HEALTH AND SPORT COMMITTEE

Wednesday 3 February 2010

Session 3

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HEALTH AND SPORT COMMITTEE
4th 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 GAVE EVIDENCE:

Dr Catriona Hayes (Scottish Government Health Finance Directorate)
Shona Robison (Minister for Public Health and Sport)
Frank Strang (Scottish Government Primary and Community Care Directorate)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)
Ian Williamson (Scottish Government Primary and Community Care Directorate)

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Wednesday 3 February 2010

[THE CONVENER *opened the meeting at 09:32*]

Subordinate Legislation

Official Feed and Food Controls (Scotland) Regulations 2009 (SSI 2009/446)

The Convener (Christine Grahame): Good morning. I welcome everyone to the fourth meeting in 2010 of the Health and Sport Committee. I remind witnesses, people in the public gallery and committee members to switch off their mobile phones and other electronic equipment.

We have received no apologies.

The first agenda item is consideration of a negative Scottish statutory instrument. Members have copies of the regulations, along with a cover note setting out their purpose and any comments for the committee's attention from the Subordinate Legislation Committee. The regulations revoke and re-enact, with changes, the Official Feed and Food Controls (Scotland) Regulations 2007, and apply to Scotland only.

Do members have any comments on the regulations?

Members: No.

The Convener: Are members content not to make any recommendations to Parliament on the regulations?

Members *indicated agreement*.

National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2010 (SSI 2010/1)

The Convener: Agenda item 2 is an evidence session on a negative instrument that amends the National Health Service (Charges for Drugs and Appliances) (Scotland) Regulations 2008 to decrease the charges for drugs, medicines and appliances from £4 to £3 from 1 April 2010. Members have a copy of the regulations, along with a cover note setting out their purpose, and comments made by the Subordinate Legislation Committee.

I welcome to the meeting the Minister for Public Health and Sport, Shona Robison MSP, to give evidence on the regulations. She is accompanied by Tom Wallace, policy manager of community pharmacy and primary care infrastructure, Deirdre Watt, team leader in community pharmacy and primary care infrastructure, and Dr Catriona Hayes, statistician in health analytical services.

A motion to annul the instrument has been lodged and will be debated after the evidence session. Once the debate has started, the minister's officials will not be able to participate; they can participate only in the evidence session prior to the debate on the motion.

I invite members to ask questions.

Rhoda Grant (Highlands and Islands) (Lab): In the recent parliamentary debate about prescription charges, I and some of my colleagues raised the issue of cancer patients and suggested that perhaps we should rebalance how prescription charges are phased out to allow cancer patients to get free prescriptions immediately. Has the minister had time to reflect on that since the debate? If not, will she consider it in future? We have heard from Citizens Advice Scotland and others that people who are in that situation have quite a lot of financial issues, and giving them free prescriptions would make a big difference to them.

The Minister for Public Health and Sport (Shona Robison): That was discussed at length in the debate a couple of weeks ago. In a year, no one will pay anything, so along with everyone else cancer patients will get their prescriptions free.

When we were looking at how to implement the policy, we decided that the fairest approach would be to abolish charges for everyone, because if we selected particular groups for exemption, we would just create more anomalies in the system. Therefore, after fairly lengthy discussions and debates within Government, we decided that the fairest approach would be to abolish prescription charges for everyone.

Rhoda Grant highlighted cancer patients. I could point to many other people who are currently not exempt, such as those who have multiple sclerosis, Parkinson's disease, glaucoma, chronic obstructive pulmonary disease, rheumatoid arthritis or cystic fibrosis, who would say that they should also be exempt and should not have to wait until next year.

We wanted to avoid having a debate among people with different conditions, so we felt that the best and fairest way was to abolish the charges at a point at which everyone would be treated fairly and equitably. That was our position during the recent debate, and it is still our position.

Ian McKee (Lothians) (SNP): Is it true that, under the current prescription charging regime, some patients are still receiving medication that

costs less than the prescription charge that they have to pay?

Shona Robison: Can you explain?

Ian McKee: The ingredient cost of a prescription is a certain sum of money, and people who pay prescription charges pay the prescription charge. Is it not a fact that some patients are paying more in prescription charges than the cost of what they are getting?

Shona Robison: I understand what you mean, and I understand that that is the case. I do not have any figures to show how many people fall into that category. The point is that no distinction should be made on the basis of ability to pay. The issue is that people who are ill should not have to pay a tax on ill health. The principle of abolition is therefore sound.

To go back to Rhoda Grant's point to some extent, we needed to front-load the process of moving towards complete abolition to help those who have chronic conditions. That is why we made the deep 50 per cent cut in the price of prepayment certificates. We recognised that front-loading the process would help those who have chronic conditions as we move towards abolition.

Mary Scanlon (Highlands and Islands) (Con): What is the average cost of a prescription?

Dr Catriona Hayes (Scottish Government Health Finance Directorate): The overall average cost is approximately £11. It might be slightly more than that, but that is the approximate cost.

The Convener: You have given an average, but I imagine that some prescription drugs cost a fortune compared with others. What is the highest figure, if the average is £11?

Ian McKee: And what is the lowest?

Shona Robison: I do not have the figures with me, but there is huge variation between drugs that are now relatively cheap, because they have been around for a long time and are produced generically, and drugs that are particularly specialised and new. The gulf is huge. We can send that information, if the committee is interested.

The Convener: An average figure is sort of useful, but we are all aware that the cost of particular treatments probably comes to thousands of pounds. There are often public arguments about the cost of some drugs.

Ross Finnie (West of Scotland) (LD): My apologies for arriving late, minister—it was very rude of me.

This question might have been asked already, in which case I apologise. I heard the tail end of what you just said, and previously I have heard you articulate the broad principles of why your Government wants to end up with free prescriptions. Has the context of the very changed economic circumstances caused you to pause to reflect? Did you take any other considerations into account? The very changed financial circumstances in which we now find ourselves have certainly caused me and my party to consider a range of expenditure commitments. Have they caused you to pause and reflect on the proposed measure, or are you of the view that the policy is unaffected by them?

Shona Robison: The economic backdrop is of course a consideration for the Government in determining how to proceed across the board, but we firmly believe that the policy is the right one to pursue, that it helps with the management of people who have long-term conditions and that it assists self-management, alongside other policies. We would not pursue a policy that we did not believe was affordable. We believe that this policy is affordable within public resources, even in the tight financial climate, albeit that it requires significant resources. So far, the policy has been within the budget that has been set aside for it. You are absolutely right that it is a matter of choice, and the economic backdrop is indeed difficult. However, we still believe that it is the right thing to do. People should not be penalised because they happen to fall ill.

The other question is, what is the alternative to what we are doing? Is it to continue with a very out-of-date system? The list of exempt conditions was drawn up a long time ago. If you do not believe that what we are doing is right, what is the alternative? Do we leave things as they are? Do we extend the list of exempt conditions? If so, who is in and who is out? When you start to unpick that, it is quite sobering, because there are hundreds of chronic conditions, and exempting some and not others is not acceptable to us—it would not be fair or based on equity. If all chronic conditions were exempted, only a very small number of people—those without a chronic condition—would pay. Rather than trying to ensure that all chronic conditions were included, we judged our approach to be the cleanest and most effective way of applying this fair policy. If you do not accept that, you have to answer the question, what is the alternative to what we are doing?

The Convener: I understand that Mary Scanlon wishes to debate the motion, so we now move to the debate on motion S3M-5461. I remind members that officials cannot take part.

09:45

Mary Scanlon: In moving the motion, I do not wish to repeat all the points that were made in the

recent debate on prescription charges. However, it is worth putting some issues on the record.

As Ross Finnie said, there is no doubt about the financial challenges that the NHS, and indeed every other public service in Scotland, faces. Those challenges will be debated at stage 3 of the Budget (Scotland) Bill this afternoon, and during the passage of every other budget bill for at least another decade.

In these difficult times, it is even more important to look at every pound that is spent, examine whether that is the best use of the limited resource and look at the opportunity cost of allocating money to reduce prescription charges. I noted during the minister's discussion with Ross Finnie that 50 per cent of people in Scotland are already exempt from prescription charges. The 50 per cent who receive free prescriptions account for more than 90 per cent of all prescriptions that are handed out.

The question that we face today is, against a background of efficiency savings and cuts in the health service, should the Government be reducing from £4 to £3 the cost of prescriptions for those who can afford to pay? Every penny spent has an opportunity cost. In a recent debate, the Conservatives suggested that the money could be used to fund a universal health visiting service to ensure that every child under five gets the vital health and development checks that this committee has recommended.

Even with the prescription charges in place, the cost to the taxpayer of prescribed items has risen from £580 million at the start of this Parliament to more than £1 billion now.

Already, 10 per cent of the population of Scotland are on antidepressants, despite the Government target to reduce antidepressant prescribing. Antibiotic prescribing also continues to rise, despite the link with hospital-acquired infections. Last year, I mentioned the 7 per cent increase in antibiotic prescribing in Wales, where prescription charges have been abolished, compared with the 1 per cent increase in England for the same period.

The Government estimates that the increase in prescriptions would be 1 per cent in the first year, and then another 1 per cent, 2 per cent and 5 per cent on abolition. We do not have up-to-date figures for what is happening in Scotland in our briefings. In Wales, the increase in prescriptions was 5 per cent in the first years, and then 4 per cent and 6 per cent on final abolition. That is well above the Scottish Government's estimates. For the Welsh equivalent of this year's reduction from £4 to £3, the increase in prescriptions was 5.44 per cent, compared with the Government's estimate of 1 per cent. Has the minister reviewed any of the estimates since prescription charges were reduced and how the cost to the taxpayer has changed?

I, and a couple of my colleagues, raised the issue of wastage last year. Has anything been done to address that?

In the unlikely event of my winning the vote today, I ask the Government constantly to review prescribing practices to ensure that prescriptions are given only when appropriate and when there is nothing better to address the condition. The example that I give, which I make no apology for repeating, is mental health. I know that it is easy to hand out antidepressants to get a patient out of the surgery, but, in the long term, psychiatry, psychology, counselling and other talking therapies might be the preferred and appropriate approach to treating the person's condition.

I move,

That the Health and Sport Committee recommends that nothing further be done under the National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2010 (SSI 2010/1).

The Convener: I will ask other members to raise points and then allow the minister to answer them. I will then allow Mary Scanlon to wind up.

