necessary service, and it is nothing like as expensive as you were told last week.

I spoke to Dr Paul Kettle, who gave evidence to you last week, after the meeting and we discussed the vexed question of costs—£556,876 is what the chief executive and deputy chief executive of NHS Tayside told their board in November 2008. From talking to GPs in NHS Highland, we have come up with the much lower figure of about £140,000 based on paying £18 an hour, not £50 an hour. In part of NHS Highland, £10 an hour is being paid. Paul Kettle sent me an e-mail—no doubt, supplementary evidence could be provided if you wished—in which he said that he is aware of GPs who are paid £50,000 extra a year or less.

If the question is whether the service can be costed and afforded, the answer is that, yes, for relatively low amounts of money an excellent service can be provided that meets all the criteria for diagnosis. There are GPs who are happy and willing to provide that service.

Tom Forrest: I want to clarify my last point about nurses. I was not advocating that we dispose of the services of the GP in the area to which I referred. I was talking about the system that we operate in our area, whereby we have a nurse and a doctor on at any given time as well as our first responders. I was suggesting that there could be a few more nurses dotted around the area to give everyone a bit of a break.

The Deputy Convener: Helen Eadie wants to ask a supplementary question on that issue. Can you be brief, please? I am anxious that we are a bit tight for time in this session and Murdo Fraser still has a question to ask.

Helen Eadie: I seek clarification from Dick Barbor-Might on his costings. If I remember rightly, the Scottish Parliament information centre briefing papers that we were given last week quoted figures anywhere between £50 an hour and £150 an hour, taking into account payments on holidays and at key vacation times. Would you like to clarify the situation?

The Deputy Convener: Can you keep your answer reasonably brief, please? Randolph Murray and Roy Macpherson want to speak on broadly the same point.

Dick Barbor-Might: Would it speed things along if I were to send a note or supplementary evidence to the committee, amplifying what I am about to say?

The Deputy Convener: That would be very helpful indeed.

Dick Barbor-Might: Thanks very much, convener. I will be brief in my response just now.

As far as I can establish—I am a layperson, but I have made as many phone calls as I can and have read what I can—there appear to be two completely different sets of emoluments. I may be wrong; forgive me if I am. One set appears to be for doctors who work for NHS 24, and it could be described as generous. I understand that £50 an hour is the weekday rate, which goes up to well over £100 an hour at weekends and on bank holidays. I have heard of GPs who have given up being GPs in order to take that work or who amplify their incomes in that way.

Helen Eadie: So how do you arrive at the figure of £10 an hour?

Dick Barbor-Might: That is the second set of emoluments. NHS 24 doctors cover huge areas and have drivers. A local GP who covers their own practice area in hours and, in the case of NHS Highland, takes a separate out-of-hours contract is paid—according to the GPs whom I consulted, and I stand to be corrected—either £18 or £10 an hour for being on call out of hours in their own practice area.

Those rates would give roughly £140,000 a year at £18 an hour and £80,000 at £10 an hour, because there are always bits and extras to add in. However, according to Dr Paul Kettle, in his experience in Orkney and elsewhere, the rate that is actually being paid is vastly lower—it is £50,000 a year or even less. In other words, health board co-ordinators who are committed to doing their job to provide the service but with all due economy do

not pay £556,876 a year—the cost that NHS Tayside claimed—and they do not necessarily even have to pay as much as £140,000 a year. The costs can come down.

With great respect to Professor Pollock, I totally agree that there is an issue of entitlement, but if a health board is faced with the statement that it would cost more than £0.5 million a year to provide the service it might well decide that that is too much. That is how Tayside health board was advised or instructed in November 2008—that it should make its decision on the basis of affordability.

I will return to the narrow point. As I say, I am a lay person but, with great respect, I suggest that we seem to need a differentiation. On one side, there are the rather generous amounts that are paid to NHS 24 doctors who have drivers, as cited by Dr Buist. NHS Tayside claims that there are drivers for local GPs who provide on-call services, but nobody whom I know knows about that. On the other side are the much more modest rates that can be achieved by health board co-ordinators who are committed to providing a service with realistic figures. That approach could make the services fairly affordable.

The Deputy Convener: If you could take the time to set out that information and submit it to the clerk, that would be most helpful.

We will have two final quick comments on Rhoda Grant's question—first from Randolph Murray and finally from Roy Macpherson—before we take Murdo Fraser's question.

Randolph Murray: I want to correct a misunderstanding that clearly still exists. In Rannoch, Dr Simmons had an associate. They worked on the basis of two weeks on and a week off, so the associate would come in every third week and she could also relieve him for out-of-hours work. There was no question of a single practitioner working himself into an early grave week after week, which was the suggestion that Dr Buist made in his evidence to the committee last week. We were amazed that he did not mention that Dr Simmons had an associate as well as the benefit of the previous doctor, who was retired but frequently called in as a locum.

An article that Mr Finnie wrote and which was published in *The Herald* in January last year states:

"GPs must drive to deliver quality 24-hour healthcare".

He argued that, in appropriate circumstances—perhaps Rannoch and other remote and rural areas of Scotland are the appropriate circumstances—GPs should return to doing that, as it is a mode of operation that has many attractions.

In response to Mr Finnie's article, a letter was published in *The Herald* by a Dr Anne Rosemary Wright from Rothesay, who made some interesting comments that backed up Mr Finnie's point. She said:

"It was naively supposed that, with the new contract and the opt-out, a similar system would continue, with changes being purely administrative. However ... against the advice of the profession, the government had created the behemoth of NHS 24 and was desperate to validate its existence".

She continued:

"The problems of single-handed and isolated small practices have not been made less by NHS 24; where this has been dealt with successfully, it has been by the simple expedient of throwing money at the problem. It has always cost more to supply services to the isolated areas of Scotland and there is no way out of this."

Oddly enough, when Dr Brian Keighley, the new chair of the BMA in Scotland, was appointed, he too said that there might be a return to 24-hour doctoring in appropriate circumstances. *The Herald* quoted him as saying:

"I fear the genie is out of the bottle ... But I lament the fact that if one of my patients gets ill in Balfron, someone else takes care of it."

The article continued:

"The BMA is unhappy at the cost of NHS 24 and Dr Keighley speculates that paying premiums to young doctors to provide out-of-hours cover might be a better model."

There is definitely a constituency in the BMA that says that we must return to what is known as traditional doctoring. Where that is done in appropriate circumstances, the doctors must be rewarded appropriately. That is probably the way forward.

11:15

Roy Macpherson: I will answer Rhoda Grant's question as I understand it. The Wester Ross out-of-hours group met 40 times before it produced its final report; I was a Johnny-come-lately, as I attended only the last meeting. The report, which was written by Liz Pritchard, states:

"The aim was to ensure that any patient requiring unscheduled OOH care could have face to face contact within one hour with a GP"

or other responder.

We seek, in Wester Ross, to get attention for a patient within around an hour. That largely covers areas that are within an hour of the big centres such as Ullapool, although in Achiltibuie it is a push to make the response time an hour.

People who live in remote parts such as Scoraig accept that a doctor cannot get there in an hour and that the doctors in the practice are doing the best that they can. If you do not know about

Scoraig, you should check it out when you get home, as it is quite notorious—well, that is the wrong word; I meant to say that it is quite a well-known place. We are seeking a response within a maximum of one hour, with most responses falling well within that time.