Ian McKee: Mary Scanlon has made some very good points. Certainly, probably too many antidepressants and antibiotics are being prescribed. However, I part company with her on how to reduce that number through prescription charges. The logic behind the position is that those who do not need antidepressants will not collect their prescription, but the patient is often not the best person to make that judgment. If too many antibiotics and antidepressants are being prescribed, the remedy is to tackle those who are writing the prescriptions by counselling them and educating them so that they do not prescribe so many of those medications. I am not so concerned about the proposal's effect on the chronic sick, because they can already get a season ticket that adjusts the price so that the cost is not huge.

From my time in general practice, I know that the people who are hardest hit by prescription charges are those who are on a limited income and who are not entitled to free prescriptions who suddenly need three or four medicines to cope with an episode of acute illness. Such people will often ask the chemist, "Which of these are the most important, because I can't afford all of them?" I was often told, "I can't get my medicine until pay day." When people need to wait for two or three days before they can buy a prescription that they need urgently, they can place a bigger burden not only on society in general but on the health service, because they might then need more expensive treatment.

A course of penicillin for an infection—I checked this the other day—costs the NHS £1.27. Charging people £4 for that means that we are profiteering from people's illness by charging more than the private sector would charge.

Finally, what is the logic of confining charges only to medicines? An equally applicable case could be made for charging people for visiting their doctor. That would cut down on the number of prescriptions that are dispensed, because people would not go to the doctor so often. If we charged people for going into hospital for an operation, we might have fewer operations and thereby save the health service money. Once we accept the principle of charging at point of need, we open up a whole Pandora's box of charges that could be levied. I believe that that is the wrong way to go. For those reasons, I oppose Mary Scanlon's motion.

Ross Finnie: Before taking part in this discussion, it might be advisable that I declare an interest—this is not in my register of interests, but I mention it for the sake of fairness and equity—by clarifying that I am a holder of an exemption certificate. That is probably a fair declaration to make in the context of this debate.

This year more than previously, I am concerned about the changed economic circumstances, which I raised with the minister earlier. In response to Ian McKee's closing argument, I point out that the regulations deal specifically with charges for drugs, and there is no suggestion—certainly from me, although I will not go into what others might suggest—of introducing charges for operations or for visiting general practitioners. Not everything that one gets from the NHS at the point of need is free—people are required to pay for dressings and all sorts of things—so we should confine our consideration to prescription charges.

As I indicated to the minister, our concern arises from the current economic climate. I accept that the cohort of people whom the minister identified includes certain persons who have long-term conditions, but that cohort also includes people who are perfectly able to pay for their prescriptions, even in the present economic circumstances.

The minister invited me to consider what the alternatives are. Having been a member of the previous Government, I am aware that whether an illness is designated in the list of long-term conditions can almost depend on which adviser one speaks to. Some advisers are more able to give an answer; others seem to produce a list that gets ever longer. However, given the present financial circumstances, I think that an alternative option would be to increase that list in a way that is consonant with its being an interim measure.

I am not content, considering the priorities for the health service as a whole, and given that not everything in the health service is free, that the proposed policy is a sensible allocation of resource in these circumstances. Therefore, for different reasons, I support Mary Scanlon's motion to annul.

Helen Eadie (Dunfermline East) (Lab): I hear what Ross Finnie says, but given that—as Rhoda Grant mentioned earlier—cancer is an issue of life-threatening urgency, the Government has been remiss in not addressing that policy area. The minister mentioned other diseases that are serious, chronic, and long term, many of which are potentially life threatening, but the urgency of cancer is such that people cannot wait. The illness, as we see when we visit our friends, relatives and constituents, eats up people's resources quickly and acutely, which is why we are most concerned that the Government has not addressed that point.

It is fine to say that all people with long-term conditions might have to wait until next year, but what will they do in the meantime? For the past three or four years, nothing has been done about the issue. The policy area is hugely divisive: we would all love to have universal benefits such as free school meals and free bus passes—which we already have to some extent—but, as Ross Finnie rightly points out, the issue is whether we can continue to afford such things.

Like every other MSP in the room—apart from the minister—I earn £57,631 a year. I feel that it is ignominious that I am entitled to free prescriptions—I get them because I am over 60—when people who are suffering from cancer are not. Those people need help in so many ways, for example with their travel expenses and their medication. I visited a Maggie's Centre only a fortnight ago, and I was so impressed with the work that is done there. It is so wrong that we are not addressing the needs of cancer patients.

The Convener: I have great sympathy with the point that Helen Eadie and Rhoda Grant have made. However, the recent debate in Parliament brought to my attention the British Medical Association's paper on the subject, which makes clear that although the BMA has every sympathy with the proposal to single out cancer patients, as has happened down south, it believes that that is extremely unfair, and that such a system produces winners and losers. The BMA's view—which happens to be the Government's position—is that the fairest way forward is to abolish prescription charges, because otherwise there would be a lot of losers.

I do not always quote the BMA, but in this instance I will rely on its view, as it considers, on behalf of its many members and the many patients

whom they deal with, that that is the way forward. We would love to abolish all charges immediately, economic weather permitting, but—to use an awful expression that I have said I would never use—the direction of travel towards abolishing prescription charges is just fairer, although I have huge sympathy for people with cancer.

In Northern Ireland, an important project on cancer patients and access to benefits was undertaken that turned out to be important in changing the benefits system there. It found that people who had cancer were getting benefits, but that they were disallowed from claiming those benefits once they were in remission. The rules on that were changed as a result. That issue needs to be addressed in Scotland. It would be useful if some charities in this country examined the Northern Ireland project and the way in which it was used to increase the benefit supply to cancer patients in particular.

Does anyone else want to comment?

10:00

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I apologise for being late and missing the beginning of the debate. I do not know whether the issues that I want to raise have been covered.

There is no doubt that the fairest system is one with no prescription charges at all: it is simple and easy. I thought that such a system would mean that we would get rid of the entire bureaucracy around those who have to apply for exemptions, but we now know, of course, that we will not get rid of that bureaucracy, because anyone who wishes to be in the minor ailments scheme will have to continue to apply for exemption. The same exemptions will apply and there will be the same unfair boundaries that existed before. We will not get rid of the bureaucracy, and all the costs and paraphernalia around it will be retained in 2011. That important issue has not been fully addressed. It is clear that there will be unfairnesses wherever the boundaries are drawn, but we will simply swap one set of unfairnesses for another in 2011. Admittedly, the situation will be less onerous, but there will nevertheless be unfairnesses.

The fact that cancer was the subject of a manifesto commitment makes it different. The Labour Party has pursued that in debates, and we still think that it is appropriate to do so. I accept what Christine Grahame said in a personal capacity about the emphasis on benefits, ensuring that people are given the proper advice, and how that is undoubtedly helping, but there are, nevertheless, individuals with cancer who need treatments for other conditions and who find things difficult.

I support the idea that we need to change the system. The previous system was out of date, unfair and contained appalling anomalies; for example, extremely wealthy people who had conditions such as an underactive thyroid received all their treatments free. That approach has no logic, and I do not really understand the original basis for it. It was probably taken because substantial numbers of people with underactive thyroids went mad before the health service came in and the consequences of that were significant. I do not think that anyone around this table would say that the previous system was fair or that it is not extremely difficult to try to apply an approach to one set of long-term conditions but not to another. That is very tough. We can guess what constitutes a long-term condition, but there will always be a boundary. It seems to me that, if we were going to have a system of prescription charges, we would need to look abroad to the systems that are based entirely on income.

I have considerable sympathy with the point that Ross Finnie made—I am sure that Mary Scanlon made the same point and I missed it. In the current climate, in which resources will be very constrained, people who are better off must make an additional small contribution. That issue will need to be revisited.

In the present situation, the Government wishes to pursue a continuing reduction of prescription charges to their abolition. I will certainly not oppose that; that is the Government's decision, based on its budget. However, we will watch closely, as we have repeatedly said in debates. We will ask serious questions about decisions on resources the first time a patient does not receive a cancer drug from a health board on financial grounds.

The costs of medicines have been restrained in the past two years compared with their costs in the previous decade, because procurement has become much better and the savings on procurement have been substantial, which has prevented the drugs bill from going up. However, that is temporary and we cannot increase the number of generic prescriptions, the figure for which is already 90 per cent. Howat and Crerar made it clear that there are very few further savings to be made in that respect. Future savings on the drugs bill will be small. New drugs are coming out that will be horrendously expensive. The question how the country will be able to afford those drugs needs to be seriously addressed as we go beyond 2011, when budgets that are continuing to increase at the moment will start to reduce for the first time.

The Convener: The minister may address points that have been raised in the debate before Mary Scanlon sums up.

Shona Robison: There is quite a lot to deal with.

It is two weeks since we fully debated prescription charges in Parliament. I welcome the opportunity to explore the issues again.

Obviously, we are discussing the penultimate step towards abolishing prescription charges for all patients in Scotland. Mary Scanlon has suggested that only those who can afford to pay will benefit. I have no doubt that the removal of the tax will be of most benefit to the sickest and the poorest people—the people to whom the vast majority of medication is currently dispensed. For example, we estimate that 600,000 adults in families with incomes that are less than £16,000 who must currently pay charges will benefit when they collect prescriptions.

Mary Scanlon said during the debate that there were anomalies in the previous system. I agree. However, she and the rest of the committee need to be clear that there are anomalies in the current system and that we can get rid of them only by abolishing charges for all. Mary Scanlon seems to be saying that because of the opportunity cost, there should no further change to the system. She seems to be arguing that every penny that we are spending on the policy should go towards something else, which means, de facto, that there should be no change to the current system. People with multiple sclerosis, Parkinson's disease, asthma, glaucoma, COPD, dementia and so on would continue to pay for their prescriptions and the anomalies in the system would continue. We do not believe that that would be right.

Abolition will also ensure that all patients can follow their GP's clinical judgment and guidance—Ian McKee made that point—and collect all the medication that is required. They will not have to make the choices that some have had to make.

"There is no doubt that the reduction will lead to better compliance."—[*Official Report*, *Health and Sport Committee*, 18 March 2009; c 1682.]

Those are Mary Scanlon's words. I have no doubt that she is right and I welcome that position. We, too, believe that the investment will lead to further compliance and improve patients' health.

As I said to Rhoda Grant in evidence, our policy approach does not single out individual conditions but has already ensured that all patients, regardless of their health condition, are benefiting. That includes the 190,000 people—100,000 more than previously—who own prescription prepayment certificates. All those people are likely to have long-term conditions.

A number of questions were raised: I will try to respond to them all. Mary Scanlon asked about the evidence so far. Overall, our assumptions included a 2 per cent increase in non-exempt scripts—that is, PPCs and paid scripts—in 2008-09. The actual figures showed that the 2 per cent assumption was robust, but I say to Mary Scanlon that we do monitor the system and keep it under review. Of course, issues such as prudent prescribing are crucial. They always have been and are no less so now.

I want to touch on the issue of cancer patients again. Helen Eadie said that cancer patients will have to wait for another year, but of course they waited for eight years up to 2007 with no change whatever to the prescription charges that they had to pay. When we came into government, we decided that that was wrong and that we should therefore begin to abolish prescription charges. I have explained the reasons why we chose to proceed as we did instead of selecting people with certain conditions. People with cancer and other conditions are already saving a huge amount of money through prepayment certificates. A patient who bought an annual PPC in the past year will save nearly £61 compared with pre-policy prices. That is money that cancer patients are saving now that they did not save before 2007.

Richard Simpson's point that he will raise the issue every time a cancer drug is not given by a health board is disingenuous, given that the matter was of as much concern under the previous Administration, although there was no proposal to abolish prescription charges. That is why Nicola Sturgeon, the Cabinet Secretary for Health and Wellbeing, took the action that she did to make the process around decisions on drugs much more transparent. I believe that we now have a good system through the Scottish Medicines Consortium, and that we have safeguards and transparency in the system that did not exist before 2007. It is disingenuous to try to link the two issues.

Ross Finnie mentioned affordability, which I have touched on. The judgment is this: two thirds of the prescription items that are not exempt are for long-term conditions, so if we accept that changes have to be made—Ross Finnie acknowledged that the present system is not right—we must ask what system we should introduce. A system that is fair and which exempts everyone who has a long-term condition will not cost very much less than full abolition. We have been over and over the figures, and I assure the committee that that is the case.

I should say that prescribed dressings will be free as well—I think that Ross Finnie mentioned that.

I hope that I have managed to address the points that were made. The abolition of prescription charges is a point of principle, but it will have practical effect. We believe that it will help people who have chronic conditions to

manage their conditions. It will also help to ensure that people comply with requirements to take medication, which we know has been not happening because of cost. Abolition is a fairer way of proceeding than picking and choosing certain conditions on the basis that they are somehow more important than others. I hope that this time next year I will again be before the committee to complete the final stage of the abolition of prescription charges. I oppose the motion in the name of Mary Scanlon.

The Convener: There are no rumours of a reshuffle, to the best of my knowledge. I am sure that you will be here next year. You have my assurance—you know what it is worth.

I think that I have discombobulated the minister.

Ross Finnie: I think that the minister was in a better position before you said that.

The Convener: Mary Scanlon will wind up.

Mary Scanlon: I thank all colleagues for their comments.

The minister mentioned that last year the number of prescriptions increased by 159,000 following the reduction in charges. Other more appropriate and more effective solutions should not be shelved, given that charges are being reduced. That is the main context of my motion. I mentioned the 7 per cent increase in prescribing of antibiotics in Wales, when the increase in England over the same period was only 1 per cent.

When I spoke to my motion, I could have gone on for 10 or 20 minutes—[*Interruption.*]

The Convener: There has just been a groan to my right.

Mary Scanlon: I appreciate that. We recently had a parliamentary debate on the subject, in which many of the issues were raised, so I did not think that it would be appropriate to repeat what had already been said—I say that in case anyone criticises me for missing anything out. I am sure that colleagues understand.

I appreciate the difficulties to do with conditions that do not result in exemption from prescription charges—that was very much an issue in the parliamentary debate.

Ian McKee and I got off to a bad start on prescription charges last year. It has been slightly better this year, although it was never suggested that patients should be charged for an operation or to visit a GP, so I say to him, with the greatest respect, that I feel that it was inappropriate to include those points in today's debate, as they are not related to it.

Spending on the national health service has only ever reduced in one year. I apologise to Helen Eadie for saying so, but that happened under a Labour Government in the 1970s, following instructions from the International Monetary Fund, so I will take no lessons from anyone, given that spending on the NHS increased over all the years during which the Conservatives were in government.

I thank Ross Finnie for his measured and considered remarks. I also thank him for taking into account the realities of the current economic situation, to which I will return.

The issue with cancer patients is not about them queueing up at pharmacies for over-the-counter drugs. It is, rather, as Richard Simpson said, about their being denied drugs that have been recommended by oncologists in acute hospitals. It was the initial denial of such drugs to Michael Gray that led to a petition being submitted to the Parliament two years ago.

10:15

Last year I met the support group for oesophageal cancer, which is concerned about lack of recognition and the failure to give people surgery. Today I have tried to point out that, when money is spent on one issue, it is lost to another.

I thank my Labour colleagues, Rhoda Grant and Helen Eadie, for their contributions. Government ministers have argued that scrapping prescription charges will abolish bureaucracy, but we know that it will not. The minor ailments scheme is excellent, although Richard Simpson was right to acknowledge that a bureaucracy will still be needed to determine who is on benefits and eligible for the scheme.

It is unfortunate that the minister came to today's meeting with a prepared speech and did not address many of the issues that I raised in my short opening speech. I did not say that those who can afford to pay prescription charges will benefit, as the minister suggested in her prepared speech, and I did not mention compliance, which is important but has been debated. The minister did not acknowledge at all the serious economic climate that we face and the huge debt that this country has to pay. She did not address the review of wastage, about which I asked. I also asked whether there would be a review of appropriate prescribing and used the example of mental health patients, for whom antidepressants are not always the best or most appropriate solution. Given that the minister did not address many of the issues that I raised, I will press the motion in my name.

The Convener: Before I put the question on the motion, I invite the minister to address a couple of the issues that have been raised.

Shona Robison: Mary Scanlon and Richard Simpson mentioned the minor ailments scheme. We have been utterly clear about the issue from the beginning, as Richard Simpson knows from the two parliamentary questions that were answered in August and September 2008, which clearly laid the policy intention out. I am sure that he will have reflected on that. At a meeting of the committee last year, he said:

> "The minister has a number of questions to answer, the first of which is on the minor ailments service. She will know that I have asked about that in parliamentary questions. The response has been that the service is not to be extended when free prescriptions are extended to all patients."—[*Official Report*, *Health and Sport Committee*, 18 March 2009; c 1688.]

In reply, I made our policy intention clear. As Richard Simpson's words demonstrate, he knows what the policy intention is. The minor ailments service is a service for people who are already exempt, the purpose of which is to prevent those who are high users of prescription and over-the-counter medicines from going to their GPs.

Helen Eadie: On a point of order, convener. The minister is supposed to be addressing the issues that Mary Scanlon raised.

The Convener: I confirm that Mary Scanlon raised the issue of the minor ailments scheme. However, the minister was tending to address Richard Simpson's points. It is Mary Scanlon's motion, so the minister should address the points that Mary made. I will allow Mary Scanlon to respond in conclusion. I invite the minister to respond to the other issues that the member raised.

Shona Robison: Mary Scanlon picked up especially on Richard Simpson's argument that a bureaucracy would be left in place around the minor ailments service, which is a good service that prevents people from going to their GP. That is why we will continue with the service. That has been made clear all along, as Richard Simpson and Mary Scanlon both know.

I will respond to Mary Scanlon's other points. I made it clear that we keep every bit of information under constant review. We receive regular monitoring reports on the impact of the policy. Mary Scanlon is absolutely right that prudent prescribing is critical—it always has been. A lot of effort has gone into this, and we have had no indications from GPs or health boards that the policy is having an adverse impact on either GP consultations or health boards' ability to manage their budgets. I reassure Mary Scanlon that we are scrutinising every aspect of the policy and will continue to do so as we move towards the abolition of charges.

Mary Scanlon: I thought that, when I wound up the debate, it was the end of the debate and the motion would go to a vote. I do not wish to continue the debate, as we have a huge amount of business to get through. However, Richard Simpson has a point. No one has said that the minor ailments scheme is not a good service. I feel that, the longer we go on about this, the more the minister is misrepresenting what has been said. It is an absolutely excellent, first-class service and no MSP would say that it is not. Therefore, the minister should not say to me or my Labour colleagues that we are attempting to criticise the service. Nevertheless, Richard Simpson has a point. Pharmacies must decide who is eligible, and not everyone is eligible for the minor ailments scheme.

I have heard a repetition of what was said before. Yes, there is constant review—that is easy to say—but I still have not heard that wastage or mental health are being addressed. Therefore, I would like to end the debate, if I may suggest that.

The Convener: Absolutely. I just thought that, as some points that you raised in your summing up had not been addressed, it was only fair to allow the minister to come back in and then to allow you to respond to what she said. I take it that you are pressing your motion, Mary.

Mary Scanlon: Yes.

The Convener: The question is, that motion S3M-5461 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Ross Finnie (West of Scotland) (LD)
Mary Scanlon (Highlands and Islands) (Con)

AGAINST

Helen Eadie (Dunfermline East) (Lab)
Christine Grahame (South of Scotland) (SNP)
Rhoda Grant (Highlands and Islands) (Lab)
Michael Matheson (Falkirk West) (SNP)
Ian McKee (Lothians) (SNP)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)

The Convener: The result of the division is: For 2, Against 6, Abstentions 0.

Motion disagreed to.

The Convener: I thank the minister and her team, and I suspend the meeting briefly for a change of witnesses.

10:22

Meeting suspended.

10:24

On resuming—

Public Appointments and Public Bodies etc (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2010 (Draft)

The Convener: We move to item 4 on the agenda, which is subordinate legislation. This is an oral evidence session on an instrument that is subject to affirmative procedure—the draft Public Appointments and Public Bodies etc (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2010. The order will amend schedule 2 to the Public Appointments and Public Bodies etc (Scotland) Act 2003, which lists the specified authorities to which the code of practice that is published by the Commissioner for Public Appointments in Scotland applies. Members have a copy of the draft instrument, along with a paper that sets out the comments of the Subordinate Legislation Committee. I welcome the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, who will give evidence on the draft instrument. She is accompanied by John Swift, the head of the health public appointments unit, and by Gillian Russell, the divisional solicitor for the health and community care division. I welcome you both.

A motion that the committee recommends that the order be approved has been lodged. As with the previous item, the motion may be debated following an evidence-taking session. If there is a debate, the cabinet secretary's officials will not be able to participate.