The Deputy Convener: Murdo Fraser will recognise that, within 3 milliseconds of the start of the meeting, established members of the committee had already caught my eye. I apologise for his being last on the list.

Murdo Fraser: Thank you, convener—I appreciate that I am here as a mere interloper on the committee, so I am happy to wait my turn. I am grateful to you for allowing me the opportunity to pose a question.

Many of the points that I wanted to raise have already been covered. I will make one brief point in relation to Tom Forrest's pertinent comment about telemedicine, which is a subject I have taken an interest in. Telemedicine is dependent on good-quality broadband access, and I know from the contents of my mailbag that the local community in this area has major concerns about the fact that many people do not have broadband access of any quality, never mind of sufficient quality to support telemedicine. It is an important aspiration, but it is probably some years away.

I will also ask about one issue that has not already been covered. It arises from NHS Tayside's submission, which states:

"We believe that the issue in Kinloch Rannoch is the community's concern around providing an emergency response—this is very different from providing GP services OOHs."

That is a significant statement, because it underlines NHS Tayside's response to the situation. To deal with the Kinloch Rannoch arrangement, the board has proposed a response that is based around ambulance cover and backed up by first responders. I ask Mr Murray and Mr Barbor-Might specifically whether they agree that the issue is about the emergency response rather than having a GP on hand.

Randolph Murray: NHS Tayside has made the issue the emergency response and not the doctoring, which was probably intentional. However, the two issues cannot be separated.

Emergencies, such as medical episodes that require resuscitation, make up a very small percentage of things that go wrong and need urgent attention—estimates range from 1 to 3 per cent. The other cases consist simply of people who feel ill or fall ill and may not know whether it is an emergency. They need to be seen. The point is diagnosis: people need someone on hand who can tell them whether or not their illness is serious; who can, if the illness is serious, treat them and prescribe something—or dispense something, in the case of a doctor; and who can call for an air ambulance if necessary.

By narrowing the issue to emergency response and simply saying that a first-aider who can resuscitate will do, we ignore the vast preponderance of aspects of feeling unwell that can require forms of treatment other than resuscitation and what emergency aid can provide. A paramedic can deal with a lot of situations, but he cannot diagnose. At some point, a community needs someone on hand locally who is able to carry out the three essential parts of the process: examination through palpation and what you might call touching to see, which cannot be done through telemedicine or over the telephone; diagnosis; and then treatment. A generalist GP can do all that.

Professor Allyson Pollock made all of this clear at last week's meeting. However good and commendable the emergency people are—and they certainly are—they cannot do what generalist GPs do. Indeed, the doctor from Hoy said that he was a generalist. A remote community that is dependent on advice being given on-site and locally needs generalists, and only a GP can play that role.

Dick Barbor-Might: I will keep my comments as short as I can because of time. Your question is very pertinent. I am sorry to witter on about this but I believe that, for us, a lot of the problem stems from the way in which the NHS Tayside meeting on 13 November 2008 was constructed. The meeting was determined by a paper from the health board chief executive and deputy chief executive that contained the costings to which I have referred and set out four options: the status quo; a paramedic in the village, for which there had been little if any demand locally; an out-of-hours GP, which people had constantly called for; and community first responders. Quite apart from the costings—which, at more than £500,000, would have frightened the horses and were in fact wildly out of kilter with all the other figures, which I shall let the committee have a note of—the fact is that the health board was comparing like with unlike.

Let me make it clear that I am not knocking community first responders; indeed, I have great respect for this group of trained and motivated people who are clearly a significant and very important adjunct to the ambulance services. However, to compare that service, in which people receive five days of training or amplified training, with GPs, who have years of training in diagnosis and all the rest of it, is not to compare like with like.

At the outset of the meeting, the chairman, Sandy Watson, told us that the meeting was not

going to discuss the restoration of GP out-of-hours service and that that was water under the bridge—or words to that effect. However, a few minutes later, the GP out-of-hours service emerged as an option, complete with that spurious £500,000 figure. Basically, what the community wanted was shot down by sleight of hand, while the option of community first responders, which is a good scheme, was promoted in a most unfortunate way. That is the nub of the problem. The community first responders service should be seen in its own terms rather than being presented as—and I say with this with great respect for the people who volunteer—something that it is not. That is what happened with us.

Tom Forrest: Research that we carried out in 2006, which provides a breakdown of the requirement for medical services, puts things into reasonable perspective. Of the 900 calls that were made in Wester Ross, which has 6,200 patients, 7 per cent really needed to be seen within the hour; 14 per cent really needed admission—although five of the people concerned were dead, so they did not need to go anywhere; and 10 per cent really needed to see a GP. What that shows is that not all calls require a doctor in attendance.

Murdo Fraser: I was trying to make the point that there is clearly a difference between an emergency response, which is delivered by the Scottish Ambulance Service, and having a GP on hand. We have identified that the community wants to have a GP on hand.

Dick Barbor-Might: I agree, but obviously one does not displace the other. Community first response amplifies the ambulance service, which complements what can be done by a GP or, ideally, a community nurse. One should not be opposed to the other. However, the superiority of the GP element is traceable not only to experience—old, new and current—but to the years of training in diagnostic and treatment skills that GPs have. We cannot afford to lose that in remote places.

The Deputy Convener: I regret to say that I must draw this first session of the morning to a close. In doing so, I express on behalf of the committee profound thanks to all of the witnesses for their contributions. If, on reflection, you think that you ought to have told the committee something, feel free to make further written submissions to the clerk, as Dick Barbor-Might plans to do. I thank those from Wester Ross, in particular. We have been talking about remote travel. Although getting to Kinloch Rannoch has its difficulties, people deserve special thanks for coming to this morning's session from Wester Ross.

I will suspend the meeting for five minutes to allow us to bring forward the second panel of witnesses. I ask everyone, including my committee colleagues, to observe that time limit strictly. I expect the five minutes to be interpreted as consecutive, rather than in any other way.

11:27

Meeting suspended.

11:35

On resuming—

The Deputy Convener: I ask people to resume their seats, please. I am sorry to appear to be hustling you, but in order to give a fair hearing to the second set of witnesses, we must press on.

With that, I have pleasure in welcoming our second group of witnesses. We are joined by Dr Michael Hall, who is clinical director for Argyll and Bute at NHS Highland; Gerry Marr, who is chief operating officer at NHS Tayside; Dr Sheena MacDonald, who is an associate medical director and chair of primary and community services in NHS Borders; Ms Pauline Howie, who is chief executive of the Scottish Ambulance Service; and Mr John Turner, who is chief executive of NHS 24. Members have received written submissions from the witnesses, so I propose again that we move straight to questions.

Mary Scanlon: There is no doubt that the representatives from the Highland group on the first panel have a good working relationship with their health board. I got the impression that that is certainly not the case in Kinloch Rannoch and that the community here has lost trust and confidence in its board. It seems to me from reading the submissions that things went sadly wrong. I hope that the committee's inquiry will help to bring about better working relationships, which is what we all want.

I want to get two questions out of the way, so that we can concentrate on what is ahead of us. It appears that a change of policy took place when Sandy Watson replaced Peter Bates as chairman of Tayside NHS Board, and that GP out-of-hours provision in Kinloch Rannoch, which had been seen as being vital, was more or less dropped after a meeting that took place—I think—on 13 November 2008. There is also a feeling in the community that the provision to board members of an inflated cost figure of more that £556,000, when the cost of providing the service was closer to £140,000, enabled board members to make the decision that led to the lack of provision that we have today. Could we perhaps clear the air on those two issues? Why was £556,000 given as the cost when the real cost is much lower? Why was there a change of policy to drop out-of-hours provision in the area?

The Deputy Convener: Before Gerry Marr answers that question—which is perfectly legitimate—I remind Mary Scanlon and witnesses that this is not an inquiry into what NHS Tayside did or did not do; it is an inquiry into the provision of services in remote, rural and island communities and the principles that are associated with that. I ask Gerry Marr to respond against that background.

Gerry Marr (NHS Tayside): There was no change of policy. What happened was that the expert panel that was interviewing for the service said—quite rightly, in my view—that the most important issue was the provision of GP services to the Kinloch Rannoch community. It was a case of "striving"—one of the witnesses from Kinloch Rannoch used that term—to ensure that, through the specification, an out-of-hours service would be provided.

In reality, the expert panel took the view that the application from the Aberfeldy practice was the best one to secure GP services for the people of Kinloch Rannoch; unfortunately, it could not secure a commitment to out-of-hours provision. In other words, there was no change of policy. The decision that was taken was based on an expert assessment of which was the right practice to provide services in Kinloch Rannoch. As members know, the community is forthright in its praise of the Aberfeldy practice, but the knock-on effect was that we had to reconsider out-of-hours provision. There was no change of policy associated with the change of chairmanship in NHS Tayside.

The costs, as they were drawn up by our accountants, were based on the fact that we were not offering a contract to existing practices. Some of the figures that have been quoted are for practices that have agreed to take on out-of-hours provision for a negotiated sum to enhance their practice income. The £140,000 figure is speculative, but I can expand on that if the committee wishes. I would not even recommend the service at £140,000 because we do not believe that it is the right service to recommend. The figure of £500,000-odd was not pivotal in the decision that the board took on provision of services, and the paper that was referred to by Randolph Murray considered emergency cover for Kinloch Rannoch and not out-of-hours provision, which is a fundamental difference. I am happy to expand on that in the course of giving evidence.

Mary Scanlon: It is helpful to get that on the record; I thank the deputy convener for bearing with me. In your submission you state that the service that is provided here in Kinloch Rannoch is above and beyond what is recommended and that you meet NHS QIS standards and that those standards cover safe and effective care. Will you outline what you see as the basic minimum standard that is appropriate for this area?

Further, we have an excellent submission from the Scottish Ambulance Service that highlights that much more work needs to be done in this area. It says that the

"referral route and outcomes for patients are inconsistent ... the Ambulance Service is filling 'gaps' in provision ... Provision is inconsistent"

and that "patients are confused" about what is the most appropriate service to seek. When talking about the minimum service, will the witnesses comment on those Scottish Ambulance Service concerns?

Gerry Marr: Routine general practice call-outs are stratified into one, two or four hours. We monitor all our call-outs against those standards and there has never been a breach beyond the hours that have been set as the standard response time for general practice. Indeed, we have often made times well within the hour.

The other issue is emergency cover. We are really pleased that the Kinloch Rannoch community enjoys two sources of air ambulance provision; one from the ambulance service and the other from the emergency retrieval service that operates out of Glasgow. Kinloch Rannoch is the only community in this part of the country that has been covered by that service. It is reasonable to say that we have given the area an enhanced emergency response from first responders—that might be mentioned in later evidence—right up to two potential air-ambulance response sources.

Pauline Howie (Scottish Ambulance Service): The Scottish Ambulance Service is responsible for emergency and urgent responses and NHS boards are responsible for providing out-of-hours medical services. We offer a 24/7 service. We have seen a huge increase in our emergency workload over the past five years: indeed, out-of-hours emergency calls from a number of sources have increased by 41 per cent since 2004. In many areas, we feel that we are covering gaps in service provision.

We have sought to work collaboratively with NHS boards and NHS 24 on considering models to fill those gaps, some of which are described in submissions that the committee received, such as the see-and-treat models that we have in Aberfeldy, Angus, Fife, Lothian and many other parts of the country, and the community first-responder models, whereby we work as part of GP practice teams in many areas.

Last year, the remote and rural implementation group submitted a paper that was published by the Cabinet Secretary for Health and Wellbeing, about in-hours and out-of-hours models of care for remote and rural areas. Now we are working with each NHS board to develop local plans to adopt those models, and with communities on what NHS

provision exists, what those communities want, and what they might be able to offer in voluntary help. We are really pleased to be working with communities, NHS boards and NHS 24 in developing those solutions.

11:45

In addition, we are working closely with NHS 24 around triage of calls. As you know, NHS 24 fronts the out-of-hours call-taking service. There are many conditions for which NHS 24 and the SAS feel we could improve referral routes by having other areas to refer people to, rather than always just ambulance provision or GPs. The Scottish Government has commissioned us to develop a more robust and refined clinical triage system, which we will take forward in partnership with patients and other representatives over the next few years.

Mary Scanlon: Your paper states:

"patients are confused ... the traditional role and expectation on GPs as the first point of contact remains."

Is that unrealistic now?

My final question is to NHS 24. The NHS Highland paper expresses concern that

"at times of increased activity ... calls are passed back untriaged"—

which is

"unhelpful, as is the level of 'speak to doctor' advice calls which are required to be assessed by a GP despite passing through the NHS 24 system."

Will you respond to that?

The Deputy Convener: Can you just hold on to that question for two or three seconds while we deal with the first issue, which was the supplementary question to the Scottish Ambulance Service? Just before Pauline Howie responds, it might be helpful if I allow Ian McKee to ask a specific supplementary.

Ian McKee: I was interested in your comment that there has been a huge increase in emergency service call-outs in the past five years, which seems to be fairly coincidental with the beginning of the new GP contract. Do you think that the increase in the number of emergency call-outs is because people have lost continuity of care with their GPs? If that is the case, might not the witnesses on the first panel have a point when they say that one of the advantages of having a GP based in the area was that the extra costs of call-outs, for example, might be avoided?

Pauline Howie: I think the problem is that people are not sure who they should contact out of hours. I say that on the basis of information that we gleaned from a massive public consultation that we undertook last summer, in which we asked people what they wanted from their ambulance service in the future. People told us that they were confused about who to contact for help. They were clear about 999 services but were less clear about some of the other services. That is why we have been working closely with NHS 24 to better triage the calls and open up access to better referral routes that are more appropriate to individual conditions.

Ian McKee: Do you think that the changes that occurred in 2004-05 are responsible for the higher use of emergency services?

Pauline Howie: Our overall demand both in and out of hours has increased by 35 per cent—it has increased by 41 per cent in the out-of-hours periods.

John Turner (NHS 24): It might be helpful if I clarify for the committee our respective roles and responsibilities.

The Deputy Convener: If you manage that, we will be very pleased indeed.