If members have no questions, and no one wishes to debate the motion, I ask the cabinet secretary to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the draft Public Appointments and Public Bodies etc. (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2010 be approved.—[*Nicola Sturgeon*.]

Motion agreed to.

Health Board Elections (Scotland) Amendment Regulations 2010 (Draft)

The Convener: The next item is an oral evidence session on the draft Health Board Elections (Scotland) Amendment Regulations 2010. They amend the Health Board Elections (Scotland) Amendment Regulations 2009, which set out the arrangements for pilot health board elections. Members will have received a copy of the draft regulations along with a paper setting out comments from the Subordinate Legislation Committee.

The Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, is still with us to give evidence on the draft regulations. She is accompanied by Robert Kirkwood, business planning executive, and by Gillian Russell, divisional solicitor in the health and community care division of the Scottish Government. A motion that the committee recommends that the regulations be approved has been lodged and will be debated following the evidence session. Once the debate has started, the officials cannot participate.

I invite questions from members.

Ross Finnie: I have more of a comment than a question, convener. I raised and pursued this issue during the passage of the Health Boards (Membership and Elections) (Scotland) Bill, and I am bound to say that I think that the instrument clarifies perfectly adequately the points that were highlighted by the committee, raised in the various debates and responded to by the cabinet secretary.

Indeed, I am slightly puzzled as to why a secondary question now appears to have arisen. I never thought that there was any doubt that if a person with a residence qualification applied to be included on the electoral register and, having been accepted, was granted the right to vote as is required under the legislation, the person who had to decide the constituency in which they exercised that vote was the person on whom the right had been conferred. I cannot understand why the Subordinate Legislation Committee suggests that it could be inferred that an electoral registrar might have such a right, and I do not share that committee's confusion on the matter; I am quite clear that it is the elector who must make that decision if they are not to fall foul of the principal legislation.

Secondly, as the cabinet secretary pointed out during the passage of the primary legislation, the act makes it quite clear that a person will not be able to vote twice. I interpret that to mean that anyone who tried to do so would be breaking the law, which is why it does not surprise me that it was suggested that an offence be introduced in that respect.

I am quite clear, Presiding Officer—

The Convener: Presiding Officer!

Ross Finnie: You are going up the chain, convener. It is happening to everyone.

I am quite clear that the amendment regulations will do what they set out to do, which is to clarify issues that were raised during stage 2 of the Health Boards (Membership and Elections) (Scotland) Bill. At that time, the cabinet secretary committed to providing clarification so, on this occasion, I find myself wholly supporting the regulations. It is perfectly legitimate for the Subordinate Legislation Committee to raise such issues—after all, that is its job—but I do not believe that those concerns cause any problems for agreeing the regulations.

The Convener: Those comments were more points for debate, but they are nevertheless on the record.

Motion moved,

That the Health and Sport Committee recommends that the draft Health Board Elections (Scotland) Amendment Regulations 2010 be approved.—[*Nicola Sturgeon*.]

Motion agreed to.

The Convener: That was short and sweet. I suspend for five minutes.

10:30

Meeting suspended.

10:43

On resuming—

Rural Out-of-hours Health Care Provision Inquiry

The Convener: We move to item 8 and thank the Cabinet Secretary for Health and Wellbeing for her patience. This is the final oral evidence-taking session in the committee's short inquiry into out-of-hours health care provision in rural areas.

I welcome the cabinet secretary, Nicola Sturgeon, to give evidence. She is accompanied by Frank Strang, who is deputy director for primary care, and Ian Williamson, who is performance manager of the Scottish Ambulance Service and NHS 24. I welcome them both. We will go straight to questions from members.

Mary Scanlon: We heard from NHS Quality Improvement Scotland and Audit Scotland that there is a lack of quality standards and that a review was planned because patients did not know what to expect. I felt that that response was very honest and would lead to greater accountability. However, in the British Medical Association's evidence, it said that QIS has

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

Also, the NHS Tayside submission states, in reference to Kinloch Rannoch, that the out-of-hours cover is

"within a framework that meets and exceeds the legal, regulatory and inspectorate requirements and standards".

Those are the standards that QIS and Audit Scotland say do not exist, so I am a wee bit confused.

10:45

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I will try to reply to that as straightforwardly and simply as possible.

I know that the standards have been discussed at the committee's previous evidence sessions. There are QIS standards for the provision of safe and effective primary medical services out of hours—I have those standards in front of me. I assume that the committee has seen them but, if not, we can make them available.

I can give members a couple of examples of the standards that are included. Under the heading of accessibility and availability, boards have to ensure that

"Access to, and delivery of, services is not compromised by physical, language, cultural, social, economic and other barriers."

Clearly, there is a reference to geography in that. Another example, under the heading of audit, monitoring and reporting, is that boards must have in place a set of key performance indicators that cover patient involvement and clinical and organisational aspects.

Those are the kinds of things—there are many more—that the QIS standards cover. Boards also have in place a range of different performance and quality indicators that they measure their out-of-hours services against. QIS also assesses the services against those standards.

If there is an issue with the standards, it is that, although all boards are required under the QIS standards to have quality and performance indicators in place, the indicators in one health board are not necessarily the same as those in another. There are not detailed, consistent, Scotland-wide quality indicators. That means that, although individual boards can assess their out-of-hours services against their own standards, they are not necessarily comparable with those of other boards.

The other criticism—if I can call it that—that has been levelled at the QIS standards is that perhaps they are too process driven and do not focus enough on clinical outcomes. The debate that there has been in previous committee evidence sessions has been interesting and has allowed me to reflect on that matter.

I should say first that I am satisfied that boards, through their local arrangements and key performance and quality indicators, are in a position to assess the quality of their out-of-hours services. However, at this stage—six years on from the new GP contract—I think that there would be great merit in asking QIS to look afresh at the standards and to ask whether it can develop a set of quality indicators that would be consistent throughout Scotland and allow comparison between different board areas. My officials have been in discussion with QIS about that, and I intend to ask QIS over the next period to review the standards to take into account some of the comments that have been made in the committee.

Mary Scanlon: That is a good point. I hope that a lot will happen following the committee's report and, if we can get clear standards, that will be a huge benefit. However, I want to put on record that Audit Scotland said that, as you acknowledged, the

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

In 2007, Audit Scotland said that there was

"no coherent national approach for monitoring"

and enforcement and a lack of clear quality standards for out-of-hours service. It is worth putting that on record because I think, looking at patient safety and service quality, that it is slightly disingenuous of NHS Tayside and others to say that they have met and exceeded all the standards when Audit Scotland and QIS say that there are no standards. However, I thank the cabinet secretary for her response.

Nicola Sturgeon: It is important to get firmly on the record that there are QIS standards and that boards are assessed against those standards—NHS Tayside is rated at level 4, which is the highest level—although I will not repeat what I said about the issues with the standards that have led me to think that a review of them is appropriate.

The other point that it is important to stress is that, although the QIS standards focus on the processes that boards should have in place, the boards themselves have quality indicators.

For example, boards routinely provide real-time monitoring of how they handle calls and deliver services against the NHS 24 timeframes. They produce performance-monitoring information about service costs, call demand and call disposition. They have in place procedures for investigating and learning lessons from any adverse incidents. They also have in place arrangements under which they report as part of their clinical and corporate governance reporting.

I do not want the committee to be under the misapprehension that no standards are in place—I am sure that it is not. Standards are in place but, on the basis that we should always aim to learn from experience—particularly six years into the new contract—it is timely for QIS to look afresh at the standards and to consider whether a common standardised set of clinical outcomes could be developed for boards to assess themselves against, for QIS to assess boards against and to allow comparisons between boards. For reasons that we might discuss later, that task will not be without challenges. The nature and geography of Scotland mean that, by necessity, boards deliver out-of-hours services in different ways. Nevertheless, the exercise is worth doing.

Mary Scanlon: That answer is helpful and brings us to where we are today. A huge number of submissions say that patients are confused. We do not know whether patients' expectations are realistic. At Kinloch Rannoch, Murdo Fraser made the good point that an emergency response differs from the provision of GP services—an emergency response differs from clinical care.

Last night, I read a paper that I received from a Highland doctor who is about to do the four-year pre-hospital emergency care certificate, which is

on top of his five years as an undergraduate and his four years of training to become a GP. This guy will have done 13 years' training in order to join BASICS—the British Association for Immediate Care. He says that, as a result of what is happening,

"there can be little experienced clinical input to a potentially ill patient prior to them attending, by arrangement, to hospital based services."

He highlights the difference between an emergency response and appropriate clinical care. We know that the first responders in Kinloch Rannoch do an excellent job, but in no one's imagination does five days' training compare to a GP's 13 years' training.

We are finding that there is an emergency response and there is appropriate clinical care. Will you explain that to us? Have we focused so much on response times by the Ambulance Service or community first responders that we have missed the question of what the appropriate clinical care is, which might or might not be from a GP? Do you share my view that those two issues have become confused in the debate?

Nicola Sturgeon: That might be the case but, before I answer that question, I make it clear that first responders, who increasingly perform a valuable role in communities throughout Scotland, are not a substitute for a GP or an ambulance when an ambulance with a paramedic is required. First responders supplement the care that is otherwise available and provide a more immediate response when that is of value to a patient. It is important to be clear about that.

Most important of all is that, when patients access care out of hours, they are referred to and access the appropriate care for their needs. A big misconception is that NHS 24 provides out-of-hours services. It does not. Its job is to provide the call-handling service, the triage and the referral to the appropriate services consistently throughout Scotland. NHS 24 therefore has a key role in ensuring that patients are referred to the appropriate service, which is the Ambulance Service if the incident is immediate or life threatening. If the matter is less serious, the appropriate service might be a minor injuries unit, a GP out of hours, a community paramedic or a patient's GP in hours, when their GP's surgery next opens. That is appropriate. Obviously, people who know—or whose relatives or those who are with them know—that they are in immediate danger or a life-threatening situation will phone the Ambulance Service directly.

Given our geography, we will, no doubt, go on to talk about specific concerns and challenges in certain parts of the country. However, it is important that we have in place systems that refer people to the care that is appropriate to their needs at any given time, and I believe that we do.

Mary Scanlon: Pauline Howie, the chief executive of the Scottish Ambulance Service, told us last week in Kinloch Rannoch that the service has had a 35 per cent increase in the number of call-outs during the day since the new GP contract was introduced and a 42 per cent increase in the number of call-outs out of hours. The service feels that it is filling the gap although it is an emergency response. When we are considering issues of clinical care and emergency response, that figure sums the situation up.