John Turner: During the out-of-hours period, the citizens of Scotland who feel that they have a health need have three options: to contact the ambulance service; to contact NHS 24; or to take themselves to an accident and emergency unit. They should contact the ambulance service in emergency situations. At national level, people who have a health concern that they feel cannot wait until the GP practice opens the next morning should contact NHS 24 during the out-of-hours period. NHS 24 provides telephone triage and assessment.

Some members of the committee have visited NHS 24 services, and I extend an invitation to visit to other members of the committee and community groups who might value the opportunity to meet our staff and see our services, of which we are extremely proud in terms of their quality and the range of provision that we give to the people of Scotland.

When people call NHS 24, we triage and assess them and we pass to the local health board the details of those patients whom we assess as requiring face-to-face care. That health board is responsible for delivery of that face-to-face care, whether it involves GP care, minor injury unit care, accident and emergency care or whatever. I want to make it absolutely clear that there are no such things as NHS 24 doctors or drivers. All the people who deliver face-to-face care out of hours are the responsibility, in the main, of the local health board.

The Deputy Convener: That is a helpful clarification, although it might not assuage the deluge of questions.

Mary Scanlon: I listened carefully and noted that you said that all calls to NHS 24 are triaged. I am on record as saying that NHS 24 has improved enormously since it started up, when there were quite a few teething problems. However, as I said, NHS Highland's submission states that

"calls are passed back untriaged",

which it says is unhelpful, as is

"the level of 'speak to doctor' advice calls which are required to be assessed by a GP despite passing through the NHS24 system."

Those are NHS Highland's words, not mine.

I find that there is a great deal of patient confusion, with questions about who to call, when to call, how to call and what is the most appropriate service with which to get in touch. I understand that there is a pilot project in which the Scottish Ambulance Service is working more closely with NHS 24. Are we moving towards a merger between the Scottish Ambulance Service and NHS 24, or at least towards a closer working relationship? Would that help to clarify roles?

The Deputy Convener: Again, it would be helpful if we could deal with those questions in order. Dr Hall, do you wish to comment on the submission from NHS Highland?

Dr Michael Hall (NHS Highland): I have been a GP in Campbeltown since 1980, providing 24 hours on-call service as part of an extended role in the community hospital, so I have a great deal of experience in this area.

No single model of out-of-hours provision will suit every case. The situation in Kinloch Rannoch is just an example from the many problems that we have faced since GPs were given the right to opt out of out-of-hours provision. I am on record—in *The Herald* many years ago—as completely disapproving of that right. I think that every GP should have some out-of-hours role. The creation of that right is the reason why health boards are now faced with the almost impossible task of trying to sort things out. It is like putting a square screwdriver into a round hole. That said, the problem is not just in Scotland. It is faced everywhere—in Canada, Australia and New Zealand, for example. That is some background information.

Advice calls are just a small part of the work. In my opinion, NHS 24 will triage calls. There is a clinical protocol, which is like a pathway, for people with complaints. At the end of line, it will be said that the person should be seen or that there should be a house visit, for example, or it may not be possible to reach a decision. There should not be any advice calls. If NHS 24 cannot make a decision at the end of the protocol, the patient should be seen.

Mary Scanlon: By a doctor.

Dr Hall: The patient should be seen not necessarily by a doctor, but somebody should see them. Who it is depends on where the person is and what the model of care is. There could be a community hospital in which GPs do 24 hours on call in extended roles, such as those in Campbeltown or Lochgilphead, with emergency nurse practitioners triaging the patients. That is the gold standard of out-of-hours care.

For the most part, house calls should be put in a museum. I discussed that earlier with a colleague. People who are unwell cannot be accurately assessed in a back room with a 40-watt light bulb. I have been there and done that and in modern medicine it is not safe. Patients should be seen in appropriate surroundings. They do not need to have lots of high-powered tests that one might get in a big teaching hospital. Basic recordings can be considered and accurate assessments of their unwellness can be made. Patients can be a bit unwell, but not all patients with chest problems present just with chest problems; they also present with abdominal pain. Although long-term conditions can be managed up to a point, people still become unwell with other problems.

The Deputy Convener: You have taken us into areas that we need to explore further. However, to be fair, I want to invite John Turner and Pauline Howie to pick up on the points that were raised relating to triage and the ambulance service. We will then come back to what Dr Hall said. No doubt other members will pursue that.

John Turner: On untriaged calls and the NHS Highland submission, I think that pre-prioritised calls were being referred to. That is an arrangement that we run in partnership with health boards. At very busy times, patients phone us and we assess them, but if NHS 24's nursing resource is exceptionally busy due to high demand, we have, by agreement, an arrangement that means that we can pass a small percentage of those calls out to the local GP out-of-hours service, which picks them up for us. That is always done by advance agreement between NHS 24 and the local out-of-hours service.

The Scottish Ambulance Service and NHS 24 work closely together. Members may be aware that, in Cardonald in the west of Scotland, the Scottish Ambulance Service medical dispatch centre is co-located with the NHS 24 service. We are introducing that model in South Queensferry in the east and in Inverness this year. Therefore, there will be even greater joint working with the ambulance service. If a patient calls NHS 24, or someone calls on their behalf, and it is immediately clear that they are in a life-threatening situation, we can pass the call straight through to the Scottish Ambulance Service, who will deal with

it exactly as if the call had gone through to it in the first place. When patients call us, we sort and sift the calls on the basis of whether they are immediate life-threatening conditions, serious and urgent conditions and so on. We ensure that we get the patient to the right service as quickly as possible.

12:00

The Deputy Convener: I say in parenthesis that, on a constituency basis, I visited your Cardonald centre and witnessed the experiment in bringing the two services together.

Pauline Howie: Just to elaborate on that, the Scottish Ambulance Service is co-located not just with NHS 24 but with Glasgow's out-of-hours service at Cardonald, and in the Highland hub we are co-located with the Highland out-of-hours service in Inverness. Those models are working extremely well.

Rhoda Grant: We heard from the Scottish Ambulance Service that it feels that it is carrying an added burden because of the failure of out-of-hours services. However, NHS Highland's submission states that a burden is being placed on the GP out-of-hours service because of

"the absence of a timely ambulance response."

It seems that there is some disagreement about who is responsible and what is a timely response. We heard evidence last week that an ambulance can take up to four hours to arrive in some remote and rural areas, which does not really constitute an emergency response. Some of the witnesses on the first panel this morning talked about ambulances being placed 57 miles apart.

It appears to me that there needs to be more crossover than exists at present, with GPs who can provide an emergency response, go out and resuscitate, and deal with people who are often overlooked—we read evidence about that as well. I wonder how we can bring out-of-hours provision and the ambulance service together to ensure that people get the right outcomes, rather than having staff who say, "That's my job and that's their job"—or who pass the buck, for want of a better expression.

Pauline Howie: We tried to make the point in our submission that we favour more integrated models of care. Indeed, some of those models are set out in the remote and rural areas implementation group's framework of different options for delivering emergency responses in remote and rural areas. As part of our action plan to take those models forward, we are working with BASICS—British Association for Immediate Care Scotland—GPs, for example, who offer that immediate response. We now have 62 BASICS schemes live in our systems and they are being added to every week as we work collaboratively with them and with local communities. No one option—

Rhoda Grant: Are the BASICS GPs with whom you are working the ones that already operate out-of-hours services or is that a separate strategy that you have established, which sits apart from out-of-hours provision?

Pauline Howie: Some of them provide out-of-hours care, but the BASICS scheme is separate.

The main point is that there are many models and no single solution will fit every community. It depends on the geography, the demography and what the communities, the health board, NHS 24 and the Scottish Ambulance Service can jointly work towards providing.

The Deputy Convener: Does anyone else want to pick up on that point?

Dr Hall: I will be fair to the ambulance service, which is not usual for me. [*Laughter*.] What we need is perhaps a new model of transport to take patients to out-of-hours centres when that is appropriate. It is not necessary in some instances to have a paramedic plus other ambulance personnel just to take somebody in to be seen or to transfer them to a tertiary unit. In parts of Argyll, the main ambulance can be sent up to Glasgow, in which case it is away for hours. If there was another model of transport, provided the patient did not need monitoring, it would just be a basic transport service, albeit an extended one, and it would not need to take highly trained ambulance personnel away from the locus.

The Deputy Convener: Rhoda, are you happy with that?

Rhoda Grant: I am content with that.

The Deputy Convener: Murdo Fraser has caught on very quickly about how to catch the convener's eye.

Murdo Fraser: I have a couple of questions. My first one is a specific question about Kinloch Rannoch, and my second is more general.

On GP home visits, NHS Tayside submission's states:

"One crucial factor is the ability to respond to a home visit within one hour."

Does Mr Marr accept that, given the geography and the state of the roads in this area, a GP who is based in Aberfeldy or Pitlochry would have great difficulty in meeting that time limit, even in good weather? In poor weather, such as that which we have seen during the past few weeks, it would be impossible to meet that target. Does that not mean that some of the local residents are put at risk?

Gerry Marr: I would be happy to submit as supplementary evidence the results of our monitoring of all responses, so that Murdo Fraser can assess the response times. The people who have had those calls advise me that the response times were within that limit. To put it into perspective, in Kinloch Rannoch over a whole year, there are 113 calls, 22 of which require a GP response. We are talking about very small numbers.

On the broader issue of Kinloch Rannoch, our assessment of how we provide out-of-hours services stratified them as the routine response for out-of-hours care and the emergency response. What we have not said is that the criterion for assessing the adequacy of the service is the physical presence of a GP who would deal with only 22 instances in an entire 12-month period. We do not think that that would be a quality service that would maintain the skills of general practitioners. We believe quite firmly that the solution that is in place for routine GP call-outs from Aberfeldy is appropriate.

To pick up on some of the evidence that the previous panel of witnesses gave, one of our colleagues from Highland said that the Ullapool practice is serving four communities, and that people are satisfied with that, but three of those communities are further away from Ullapool than Kinloch Rannoch is from Aberfeldy. Therefore, I cannot understand why we judge the provision and quality of an out-of-hours service on the physical presence of a GP who might be required to undertake only 22 interventions in a 12-month period.

The Deputy Convener: Before we move on, I should say that the committee always welcomes additional submissions. However, I have a feeling that, if you check last week's *Official Report*, you will see that the information to which you refer has already been provided.

Murdo Fraser: I would be interested to see that information if it has not already been provided. I sound a cautionary note about the call-out figures that you quote. You will recall that we heard in the earlier witness session about local communities' concerns that local people have, in some cases, given up calling NHS 24, and have found other routes in the community, so perhaps the figures that you mentioned do not portray the whole picture.

Gerry Marr: I was very interested in those comments. We have an out-of-hours reference group for Kinloch Rannoch. It has met on nine occasions, and it involves all the stakeholders. From what I heard this morning, it would be useful to sit down to look at the data with out-of-hours Kinloch Rannoch and clinical experts, and begin to understand to what extent that is a problem and, indeed, whether it is a problem at all. I would certainly extend such an invitation to out-of-hours Kinloch Rannoch.

Murdo Fraser: Thank you. That is helpful. I have a slightly broader question, which touches on some of the issues that we have discussed and on something that I raised at the first evidence-taking session: the confusion, or blurring of responsibilities, between emergency response and out-of-hours GP service. In the public mind, there is a bit of confusion as to what exactly the difference is between the two services. Do the witnesses accept that emergency response does not replace out-of-hours GP cover and that the two are quite different? In the first evidence-taking session, Mr Murray stated that the point of having a GP in place is diagnosis, which the emergency service does not necessarily provide.

Will the witnesses also comment on the point that having a GP in place to make the initial diagnosis may lead to cost savings in secondary care because it means that people are not inappropriately taken away in an ambulance to a hospital? If the matter can be dealt with by a GP in the community, there is no need for an ambulance to attend, which I am sure can be extremely expensive for the Ambulance Service.

Gerry Marr: To respond—

The Deputy Convener: As Dr MacDonald is the only person who is yet to be asked to contribute, this is a good opportunity to invite her to respond.

Dr Sheena MacDonald (NHS Borders): I will respond to the general point and some of the issues that were raised with the earlier panel of witnesses. I am a general practitioner and have 24 years' experience of working in and out of hours.

The Deputy Convener: There is a bit of a competition here. I hope that you are not inviting me to come to a judgment on it.

Dr MacDonald: Dr Hall is definitely beating me—just. Between us, we have substantial experience at the front end of the service, but I also manage the NHS Borders out-of-hours service, which covers 2,000 square miles. Some of the different points of my star-shaped area are up to 73 miles apart with 20 miles on single-track roads. We have a model of service that is based wholly on the kind of service that NHS Tayside is trying to provide. It is a salaried service—our service has the highest number of salaried doctors working in it.

If I had an emergency, I would like someone who was competent and able to deal with it to come and that would always mean a trained paramedic. I have been a general practitioner in Ullapool, Skye and the Borders, and the number of times that I have had to resuscitate someone in

earnest is not high. In fact, it is embarrassingly low. In an emergency response, we need people who are trained to deal with emergencies.

There is no question but that we need general practitioners in the out-of-hours period. It is also clear that, in rural areas, they may need additional training. That is why, in NHS Borders, we provide BASICS training annually for all our salaried out-of-hours doctors and offer it to other general practitioners in the area. Over the four years since the new contract, we have increased the number of salaried doctors; the number of ordinary general practitioners who work in hours and are willing to contribute to our out-of-hours service is diminishing. We have to plan for that. There is no expectation that younger doctors who are coming through the system will be prepared to do it in the long term.

I challenge the idea that it is better to have one's own GP. Every patient and GP in Scotland would agree that the doctor who knows a patient's case, has access to the case notes and looks after them is the best person to decide whether they are admitted to hospital. However, that was not a sustainable model for the future in general practice and that is why we negotiated a new GP contract. I argue that there are ways in which individual health boards can work closely with NHS 24 to improve decision making out of hours. In my area, we have just launched an enhanced service with the local general practitioners to encourage them to be very proactive in anticipatory care planning and share that information with the out-of-hours service so that, when a patient calls out of hours, there is a plan in place for what should happen.

We struggle with IT. In my written submission, I suggested that our chronic disease management could be better, and I think that IT is one of the solutions. With my out-of-hours clinicians, I deal with five different IT systems, so it would undoubtedly help if we could integrate those and integrate the front end.