Nicola Sturgeon: Obviously, as Pauline Howie told the committee last week, there has been an increase in demand for the Ambulance Service generally. We can debate the extent to which the in-hours increase in demand is related to the GP contract, but there has been a general increase in demand that is slightly higher out of hours. The Ambulance Service is part of a multiprofessional, multidisciplinary team that provides out-of-hours services. It is important that its role is understood and that there is clear understanding between it and territorial boards. A lot of work is going into that, particularly with the remote and rural health boards, to ensure that it is understood what the Ambulance Service is there to provide.

That goes back to my point about the need to ensure that patients have been referred to the most appropriate care. Something like 6 per cent of calls to NHS 24 are routed to the Ambulance Service for an ambulance response—that is a relatively small proportion of calls. Also, rightly, procedures and protocols exist between NHS 24 and the Ambulance Service, which are increasingly working in a much more integrated way, to ensure that, if a patient calls one of those services but they would be better catered for by the other, that call is transferred appropriately.

I am not saying that everything is perfect. As with all areas of the health service and the services that it provides, there is always scope for learning and improvement. However, increasingly, the Ambulance Service, NHS 24 and territorial health boards are working in a more integrated way to ensure that all their roles are understood, that the Ambulance Service is responding to the calls that it should be responding to and that other parts of the health service are doing likewise.

Rhoda Grant: We were struck by the fact that there seems to be some friction between the services, as Mary Scanlon has suggested. The Ambulance Service says that it is receiving more calls and the health boards are criticising the Ambulance Service for not responding in time, meaning that they are having to pick up. The differences between the two services are clear in an urban area but not so clear in a rural area. We

were told that an ambulance could take four hours to reach an emergency in a rural area, whereas a GP could be within 10 minutes of that person. We need to consider how services are delivered, focusing not on what belongs to whom but on the fastest and most efficient response to people's needs. If someone who is having a heart attack has to wait four hours for an ambulance, the chances are that they will die, whereas a GP could come out to them more quickly, assess the situation and deal with it, maybe by phoning an air ambulance.

There seems to be a job of work to be done. I am not sure that it is helpful that we have a separation between the Ambulance Service and health boards, as that may create barriers. Somehow, we need to join them up. We also heard that the Ambulance Service is using BASICS-trained GPs as an emergency response but that those are not the GPs who are on call for the health boards. There could be two GPs on call, covering the same area and doing the same job, but apparently not within a joined-up system. The Ambulance Service and NHS 24 do not seem to know what is going on locally, so they are not always able to deal with it. I am not surprised that they do not know what is going on because there is such a mish-mash of different things happening. Perhaps some work needs to be carried out on that.

11:00

Nicola Sturgeon: There is a lot in there. I agree with the general proposition that we should have as integrated a service as possible. I take the simple view that the patient who requires an out-of-hours response, whether it is for an emergency or for something routine, is not really bothered about who provides it—they want to get the right response. The services therefore have to operate in that way.

A great deal of work is being done to try to integrate services better. Earlier, I referred to work being done jointly by NHS 24 and the Ambulance Service. They now have a joint medical director and they are working increasingly closely together. You have heard about co-location in Cardonald, and there will soon be co-location in North Queensferry. The increasing trend is for organisations to work together.

Possibly the most significant piece of work that they have embarked on is towards a common triage tool. At the moment, someone who phones NHS 24 will be assessed on a different algorithm and in a different way from someone who phones the Ambulance Service. There is a strong argument for a combined triage assessment. There are complications underlying that work, but it is under way.

Likewise, the Ambulance Service is working closely with territorial boards; Rhoda Grant is right to say that that is particularly important in remote and rural areas. We have the strategic options framework for emergency and urgent response, which is an agreement between the remote and rural implementation group and the Ambulance Service that tries to clarify, for the first time, the responsibilities of various organisations to provide a response in emergency and urgent situations.

I could go on about some of the other work that is under way. A great deal of effort is being spent on ensuring that the service is joined up and integrated and, from the patient's perspective, seamless.

I take the point about BASICS-trained GPs. They might not be used by the Ambulance Service to contribute to meeting response times, but they can be and often are. Obviously, their training is radically different from that of first responders, but the philosophy is about getting the quickest possible response to the patient. BASICS-trained GPs are therefore a useful resource. Sixty-odd BASICS schemes are currently in operation in Scotland at the moment, and the Ambulance Service requires to know where they are and when they are available, so perhaps work needs to be done to make that more effective.

You made the point about NHS 24 and local knowledge. We now have a local NHS 24 centre in every mainland health board, and work is being done to network the island boards as well. NHS 24 also has what is called a knowledge management system—that might not be the absolutely correct title—which aims to have accurate and up-to-date information on all available local services and facilities. If someone phones NHS 24 and needs to know where their local pharmacy is, NHS 24 aims to use that system to be able to tell them where it is and when it is open and even to calculate the mileage to it.

As I said earlier, I do not think that everything for which I am responsible is perfect and that there is no room for improvement. A wealth of work is being done to ensure that out-of-hours services in Scotland, which are good and are delivering a quality service to patients, get even better. I agree that better integration between the different parts of the service is extremely important.

Rhoda Grant: I have a quick supplementary question to Mary Scanlon's question on QIS standards. When we were taking evidence on that, it became clear that rates of pay between health boards are markedly different because of the new GP contract. The BMA told us that, basically, the rates of pay are driven by market forces. Depending on where a health board is and its access to GPs, the pay for on-call services can be as little as £10 an hour, but that can go up

radically to about £150 an hour. If we are considering QIS standards, we perhaps need to consider changes to the GP contract to ensure that the payments for out-of-hours services do not penalise health boards that are in those more difficult areas.

Nicola Sturgeon: I have a lot of sympathy with that. You are referring to independent GP contractors who, in effect, sell out-of-hours sessions to health boards and are paid for that. There is no doubt that, to a large degree, market forces are at play in that. There is evidence that, because of a greater supply of GPs who are willing to offer out-of-hours sessions, a downward force is at play on some of the costs. There are variations. For example, Greater Glasgow and Clyde NHS Board has had a healthier supply of GPs and registrars who are willing to offer sessions, so the board has maintained a largely GP-led out-of-hours system, whereas other boards have gone down a much more multidisciplinary route.

There is evidence that the costs are beginning to come down because of a greater supply of GPs who are willing to do sessions. In one of the committee's previous evidence sessions, somebody—I cannot remember who—suggested that that means that there is a greater supply of GPs who are now prepared to do 24/7, as they were under the old contract. However, there is no evidence that that is the case, although there is evidence that more GPs are willing to do out-of-hours sessions. That should have the effect of driving down the costs, but I am happy to consider further the point that the member makes.

Dr Simpson: It is important that you say that, because it slightly contradicts the evidence that we received from Audit Scotland that there has been a drop in the number of sessional doctors. I cannot remember the numbers offhand, but I think that it was 1,500 and something dropping to 1,400 and something. It would be helpful if you gave us information on that in writing, because what you have said is important for the way in which we consider the contracts in general in the future, although it perhaps does not apply so well in remote and rural situations.

Nicola Sturgeon: I am happy to provide more information in writing, but I can speculate, perhaps wrongly, on a possible explanation for that apparent contradiction. It might be that, as boards have developed more multidisciplinary models of out-of-hours provision, they have become less reliant on sessional GPs and make less use of them. However, I cited the evidence that more GPs are willing to offer sessions and that therefore the cost is beginning to come down. I am happy to consider the point in more detail and provide clarification.

Rhoda Grant: My more substantive question is about community involvement. I will use the example of the experience in Kinloch Rannoch. My understanding was that the community had met the health board and reached an agreement. The job was then advertised, but what happened afterwards did not follow the agreement. How can communities interact with health boards to ensure that services are delivered in a way that suits the community's needs and meets its aspirations? Is there no guidance to suggest that, if a community and health board reach an agreement and the health board then wishes to renege on that, it should go back and consult the community? The issue is about consultation and working with people.

Nicola Sturgeon: I will come on to the generality of that in a second, as it is important, but I am not sure that I entirely understand what you are referring to when you talk about an agreement between Tayside NHS Board and the community in Kinloch Rannoch.

Rhoda Grant: My understanding is that the community agreed with the health board that it would look for a GP who would provide out-of-hours services, and that that was what was advertised. People in the community tell us that the provider that was appointed was the only applicant that was not willing to provide out-of-hours services. The agreement on the job specification should have been adhered to. If the health board intended not to adhere to that, it should have gone back to the community and spoken to people.

Nicola Sturgeon: If I can manage to do so, I will address that point without getting too far into the details of the Kinloch Rannoch discussion, because, clearly, responsibility for the provision of its out-of-hours services lies with NHS Tayside and, as I understand it, some of the history of the Kinloch Rannoch situation predates my time in office. I believe that this case is the only time, not just in Scotland but in the United Kingdom, when a panel has been established to decide on a challenge to a GP's decision to opt out of providing out-of-hours care. NHS Tayside did not oppose the decision to opt out in principle, but it wanted the arrangement to be phased. The panel's decision went against NHS Tayside. The advert for someone to replace the retiring GP was for a GP who would do out-of-hours work. NHS Tayside made a judgment, which I cannot second-guess, that the best applicant in respect of overall service provision was the one who was chosen.

I will now deal with the generality, because it is very important not only for out-of-hours provision but for any NHS provision that there is good-quality, meaningful engagement between a health board and the communities that it serves. The QIS

standards that we referred to in response to Mary Scanlon include a number of standards for patient focus and involvement. Some of what health boards are assessed against in the standards relates to the way in which they work in partnership with individuals and communities in the design, development and review of services. That indicates the importance that we attach to such work.

I know that sections of the community in Kinloch Rannoch are not satisfied with the out-of-hours provision there. We may or may not come on to some of the detail of the situation later, but I understand the concern that any local community will have to ensure that it has the best service provision possible. I made it very clear when I chaired the NHS Tayside annual review, which, like this meeting, was attended by people from Kinloch Rannoch, that I expected NHS Tayside and, indeed, any health board to continue to engage, consult and try to satisfy and address the concerns of local communities.