I argue strongly on the issue of secondary care admissions. There is equity and fairness in the model; we must have an equitable and fair model of out-of-hours service delivery. It must be efficient and must deliver what we have to deliver out of hours.

12:15

NHS Borders has the fourth-highest costs in Scotland, but they are not significantly higher than NHS Tayside's and they are much less than NHS Highland's, yet 90 per cent of our GPs feel that we offer a good if not excellent service. Our level of complaints is fairly low and we do well against the performance indicators for response times, despite our enormously challenging geography. In a system such as ours, in which we have a very integrated approach with NHS 24 and a very close relationship with the Ambulance Service, untriaged calls are not an issue. We know that people are coming, we plan for that and we bring in additional staff to deal with it. The ambulance will call us if we may be closer and able to respond more quickly. I think that there are creative solutions and I would argue that, instead of having a tired GP who is not up to date and has not necessarily been providing emergency care daily, our service provides a very good level of service.

Gerry Marr: Murdo Fraser has opened up a significant policy area in respect of distinguishing between the routine out-of-hours service that is required for a community and the emergency response. That is, in essence, what we are all working towards in our different rural communities. In Tayside, there are different responses in each area. In Angus, we run a see-and-treat service, but we have different solutions in parts of Perthshire.

Although I am not a GP with 24 years' experience, I feel able to speak about the issue because I am a nurse and I know something about it. We went for the first responder scheme in our rural environment, not as the emergency service but as a stratified first response, because what is critical, particularly in respect to resuscitation, is the crucial time on airway and circulation. We believe that the first responder gives a patient in a rural community the best chance and we can then respond rapidly through the Ambulance Service including, in some circumstances, the air ambulance service. We have thought the matter through very carefully so that we provide a stratified response that gives the patient the best chance in circumstances when they may require resuscitation. What Sheena MacDonald said was interesting. Throughout our consultation we were told, "Please, it has to be someone like a paramedic," and, "General practice practitioners do not have a vast experience of resuscitation."

Dr Hall: I will pick up on the point about GPs making diagnoses. The important issue about out-of-hours health care, rather than an out-of-hours service, is assessing whether someone is unwell. The longer you practise medicine, the more you realise that you often get it wrong. You can try and make a diagnosis, but it is about assessing whether the patient needs to be admitted.

I agree about the concept of the salaried service. In Argyll, there are a number of areas where people slot into doing sessions. At the drop of a hat, they can phone in and say, "I am not coming," or they do not turn up. There is almost no governance over how good those people are and they can come from different parts of the country. They put their names into a slot and do a six or

eight-hour out-of-hours session. The salaried service means that we know what we are getting. In Argyll, we have recently employed two salaried GPs to cover what was a single-handed practice to sustain the out-of-hours service. Although the panel members in the previous evidence session gave examples of lots of GPs doing their own 24/7 out-of-hours cover, I do not think that that is sustainable in the future. The younger GPs who are now coming out of medical training will not do 24/7 on call.

John Turner: I will make a few points that build on those that my colleagues have made. I underline that, for any citizen of Scotland who calls NHS 24 and is assessed as requiring to be seen by a GP, that is organised by the local health board and the patient will see a GP.

To help, I would like to draw out a few extra points. First, we have in existence something called the emergency care summary, which is a note of the medications that people are on. If a GP changes someone's medication, NHS 24 will know that at 6 o'clock in the evening on the same day if the person happens to call because they have an issue with the medication. We are developing the system to take account of the needs of palliative care patients. We also have a facility whereby a GP can make special notes that come through to NHS 24 in relation to any of their patients. Those notes might be about special care needs such as palliative care needs, or about a patient with learning disabilities. That information comes to NHS 24 and assists our nurses in their assessment of the patient.

Finally, on the point about people knowing which service to access, we have been involved with a pilot that the Scottish Government has been running in Grampian called know who to turn to. That is about giving advice to members of the public about when to self-care, when to go to the pharmacist, when to call NHS 24, when to go to the GP and when to contact another health service. The scheme is under evaluation, so we will see where it takes us, but it might lead to interesting considerations about how we can further support people to access absolutely the right service for them at the right time.

Ian McKee: Gosh, this is difficult, but I should at this stage modestly declare an interest in that I have done 40 years of general practice.

The Deputy Convener: This is now an auction. In fact, there might be members of the public who wish to bid in the process. I was bid 24 years, but it has now been raised to 40. I am not sure whether I will get a higher or better offer. Please carry on, Ian.

Ian McKee: During nearly all that time, I had responsibility for out-of-hours cover at some time or other. I am well aware of the danger of extrapolating from personal experience to make assumptions about other people's experiences. We have heard evidence that what suits one area does not suit another. However, we can learn lessons from one area and consider them in the context of another.

The evidence is confusing me, as I have heard almost contradictory things. We heard evidence from NHS Highland that many GPs see a future in providing 24-hour care for their patients. I do not mean 24 hours, 365 days a year, but they would be happy to do it if we could help them to have a reasonable lifestyle, to get further education and to get their holidays and time off. However, we have also heard that a GP who works in the daytime is too tired to do their job in the evening.

We have heard evidence that, in the Kinloch Rannoch area, there are only 22 emergency call-outs a year, but a doctor who works in the area will have daytime emergencies to add to that. If an emergency takes place at 5 o'clock and a doctor is handling it, that doctor might be the best person to deal with it at 8 o'clock, because the condition might have moved on slightly and a new doctor coming in would not see it in the same light. The evidence is rather confusing.

In evidence to the committee last week, Barbara Hurst of Audit Scotland referred specifically to Dr Sheena MacDonald's area, the Borders. I asked Barbara Hurst:

"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?"

She said that it is possible and that it happens

"In the Borders, for example".—[*Official Report*, *Health and Sport Committee*, 20 January 2010; c 2565.]

However, that does not sound like the description that Dr MacDonald gave. Does NHS Borders take on salaried practitioners to do daytime work and make it part of their contract that they do out-of-hours work, too, or is Barbara Hurst not correct?

Dr MacDonald: She is correct, but those practitioners are not necessarily working with independent contractor status in individual practices. We have tried to make the job more attractive to doctors generally. We believe that we have to consider a cohort that is separate from the daytime independent contractor group to provide the out-of-hours service. In our area, unlike in Highland, practitioners are voting with their feet. Originally, we had quite a lot of support from independent contractors, but that is gradually dwindling. We have therefore considered other areas where we believe general practice has a role.

We now have general practitioners in A and E for 22 out of the 24 hours of the day, seven days a week. That gives them daytime work, as well as out-of-hours work, to make it a more attractive option for them. We have used out-of-hours GPs in other ways—for example, to support sickness absence in daytime practices. We are building up a portfolio of hours that may be more attractive, to try to retain doctors in what we call an unscheduled care service that covers some in and out-of-hours responsibility.

One of my colleagues alluded to the fact that some independent contractors in Borders opt back in to provide some services. Some of our independent contractors are part of our salaried service, as they have said that they would like to provide a certain number of hours a week. However, the service could not be sustained by such opting back in—it cannot depend on that.