I asked NHS Tayside to send me a copy of its most recent community update in Kinloch Rannoch. I do not know whether committee members have seen it; if not, I am sure that NHS Tayside will make it available to you. A range of engagement is under way with the community, one practical outcome of which—I accept that it does not satisfy all the concerns of some of the campaigners involved—is that the air ambulance service and the emergency medical retrieval service are now able to land on the playing fields in Kinloch Rannoch, because the agreement of the local community was obtained and NHS Tayside purchased landing lights.

As you have heard me say many times before, community engagement is of paramount importance. If a community is not satisfied, I will usually take the view that the board has to do more to address concerns but, ultimately, there will always be situations when a difference of opinion between a board and sections of a community cannot be addressed to everybody's satisfaction. Such situations will often arise, but there is certainly a strong onus on any health board to engage on an on-going basis with the communities that it serves.

Rhoda Grant: I understand that and take it on board. I know from my own casework that, when I deal with communities in my own area, trying to get health boards to listen seems to cause huge frustration. People feel that they cannot do anything to put pressure on the health board, that it does not listen and that it just ticks a box, saying, "We consulted, we called a meeting and we had a focus group." It says that it held a big consultation—such as the one that is going on in Skye—but at the end of the day it is going to do what it wants to do. People feel really frustrated that they cannot engage properly. I am not suggesting that the cabinet secretary has a magic wand, but can standards be set around health board community engagement to ensure people feel that, although they perhaps did not get what they wanted, they at least had a fair hearing and their views were taken on board?

11:15

Nicola Sturgeon: I am sympathetic to that point. As I said earlier in relation to the QIS standards, this is an area in which local boards are expected to have processes and procedures in place that they can be judged against. It is important, although sometimes difficult, to distinguish between engagement and the outcome of that engagement. I am not talking specifically about Kinloch Rannoch—there will be many examples around the country of a health board being unable to provide a particular service that a local community would like in the way that the community would like it to be provided because the health board has to take account of the provision of services right across its area. Health boards must make judgments about the optimal provision of services across their whole area. Therefore, there will be occasions on which a community and a health board will just not see eye to eye.

That does not mean that a health board does not have a continuing obligation to consult, to engage, to explain and, when appropriate, to listen to communities. As you will know from previous decisions and comments that I have made, health boards sometimes get things wrong. When they clearly get things wrong, they should listen to local communities. However, the fact that a health board and a local community do not always see eye to eye does not always mean that the health board has got it wrong; sometimes, it just means that there is a genuine difference of opinion.

Frank Strang (Scottish Government Primary and Community Care Directorate): The QIS standards are relevant in that context in that they require health boards to involve patients not only in the design of the services, but in expressing satisfaction afterwards. That closes the loop. Health boards must not only consult on the implementation of services, but report on satisfaction rates, and there is no escaping from that.

Nicola Sturgeon: Most, if not all, health boards have carried out surveys of patient experience of out-of-hours services. Generally speaking, although there will be specific concerns in specific communities, testing of patient satisfaction with out-of-hours services shows that the level of patient satisfaction is very high.

The Convener: Helen Eadie has been very patient.

Helen Eadie: Thank you, convener. I want to continue that thread about small, sparsely populated communities. It is difficult to monitor and, as a result, to evaluate the number of situations in which care has been denied in such communities. Last week, we heard lots of anecdotal evidence of poor outcomes for patients. The fact that such communities contain only a small number of people is not a reason for removing entitlements—that is at the heart of what we have been hearing. In every community throughout Scotland, people are saying that they should have core rights and entitlements.

I think that that was in Professor Allyson Pollock's written submission. She argued—it is a point with which I agree—that health boards should not be able to remove those core entitlements from groups without the assent of either the cabinet secretary or the Parliament and without proper consultation. However, we heard in evidence last week that the consultation stage had been bypassed and that the community felt strongly that it had never been given the opportunity to see what the alternatives and their implications were. Those of us who were at the meeting last week got the impression that that is the sort of thing that leaves communities with a bad taste in their mouths and feeling that a fundamental injustice has never been remedied.

Back in the first session of Parliament, we considered a petition about changes that were being made by Greater Glasgow NHS Board without public consultation. We then had issues with the public consultation on “Right for Fife”. In those days, although the health board arrived at a decision, it was always signed off by the minister. When there is a fundamental change, communities are right to argue that the change should be signed off by a cabinet secretary or a minister. Would you like to comment on that?

Nicola Sturgeon: Major service change proposals from a health board still have to be signed off and approved by a minister—there has been absolutely no change in that position. According to my memory, that is as it has always been; I have some experience of that as the only health minister to have overturned health board decisions that had previously received ministerial approval—I am thinking of the proposed closure of two accident and emergency departments. There has been absolutely no change to the requirement for ministerial approval.

I do not want to go too far into the history of the Kinloch Rannoch situation, but the removal of an out-of-hours GP who was resident in Kinloch Rannoch was not initiated by NHS Tayside—it is not something that the health board decided would be a good idea; there were circumstances outwith the board’s control. When it advertised for the GP the board made clear its strong preference for out-of-hours provision, but that did not prove possible. There are differences of opinion about the different applications that were made, but the board made a judgment about what it thought was the strongest overall application.

On the wider point about core rights, I passionately believe that people should have the right to high-quality health services no matter where in Scotland they live. A fifth of our population lives in remote or rural areas, and we have to strive to deliver quality services. One of the many reasons why I was irritated by the recent Nuffield report was that it took no account whatever of the additional costs and staff resources required to provide quality services to people who live in some of our remotest communities.

There is a debate around that core entitlement when it comes to out-of-hours services. Increasingly, health care—not just out-of-hours care but in-hours care—is delivered by multidisciplinary teams. GPs will be a strong part of those teams, but nurse practitioners, community paramedics and staff working in minor injury/illness units are all professionals who contribute to the team.

We must challenge the notion that quality out-of-hours services are not being provided in some communities in Scotland because, given their geography, they do not have a resident, 24/7 GP. There are many examples in the Highlands of villages that rely on out-of-hours GP cover that is provided from a different village. However, it is the multidisciplinary team that really provides the quality health care. Without getting sidetracked into the situation at Kinloch Rannoch, I point that service provision there includes services from NHS 24, the Scottish Ambulance Service, the minor injury/illness unit, a community paramedic and an out-of-hours GP with a car and driver. There is comprehensive out-of-hours provision there.

I do not want anybody to suggest that I do not understand the concerns that any community will have about such matters. Of course people will feel safer if they have a resident GP providing out-of-hours cover, but we have to consider the totality of the services that are provided. Many remote and rural communities are not simply reliant on GP cover.

Helen Eadie: I totally accept what you are saying. There are many health professionals scattered around Scotland and, as we listened to last week’s evidence, the point about integration, which Rhoda Grant has mentioned, made an impression on me. We were given an example of

an incident that could have been attended by local GPs, yet someone 100 miles away became involved. It did not seem as if intelligence was being used, and the new technology did not seem to be working.

You have perhaps covered that point about better integration, but I will quickly mention another issue to do with cost, on which the National Audit Office did some work in 2009. In her paper, Allyson Pollock wrote that the estimated cost of running out-of-hours services was approaching £68 million in 2005-06—some years ago now—and added:

"but there has been no evaluation of the costs and benefits of the changes to OOH provision."

Is that the case?

Nicola Sturgeon: The most recent year for which I can give you figures is 2008-09. The cost of providing out-of-hours services in that year was £70.016 million. That is an increase of 3.5 per cent on the figure that you quoted from 2005-06—it is a lot of money and a big expense for health boards, especially those that cover remote and rural areas. However, the scale of the increase suggests that boards are managing to contain the costs of out-of-hours care in a way in which some thought they would not. I hope that the updated figure is helpful to you.

Helen Eadie: It is. Tayside NHS Board claims that it would cost almost £500,000 to reintroduce the out-of-hours service. That is a huge claim, given that the initial cost of opting out of 24-hour care should be just £12,000. When such figures are put to your officials by boards across Scotland, to what extent do they dig into them, to verify those claims?

Nicola Sturgeon: A great deal, as I am sure any board official would tell you. Instead of my trying to second-guess the figures that NHS Tayside has given to the committee, we can provide you with further clarification of them or ask NHS Tayside to do so. I am not speaking for the board, but the central point that it was making was that the cost of providing a resident out-of-hours GP in Kinloch Rannoch, rather than the multidisciplinary approach that is provided at the moment, would be disproportionate. I have seen figures that suggest that in the past year there were 22 out-of-hours GP calls from Kinloch Rannoch. That is the basic point that the board was making.

We must be slightly careful when we talk about comparative costs. That issue is important, given the scale of the NHS budget, especially in tight economic times, but—rightly—the first concern of people living in Kinloch Rannoch or any other part of the country is not how much it costs to provide services but whether services are safe and effective. I do not want to put too much emphasis on the financial part of the discussion. My concern is to be satisfied that a community anywhere in Scotland that has concerns is being provided with out-of-hours services that are safe and clinically effective. That should be the first and paramount consideration.

Helen Eadie: I agree. It would be wrong of us as politicians to tell people that they cannot have a service because of its cost. However, according to Allyson Pollock, if we extrapolated the National Audit Office's figures, the additional funding at Scottish Government or health board level for Kinloch Rannoch would be £24,000 at most. I ask you to bear that point in mind and to compare what the National Audit Office and Allyson Pollock are saying with what NHS Tayside is saying. Sometimes it can be convenient for health boards in Scotland to hide behind the argument that reintroducing a service will cost an extra £500,000, which makes everyone frightened to dare to go there. In fact, we must listen much more sympathetically to the needs of communities, based on the realities.

Nicola Sturgeon: I take Helen Eadie's point—perish the thought. I will leave it to NHS Tayside to provide the committee with clarification of its comments about costs. However, to be fair to NHS Tayside, its decisions in Kinloch Rannoch are not based solely on cost—they are also based on its view of how best to provide a quality service in the area, given the demand that exists and so on. I appreciate that there are quite acute differences of opinion between the board and the local community. That takes me back to the points that Rhoda Grant made earlier. I expect NHS Tayside to continue to engage closely with the community of Kinloch Rannoch, to see what more can be done to address that community's concerns.

The Convener: If Helen Eadie gives the clerks a draft of the question that she wants to ask, I will write to NHS Tayside for clarification, on behalf of the committee. We cannot expect the cabinet secretary to know that information. Can we move on? Helen has not noticed that I am talking to her, so we will do so. If you look away, you have had it.

Ian McKee: Two points stood out in evidence and were accepted by most people. The ideal for the individual is to have their GP on call 24 hours a day, 365 days a year. However, it was accepted that that is no longer possible or, indeed, desirable, because GPs need time off for further education and so on.

11:30

The other point that we all agreed on was that one size does not fit all. Different rural areas have different needs. The thing that concerns me—it

came to my mind when we discussed the Kinloch Rannoch situation, but could be relevant all over the country—is the slight tendency for boards to try to apply urban solutions to rural settings. We could end up with out-of-hours cover that met the basic rules that were set down but was deficient in other areas. We know that NHS Tayside officials gave their board an estimate that the cost of supplying an out-of-hours service to Kinloch Rannoch would be around £0.5 million. I am told that that is because they budgeted for four drivers and three and a half GPs. In other words, they transposed the solution for Dundee to Kinloch Rannoch. Obviously, if there are only 22 out-of-hours calls a year, a GP covering that will not require nearly as much pay as someone who works all the hours between 6 and 12 or whatever in a city.

We also know that a GP or an experienced nurse who knows the patient can cut down on ambulance use, A and E work and hospital admissions. The first responder told us in evidence that he is not allowed to cancel an ambulance request, even if he can see quite clearly that an ambulance is not required. The ambulance would have to come all the way out to wherever the first responder was with the patient because that is the rule.

Could boards be asked to try harder to find solutions that provide some form of experienced out-of-hours care nearer to where it has been provided previously? For example, could the boards explore the use of a salaried GP service or the use of an experienced nurse based in the area, which could be augmented by GPs at a much lower cost than has been described by NHS Tayside? Should we ask boards to consider the situation more carefully before discarding realistic financial options, rather than transposing services that are based on a city's needs into a rural environment?

Nicola Sturgeon: Absolutely. I will come back to the latter point in a second. I thought that you made an interesting point by way of preamble, which is that, for most people, the ideal is to have 24/7 access to their own GP. I understand that, and most people would identify that as the ideal. However, we have to accept that times have changed. When I was younger, people always saw their own GP. Now, I rarely see the same GP twice at my health centre in Glasgow. Things have moved on.

Although this discussion is helpful and absolutely legitimate, there is a tendency to look at the pre-2004 era as if it was perfect. I have no vested interest in or brief to defend the negotiation of the new GP contract, because that happened before my time in office, but we should not forget the drivers for that change. The Royal College of General Practitioners said in 2004 that a quarter of GPs were considering leaving the profession. There were real recruitment and retention difficulties, particularly, but not exclusively, in remote and rural areas, which were seen to be in large part down to the out-of-hours obligation. There was also a feeling that GPs had to improve the quality of in-hours care. The quality and outcomes framework was partly designed to do that. What existed pre-2004 was not perfect, and we should not suggest that it was.

On your substantive point, I absolutely agree that one size does not fit all anywhere, but particularly in Scotland. That is why, although we have a Scotland-wide system for triage, assessment and referral through NHS 24, it would be entirely wrong in my view to try to design a Scotland-wide out-of-hours model. Boards should not apply urban solutions to rural situations. Plenty of boards—I cite NHS Borders as an example—have put in place innovative models using salaried GPs and nurse practitioners, and in such cases the majority of out-of-hours visits are seen to by nurse practitioners. There are good examples of models being put in place to fit particular circumstances, and that is right.

My direct answer to your direct question is that boards should be encouraged, and I would expect them to try hard, to go the extra mile to find solutions that address the concerns of local communities and, in line with my philosophy, provide as much care and response to communities as locally as possible. In practice, however, that will inevitably take different forms in different parts of the country.

Ian McKee: Taking the Kinloch Rannoch experience as an example, although I am sure that the same thing can happen elsewhere, it seems that the board advertised for a GP who was willing to provide out-of-hours cover and asked applicants to suggest ways in which that should be done. Not surprisingly, there was not a huge response. I believe that, in a remote and rural area, the board has some responsibility to devise a scheme itself, based on the area's requirements. In some areas, GPs who have recently retired but kept their registration might well be prepared to help out. The reason why loads of GPs wanted to get out of out-of-hours provision when the new contract came along—apart from reasons to do with how little was being paid—is that they were not given help. Some GPs had to do 24 hours and, if they were ill, they were still responsible.

Do you agree that, when a vacancy comes along in a rural area, the health board that is responsible for the area should try much harder than was the case in the Kinloch Rannoch example to devise a more local professional

response that allows people time off and the ability to keep up to date?

Nicola Sturgeon: Yes. I do not know that anybody would disagree with that. It is incumbent on NHS boards to try to find the most local solution.

I do not want to go back to the NHS Tayside and Kinloch Rannoch example again, but the situation in which there was no resident out-of-hours GP was not one of NHS Tayside's making. It advertised the position, got limited applications and made a judgment about which was the strongest application overall. That does not absolve it or any other board of continuing to try to find the best solutions. If NHS Tayside was sitting here, it would defend the out-of-hours arrangements that it has in place for Kinloch Rannoch. Does that mean that it should not be open to new ideas and suggestions about how the service can be further augmented and how it can further address local people's concerns? Of course not. It should always be open to that, as should all NHS boards.

Particularly in rural areas, there should be innovation, and thought should be given to solutions that are perhaps not obvious. There are examples in other parts of rural Scotland where such innovation is delivering high-quality services. I repeat what I said earlier about first responders not being substitutes for GPs, but things such as first responder schemes are in themselves innovative ways in which to build community resilience. They provide communities with a level of service that cannot always be provided in the traditional ways that are used in more urban areas.

Ian McKee: I just hope that you will reinforce what you say in your advice to the boards, because there is some evidence that boards will quite quickly revert to what I call the urban solution, which is easily done and which meets certain basic qualifications, whereas it is quite hard work to devise something more innovative for a specific area. If you encourage boards to make that effort, I will be pleased.

Nicola Sturgeon: Boards will always be encouraged to do that. NHS Tayside covers both urban and rural areas, but if many boards in Scotland applied urban solutions to some of the problems that they face, they would quickly get into significant problems. The remote and rural work programme that is under way is all about trying to find new solutions and new ways in which to provide services to remote communities.

Traditionally—long before I was in this role—there was a mindset that it was too difficult to deliver some services in some remote communities, and that it was easier to close the rural general hospital and send patients elsewhere. That mindset has shifted, and the emphasis now is very much on sustaining services locally. It is not always possible to do that, and sometimes it is not in a patient's interest to access a service locally when they would get a better service somewhere else. However, I believe strongly in the presumption of local delivery.

The Convener: Ian McKee raised the point that first responders are not in a position to cancel ambulances. Do you have any comments on that? I think that the issue has been raised with the committee.

Ian McKee: It was raised in evidence.

Nicola Sturgeon: I am happy to look into that.

The Convener: Would Mr Williamson like to assist?

Ian Williamson (Scottish Government Primary and Community Care Directorate): I suspect that that is the case with first responders, and that it has been considered as being in the best clinical interests and as constituting best clinical governance. It minimises a perceived risk in those few circumstances in which the community first responder might otherwise take the option to stand down the ambulance and their judgment turns out to be wrong and something goes wrong. It is undoubtedly risk averse.

The Convener: I understand the reason; I just wanted to explore the point.

Ian McKee: I was not saying that it was wrong, but that it happens.

Ian Williamson: The point was about the use of resource.

Ian McKee: Yes.

Nicola Sturgeon: All these systems are risk averse to a great extent. I am aware from previous evidence to the committee that some people from the Scottish Ambulance Service think that NHS 24 systems are too risk averse and often lead to people being sent ambulances. The systems are risk averse, especially when telephone triage is involved, because we want to minimise the risk of the wrong judgment being made.

Ian McKee made the point about reinforcing some of what I have said with health boards. I do that routinely with committee reports, but I will ensure that boards pay close attention to the report that the committee produces from its inquiry, and that they discuss any suggestions or ideas that arise from it.

Michael Matheson (Falkirk West) (SNP): We have already discussed GP out-of-hours services this morning, and some of the evidence that we have received suggests that the reluctance on the

part of some GPs in rural areas to participate in out-of-hours services is potentially to do with the financing of those services. It has also been suggested that some GPs in rural areas are not prepared to take up out-of-hours sessions because of the associated risks. Those are clinical risks—for example, GPs may be presented with a case but may not have the necessary clinical skills or back-up to deal with it in a particularly remote area. If NHS 24 refers someone in a city to an out-of-hours GP service, the GP may make an initial assessment and refer the person on—to the sick kids hospital, for example, if the patient is a child—for a specialist assessment. The hospital may be only a mile or two down the road in that case. A GP who is working in a remote and rural area, however, does not have that luxury, and may not have the clinical skills to make a clear judgment on the case.

One concern that has been raised is how we can equip GPs in that situation to be more confident in taking up out-of-hours sessions. That does not necessarily mean that they should be BASICS trained, but—as some witnesses have suggested—there are technological ways in which boards could address such problems. That could involve telehealth or other ideas that would help to give clinical back-up to GPs in such situations, so that they could access a specialist for advice without having to refer someone on. It may otherwise take someone a two, three or four-hour drive before they even get to the hospital where the specialist works.

Nicola Sturgeon: That is an important point. We must ensure that those GPs and other clinicians who are working in rural areas, with all the associated issues, have the right training and back-up. A big thrust of the remote and rural strategy is how we train people who work in remote areas differently to equip them with the right skills. A lot of emphasis is placed on what are called obligate networks, to make it clear what other boards are required to do to support the work of rural health boards and the clinicians who work for them. NHS Education for Scotland has an education and training framework for non-medical professionals who work in out-of-hours provision, to ensure that they have the right skills and competencies to do that work.

Michael Matheson's general point is well made. I am happy to look at whether NES or the boards could do more to support GPs who might be keen to contribute to the provision of out-of-hours services.

11:45

Michael Matheson: What struck me from some of the evidence that we have received is that the problems that we are discussing are not new—they have been around for a long time, as have the concerns of GPs in the areas in question. My concern is about the pace at which some of the changes take place. When technological routes exist that could be used to address such concerns, it seems to take a considerable length of time for health boards to adopt them. I understand that testing is sometimes required, but I think that the communities that are concerned about the services that they receive would like to see health boards stepping up the pace at which they introduce some of those measures. To go back to what Mary Scanlon said, it is not just about someone turning up; it is about people receiving the right clinical response. We must help to ensure that people get the right clinical response as quickly as possible.