Ian McKee: I am trying to tease out whether the independent contractor set-up is best suited to rural areas. In many ways, it seems to have been devised to fit in with urban areas. A global sum is awarded for the number of patients that GPs have and the services that they provide. If a GP can cope with very few patients because of rurality, the independent contractor service does not seem to fit the bill so well. If you had more salaried practitioners who could be paid an appropriate salary for the job—the salary that would recruit people to do it—could you provide a more effective service?

Dr MacDonald: That may be part of a basket of solutions that may be appropriate for certain areas. As we have heard, some health boards have appointed salaried doctors to a practice specifically to ensure that the out-of-hours period is covered. It still needs to be an efficient and effective model. Gerry Marr made the point that the right people need to do the job. Immediately prior to the new contract, some rural areas in Scotland had the co-operative model, which involved a number of GPs covering quite a large area. That is definitely workable within a health board solution. In effect, we are running a Borders-wide co-operative in which the increasingly experienced salaried service is covering a lot of hours.

There are opportunities to look at different models, but they must be set in the context of equity and fairness and, as Gerry Marr is aware, the financial context that each health board faces at the moment. Finance must not be—and never has been—the driver in rural areas. Scotland in general faces challenges to its health spending from the rest of the UK because of our rurality and geography. Those of us who cover larger mileages in areas with sparser population argue that it is more costly to provide out-of-hours services in those areas. That needs to be acknowledged.

Ian McKee: From the point of view of individual GPs, as independent contractors, is it financially advantageous to work in a rural and remote area or in an urban area?

Dr MacDonald: Unfortunately, I cannot answer that question. When I worked in rural practice, I did so under the inducements scheme and it was financially neutral to work in a rural area. Dr Hall may be able to provide an answer.

Dr Hall: The model that we produced in Argyll provided an extended payment for out-of-hours work. There is no doubt that a financial carrot must be provided for someone to be available 24 hours a day, even if it is not seven days a week. The point of having a salaried service is that salaried people cannot opt out of what is in their contract. As members know, independent contractors—normal GPs in a practice—can say that they will do out-of-hours work, get the job and immediately say that they have changed their mind. Health boards are then stuck with trying to find a solution. Unless the regulations change to prevent GPs from opting out of providing out-of-hours services, that will continue to be the problem.

Ian McKee: A salaried contract, with a reasonably negotiated financial inducement, could solve some of the problems, as both the health board and the person applying for the job would know where they stood.

12:30

Dr Hall: I think that that is the future in many areas. Even in normal 9-to-5 general practice, an increasing number of new medics are not interested in becoming partners—again, I will probably be highly unpopular for saying that. The business side of medicine does not interest them; indeed, the business side of medicine is becoming less and less, partly because out-of-hours provision has gone. It is all about daytime work, which can be done with a salaried service.

Gerry Marr: It is certainly the case that the salaried GP scheme that is coming into out-of-hours provision is currently the best option, because it gives us continuity. We do not have to depend on chasing doctors out and worrying about covering out-of-hours rotas. That creates stability, which many health boards are working towards. However, there is concern about some of the schemes that GPs have opted into. There is concern about how many of those will become unsustainable when people come up to retirement. How many Kinloch Rannochs are around the corner? The trigger for that problem was a general practitioner's retirement. How sustainable will the solution be in future when hard-working GPs retire and people cannot be recruited into the same configuration of services? Boards are concerned about properly assessing that.

Ian McKee: Did you consider a salaried GP for the Kinloch Rannoch post?

Gerry Marr: Not a resident one. Many of our GPs are salaried GPs in our out-of-hours service.

Ian McKee: So you did not consider a salaried GP for the Kinloch Rannoch post.

Gerry Marr: No, not to be resident.

Ian McKee: Why not?

Gerry Marr: Because there are only 22 calls a year. A number of GPs would need to be recruited to be resident. I am making a distinction between being resident in Kinloch Rannoch and a GP out-of-hours service. We have a GP salaried out-of-hours service in Kinloch Rannoch, supplied from Aberfeldy and recruited to NHS Tayside out-of-hours service, but we do not have a resident, round-the-clock GP service in the village. That is the difference.

The Deputy Convener: Does Ian McKee have any more questions?

Ian McKee: I have elucidated the points that I wanted to elucidate.

Rhoda Grant: I have a short supplementary question. Does anything prevent health boards from employing all their GPs as salaried GPs rather than as independent practitioners to get over what appears to me to be a terrible problem that is caused by the GP contract?

Gerry Marr: I understand that there is no barrier to that, but we would have to persuade independent practitioners who have been in practice for many years to make that switchover. We now have a mixed economy of salaried GPs and independent practitioners. Michael Hall said that, increasingly, many GPs are not interested in the business side of medicine. The demography of the GP population is such that GPs are looking for part-time work and salaried options, not to be principals in practice. Both options are currently available to GPs.

Rhoda Grant: But as people retire, they could be replaced with salaried GPs rather than private practitioners.

Dr Hall: That could be done only if they were not part of a practice. Do you understand what I mean?

Rhoda Grant: Yes. That is because the practice would be privately run, and it would be up to it—

Dr Hall: If, for example, I retired, the health board could not go to the practice and say that I could not be replaced and that it wanted a salaried person in there.

The Deputy Convener: I know that Helen Eadie has not yet asked a substantive question, but does Mary Scanlon want to ask a supplementary question on the topic that we are discussing?

Mary Scanlon: No. I am at the end of the table. I had a supplementary on the question that Murdo Fraser asked; I have been trying to get in since then.

The Deputy Convener: I am sorry. The issue that was being discussed took up a substantial amount of time.

Mary Scanlon: I appreciate that.

Helen Eadie: My question is about co-operatives, which were talked about earlier, and independent contractors. The legislation does not make it possible for a community to form a health care co-operative, but if it were changed, there would be no reason why a community could not be allowed to do that. If changes were made to enable a community to form a co-operative, it would be able to bid for the GMS contract with the health board. It could appoint its own medical team locally, which might comprise a GP and a specialist nurse. I would like to hear the reaction, particularly from GPs, to such a thought. It is a realistic thought, given that amendments on the subject were proposed this week to the Tobacco and Primary Medical Services (Scotland) Bill, which is being considered by the Parliament.

If the community was given the appropriate budgets from the health service, it could employ the salaried staff. From reading the submissions that we have received, I note that the budgets have already been moved out to community health partnerships, so that would not need to be changed. It has already happened under point 2 of the service delivery framework, as the supplementary evidence paper that the committee received from NHS Highland makes clear.

The Deputy Convener: Which of our two witnesses—who both have rather fewer years' experience than Dr McKee—wishes to take up that offer?

Dr MacDonald: I am extremely anxious about such a model from a clinical governance and standards perspective. There have been real benefits from community health partnerships and/or primary care departments. In my area, there is only one CHP, so we have one managerial body looking after primary care, but that brings a lot of the advantages of a salaried service that we are discussing, in terms of standards and quality. Changing that model would feel almost like a disintegration; we have found that there are enormous advantages in working as a single system with our colleagues in NHS 24 and the ambulance service.

If we disaggregate that—especially in an area with a population of 110,000, such as that which I

cover—we might lose some of the benefits that we have gained from continuing to have a corporate single-system overview of the way in which we provide services in the out-of-hours period. We often say, "Let's change the structure" to solve a problem, but part of the problem that we are hearing about today is the failure—or perceived failure—to engage with local communities.

I am not entirely sure that structural change would necessarily deliver changed behaviours, which is what we need. We need a much more open and transparent patient-centred approach, and we need to be clear in helping people who are less expert to understand some of the complexities of what we are trying to deliver. I would be quite nervous about such a change.

Helen Eadie: Would a community co-operative not be subject to the same governance arrangements as an independent contractor? We are trying to empower communities and address the issues that are exemplified here in Kinloch Rannoch and are clearly evident in other parts of Scotland. Is that not an argument for accepting that there must be a different solution? It is clear that people in remote and rural areas of Scotland feel disfranchised and believe that their concerns are not being taken into account.

I presume that you have all seen Randolph Murray's paper, which outlines the failings of NHS services and points to very serious problems. I am not sure that I accept some of your arguments about communities engaging in the co-operative benefit route—there are many models of co-operatives and community co-operatives. It seems that you are thinking of only one version of a co-operative mutual solution to those issues.

Dr MacDonald: Are you suggesting a model for in-hours and out-of-hours services? Are you talking about the whole of the health budget?

Helen Eadie: No—the model would be for primary medical services, but it would cover in-hours and out-of-hours care.

Dr MacDonald: That would be an enormous step change from the current position, in which individual businesses are moving towards—

Helen Eadie: But there is not a distinction between the model that I described and an independent contractor; it is still a service bidder effort. I will leave that issue, as I have heard your response, but if I could just quickly—

The Deputy Convener: No, sorry. Could we have the benefit of hearing from Dr Hall? He was itching to contribute, given his anxiety to increase his years of experience before he is got rid of in some co-operative.

Dr Hall: There would be an issue with governance. Who would be responsible for the standard of medical care? The way that GP practices are set up is based on certain standards. Even independent practitioners are governed by standards. We have quality outcome frameworks so that clinical directors can examine how practices perform—to use that word—on so-called quality standards. Not all quality outcome framework points indicate good medical practice, but the framework provides a hard assessment of whether the population receives quality care, because there are many quality care issues within it. Therefore, if somebody works outwith that framework, it becomes difficult to wire them into the existing system.

Like Sheena MacDonald, I like to think that, as clinical directors and within the CHP, we would be able to work with communities to find a solution, but it comes back to the original point that the reason that there were single-handed GPs in remote and rural areas is that the population wanted a doctor in their village. There is now a law that does not wire GPs into that system any more, which is why we are faced with the problem of out-of-hours care. The need for local health care still exists, but it is different from what it was 20 or 30 years ago. The quality of care in those days was extremely good but, nowadays—dare I say it—there is less room for error. One must be right up there ensuring that assessments are correct and patients are given the best outcomes.

Helen Eadie: The only point that I would make in response to that is that the community health co-operative would have the appropriate professionals on its board of management. That would help to ensure that the governance arrangements were sorted. It would also enable the local community to find solutions to its problems. I am not suggesting that it would boil down to individual villages; a bigger geographical area could be covered.

I have a question about the overall co-ordination of the out-of-hours services. There is a national implementation group, but does it have a national sub-group to consider the particular issues in remote and rural areas? Who are the parties that sit on the national implementation group?

Dr Hall: Recently, NHS Highland was involved in the remote and rural implementation group, which considered out-of-hours issues and a number of issues on remote and rural health care, including the emergency medical retrieval service. There has been a lot of work and a lot of talk to try to find solutions involving communities from Orkney down to Campbeltown, but I do not know whether there is one solution that will fit all.

Helen Eadie: Do the Borders, Argyll and Highland regions come together regularly to review and monitor the out-of-hours services and consider what improvements could be made?

Pauline Howie: The remote and rural group that Dr Hall spoke about has representatives from all the rural boards on it, including from the Borders, Dumfries and Galloway, Argyll, the Highlands, Grampian and Tayside. The group came together for a specific piece of work. It had five major work streams—emergency response was one of them, as was out-of-hours services, I believe.

12:45

Helen Eadie: Who are the participants in that group? I could guess who some of them might be, but is there a source that can tell us? Also, is that work on-going or was it a specific piece of work that had a start and a finish?

Pauline Howie: The group produces a quarterly update that we could submit as supplementary evidence.

The Deputy Convener: We have time for a final, brief question from Mary Scanlon.

Mary Scanlon: I will be brief. Murdo Fraser's line of questioning was interesting, as Gerry Marr acknowledged. The NHS Highland written submission states that out-of-hours

"GPs who are under-utilised may not be considered by"

the ambulance service

"to support provision of emergency response."

To be fair to them, the petitioners from SOS Kinloch Rannoch were not complaining just about a GP; they had several concerns about the ambulance service, which are shared by Gerry Marr. The written submission from NHS Tayside states:

"There is widespread concern about the accessibility of the ambulance service in rural areas with slow response times reported and backup ambulances stationed outwith the area."

So, Mr Marr, when you say that the first responders should not replace the emergency service, you are acknowledging that, if an ambulance does not come for two or three hours, the first responder is becoming the emergency service. That is a concern to local people. Is that reasonable?

Gerry Marr: It is reasonable to recognise that roads, transport and all those things are a challenge, as well as the technology that we heard about earlier. I would have to go back into my papers, but I am not conscious of emergency response times in the region of two or three hours, to which you have referred. I am happy to take the matter up with SOS Kinloch Rannoch.

Mary Scanlon: You state that it is a "widespread concern"—that is in your submission.

Gerry Marr: Yes.

Mary Scanlon: It is a serious concern.

Pauline Howie: We have spoken a bit about first responders and some other models of delivering additional resources as well as ambulance cover. Nevertheless, I reassure the committee that the Scottish Ambulance Service takes remote and rural issues seriously; hence, a major part of our work programme is consideration of how we might enhance provision in remote and rural areas.

We have been increasing our cover throughout urban and rural Scotland in recent years, and we now have the fastest-ever response times not just in urban areas, but in rural areas, too. The service in those areas is supplemented by a very good air ambulance service, whose activity has grown tremendously in recent years with a 16 per cent increase in demand in the past year alone. The air ambulance is used by the emergency medical retrieval service, too, which brings highly specialised skills to remote and rural communities and is particularly welcomed in island communities. We also have more highly skilled staff than ever before. Ten years ago, we had 200 paramedics; we now have 1,500 and we are adding to that number all the time. There is a range of models that we want to work through with local communities to ensure that we continue to enhance cover in those areas.

Mary Scanlon: I am sorry to interrupt, but I ask you please to address my point, that out-of-hours

"GPs who are under-utilised may not be considered by"

the ambulance service

"to support provision of emergency response."

Pauline Howie: We are working with NHS Highland and others to identify those GPs who might be willing to offer that level of response and work with us as part of an integrated solution.

The Deputy Convener: Thank you very much indeed. I must draw this second evidence session of the morning to a conclusion. I thank our second panel of witnesses for their very full replies and acknowledge that they, too, have travelled some distance to be with us. That is much appreciated.

I remind those in the public gallery, who have been very well behaved, of my offer at the outset—the MSPs who are here will be happy to speak with you for the next 15 to 20 minutes after the meeting has concluded.

Meeting closed at 12:49.

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