Nicola Sturgeon: I know that the committee is extremely interested in telehealth and thinks that we should move more quickly to apply and put into more widespread use the telehealth solutions that are piloted or trialled. That is a fair point. The fact that the Scottish Centre for Telehealth is now under the aegis of NHS 24 may help in the application of telehealth solutions to out-of-hours care; indeed, that was one of the drivers for the decision to merge the two organisations. Progress is being made that will mean that telehealth will become more of a solution in some of those areas. I accept the committee's view.

On the other hand, we should not underestimate how much progress boards made on out-of-hours services between 2004, when the opt-out for GPs came in and it became boards' responsibility to provide such services, and 2006, when some of the early challenges and problems had been resolved. The NES training framework is a key example of that. Real progress has been made on out-of-hours provision and boards deserve a lot of credit for that, but we need to ensure that we continue to build on that and that new solutions—telehealth solutions, in particular—are applied appropriately. As in many other areas of service delivery, telehealth can radically reform our ability to provide services in some of our most remote communities.

The Convener: Before we get into telehealth in more detail, I remind the committee that we will consider our draft report on the clinical portal and telehealth next week. That is timeous because although we will produce two separate reports, they will be strongly interconnected.

Dr Simpson: My question is on telehealth because, as the convener said, there is a link to our work on that. There are two aspects to telehealth. One is the additional connectivity that it can give the entire team in a rural area. I would like us to think beyond the box. We tend to think only about NHS staff, but in more rural

communities there are sometimes police and fire service volunteers who are partially trained in first aid. We still tend to think in silos, but we need to adopt a much more comprehensive approach.

On separating out the emergency response, the military is another group that we should be thinking about and which we can learn from. The field force work that is being done at the moment is truly staggering, and what paramedics do under direction from a doctor in the base camp is amazing and life saving. We should not ignore the potential for learning from that.

The second issue is e-care. We should consider what is being done in a number of areas—we heard about that in our other inquiry. In rural communities, much closer monitoring might prevent the readmission to hospital of people with relapsing conditions. It is about ensuring that the boards focus attention on individuals who require ancillary care. That will give them and their carers confidence, and it will give them access to a centre by telelink. It is about learning from Dr Ferguson's rural accident and emergency work in Grampian and extending that to the e-care system. All those measures would give communities greater confidence.

I welcome the cabinet secretary's general response to the issue of standards, which are generally to do with processes. I am pleased that she is considering how that can be moved on. The issue is not easy; indeed, it is extremely challenging. However, it is worth while our considering moving beyond that issue to get boards to concentrate on how they can deal with things in remote and rural settings, which may be slightly different from central areas.

Nicola Sturgeon: I agree strongly with everything that Richard Simpson has said. As he mentioned the military, I will unashamedly take a wee diversion. I pay tribute to 205 squadron, which I visited in Glasgow before Christmas. It is currently running the field hospital in Camp Bastion in Afghanistan, and is doing a fantastic job. I am sure that everybody is proud of it.

It probably should not have taken so long into the meeting before Richard Simpson's first point was made, because it is fundamental. We are talking about the NHS, which is important, but it is part of a much bigger picture. When we talk about out-of-hours services, we cannot ignore social care services, the police and fire services, and all the agencies that have a part to play. In their out-of-hours models, many boards are increasingly looking to the linkages not only between NHS professionals, but between the NHS and other agencies. That is a fundamentally important point that we tend to forget when we talk about the NHS. Richard Simpson is right about that.

The points that have been made about e-care are hugely and fundamentally important. In a sense, it makes the link between out-of-hours and in-hours provision. One of the drivers of the new GP contract was the need to improve the ability of GPs to provide good-quality, anticipatory care in hours for people with long-term conditions and therefore to make it less likely that they would require out-of-hours or emergency care. Boards that pool together their out-of-hours services are thinking, and must continue to think, about how more anticipatory care, e-care and e-health solutions have a big part to play in that, as they do in many other areas. That anticipatory care, which prevents people from having to rely on out-of-hours provision, is incredibly important.

I do not know whether I need to say anything more than that. I endorse the points that Richard Simpson made.

The Convener: I think that, in general, the committee thinks that we need to get momentum behind the matter, because there has not been the push to move forward with the relevant technology over many years in the Parliament.

Nicola Sturgeon: It is early days. I have previously heard committee members' comments on telehealth, some of which were well made. The placing of the Scottish Centre for Telehealth into NHS 24 gives us the chance to up the pace. I hope and expect that that will happen.

The Convener: Ross Finnie wants to say something, and Mary Scanlon and Rhoda Grant have short supplementary questions, if they can still remember what they are. I am sure that they can.

Ross Finnie: Michael Matheson made one of my substantive points, but I want to press the cabinet secretary. We have discussed a lot how we ought to move on and stop discussing whether we should go back from the current GP contract. The person from the BMA to whom we spoke a few weeks ago puzzled us greatly because he kept referring to this ideal standard of 24/7 availability but then said, "Of course, we can't have that," which did not help the general debate.

We all understand that the GP contract was necessary, for the reasons that Ian McKee outlined, but it nevertheless had an unintended consequence of creating a lack of flexibility, particularly with regard to the need to address services in rural areas. A lot of the evidence from Highland, Tayside and the Borders pointed to increasing use of salaried GPs. That sounds excellent, although there is obviously a cost attached to that. The decision about whether to use salaried GPs is up to individual boards, but is there any policy issue around that with regard to how that practice relates to recruitment and so on?

Is it to be generally understood that, for those who might wish to pursue a career in general practice, the issue of an increased use of salaried GPs is very much on the agenda?

Nicola Sturgeon: The issue is on the agenda in all board areas. Although the majority of primary medical services continue to be provided by independent contractor GPs, and I do not see that changing, boards have the ability to employ salaried GPs to give them flexibility where they consider they need it. Some boards, such as NHS Borders, have opted to use that flexibility in relation to out-of-hours provision.

It is for local boards to make local decisions on the appropriate balance, but there is no doubt in my mind that the ability to employ salaried GPs—and salaried dentists—gives boards added flexibility in terms of the provision of services. That is a flexibility that they should have.

Mary Scanlon: Helen Eadie asked my planned supplementary question but, given that I had a reserved slot, I made up another one.

The Convener: There is no need to be inventive, Mary.

Mary Scanlon: On our last day of evidence taking on this issue, I thank the Kinloch Rannoch community for leading us into an interesting inquiry from which I have learned a huge amount. Whatever recommendations we make, I am sure that they will be of benefit to people across Scotland. I trust that we will have a parliamentary debate on the issue.

The Scottish Ambulance Service submission summed up the issue for me when it said that

"the public and patients are confused about accessing care"

and stated:

"There is also some evidence that accessing care and advice out-of-hours is more convenient for patients".

That led me to think about how confused the public are. I invite the cabinet secretary to outline the circumstances under which people should call A and E, an ambulance, NHS 24 or a local doctor, if there is one.

The Convener: I will let you answer that, cabinet secretary, but I suspect that you will not write a handbook.

Nicola Sturgeon: I do not think that the public are confused at all. However, there is a serious point around the need to ensure, as far as we can, that people access the right part of the service, as that is in their interest.

Before I deal with that, I, too, pay tribute to the people from Kinloch Rannoch who are with us, and their colleagues. I am absolutely sure that they have not agreed with all the answers that I have given today—

The Convener: They have not.

Nicola Sturgeon: I have felt that, from behind me. Nevertheless, I pay tribute to any community group that cares enough about the health services that are provided in its community to embark on such a campaign. The group has raised some important issues. I know that the people in the group do not see eye to eye with NHS Tayside or me in some respects, but I hope that the on-going engagement that they have embarked on will lead to greater satisfaction over time. They have raised some important issues that will no doubt be of benefit to communities across the country, and I thank them for that.

12:00

Mary Scanlon made a good point about whether the public are confused. We have work still to do to educate the public—if I may use that phrase—about what the appropriate route to take is in different circumstances. When GP practices are closed, most of them provide a recorded message that tells patients to phone NHS 24. To a large extent, NHS 24 is the gateway to out-of-hours services. Many people criticise NHS 24 if they do not receive the desired response from the out-of-hours GP, but NHS 24 is responsible not for the provision of that service but for referring people to the right part of the service. In that respect, I think that NHS 24 does a good job.

I talked earlier about the progress that has been made by boards in out-of-hours provision, but the progress and advance that NHS 24 as an organisation has made over the past couple of years has been phenomenal. Without getting diverted into issues such as the flu pandemic, I think that NHS 24 as an organisation is performing extremely well and to a very high standard. However, we can always do more to promote awareness of the different routes into the system and we will certainly continue to look at what more needs to be done.

Frank Strang: I do not know whether the committee has taken evidence on NHS Grampian's know who to turn to campaign, which ran over a few months early last year. That considered the best way to get across messages about who the public should turn to, and a report on the campaign came out in November. If that would be of interest to the committee, we would be happy to give further information on it.

The Convener: Rhoda Grant has a question; she assures me that she has not just made it up because her original question has been asked. This question has been brewing for a while.

Rhoda Grant: Yes, it has been brewing for a while.

In a previous evidence session, we heard from NHS Grampian about how it uses telemedicine to help with out-of-hours provision. When I visited the Scottish Centre for Telehealth, I saw for myself how impressive that is. However, apart from the need for health boards to adopt the technology, one barrier to telehealth in remote rural areas where it perhaps has the potential to sort out these problems is the lack of access to broadband. Unless we can get broadband out to those communities—or give health service workers access to satellite broadband, which would be more mobile as it could travel with them as they go out and about—we will not be able to untap the potential of telehealth.

Nicola Sturgeon: That is an obvious and important point. I will not go into broadband provision in different parts of the country—the convener will be glad to know—as that is, thankfully, outwith my areas of responsibility. Nevertheless, access to broadband has an impact on our ability to maximise the use of technological solutions to some of the problems. I am more than happy to ensure, if this would be helpful, that the committee receives a written update on broadband provision and on what action is being taken to extend that.

The Convener: That would be fine, thank you.

Before anyone else tries to catch my attention—I have my eyes cast down, so I do not see anyone else with a hand up—I thank the cabinet secretary and our other witnesses for their evidence.

I put on record the committee's thanks to the Kinloch Rannoch campaigners and the Public Petitions Committee. The petitions system in this Parliament is one of the few in Europe that allows people to raise issues in the Parliament that do not just get parked but feed into committee inquiries and become an important part of the inquiry itself. I wish the campaigners from Kinloch Rannoch a safe journey home. It is a long way back.

Meeting closed at 12:03.

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