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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 11 June 2013

Session 4

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HEALTH AND SPORT COMMITTEE

19th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jayne Baxter (Mid Scotland and Fife) (Lab) (Committee Substitute)
Tressa Burke (Inclusion Scotland and Glasgow Disability Alliance)
Dr Alan McDevitt (British Medical Association Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Tuesday 11 June 2013

[The Convener *opened the meeting at 09:45*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 19th meeting in 2013 of the Health and Sport Committee. As usual at this point, I remind those present to switch off all mobile phones and BlackBerrys as they can interfere with the sound system. People in the public gallery might notice that some members and officials are using iPads instead of hard copies of the committee papers.

Agenda item 1 is a decision on taking item 4, which is consideration of a draft report on access to new medicines, in private. We would usually take such items in private. Do members agree to take item 4 in private?

Members *indicated agreement.*

The Convener: Thank you.

Welfare Reform (General Practitioner Services)

09:45

The Convener: Item 2 is to take evidence on the impact of welfare reform on general practitioner services. I welcome to the meeting Dr Alan McDevitt, chairman of the Scottish general practitioners committee at the British Medical Association Scotland, and Tressa Burke, director and trustee of Inclusion Scotland and chief executive of Glasgow Disability Alliance.

You have an opportunity to make some opening remarks. Have you agreed who will go first?

Dr Alan McDevitt (British Medical Association Scotland): I will go first.

The Convener: There you go. Thank you.

Dr McDevitt: Thank you for inviting me to the committee. At last year’s annual representative meeting of the BMA, a motion was passed about the employment and support allowance process. I am sure that that happened because doctors wanted to express their concern about the stress and distress that are caused by the dramatic changes in that process. They have undoubtedly caused distress to patients. We also expressed, through that motion, a negative opinion on the new process that is being used.

I have spoken a lot about the severe workload pressures in general practice in recent years. The changes have added significantly to that workload and pressure, especially in areas where a high number of patients receive benefits. In my practice, the paperwork is left to the end of the day because I prioritise patient contact. As I get to the time of the day when my building is about to close, I may have to decide whether to do some further phone calls, patient referrals and contacts or to do somebody’s report. With high volumes of reports and short deadlines, the reports start to compete with clinical priorities in my working day, and I certainly receive that message from many colleagues, yet I accept that the paperwork is important to patients as well.

The main pressure that comes about from the changes is the requests that we get for further medical evidence. Three out of my 16 appointments yesterday morning were people who came just to talk about that. It is absolutely true that none of my patients can afford to have less money, yet employment and being waged are arguably one of the best determinants of future health. The setting of thresholds for benefits is a political decision, and rightly so, and it should be assessed independently. GPs are unashamedly biased in favour of our patients; we are not independent in that sense. Our role in providing evidence is to provide factual information and not to say who should get benefits, because whoever has that role also says who should not get benefits. I do not want to divide my patients into the deserving and the undeserving sick and disabled. Thank you.

Tressa Burke (Inclusion Scotland and Glasgow Disability Alliance): I have something that I have prepared, so I will read from it.

Hello and thank you for inviting me along today. I thought that I would say a wee bit about the organisations that I am here to represent. I am the chief executive of Glasgow Disability Alliance, which is a membership-led organisation that is made up of disabled people. We have 1,800 members in Glasgow. I am a disabled person myself but, more important, I represent those people. I also represent Inclusion Scotland, which is the national voice of disabled people in Scotland. It has more than 60 members and a reach of thousands on a weekly basis. That is why I am here today, and why I was asked to come.

Both Inclusion Scotland and GDA have roles in bringing the voices of disabled people and people with long-term conditions to the attention of policy and decision makers, including local authorities, the Government and the Scottish Parliament. My hope is that we can all work together to ensure that their views and opinions are taken seriously, and to keep the lines of communication open.

The posters that have been put up in surgeries advising patients not to ask for medical evidence to prove their care needs, followed by an announcement in the *Sunday Herald* from Glasgow BMA, are being interpreted by disabled people as a direct attack, which has happened at a time of unprecedented and disproportionate cuts to the benefits, services and available income of disabled people in Glasgow and throughout Scotland.

We have a vast membership and, last week, more than 400 people attended a members' meeting at the Thistle hotel in Glasgow. There was such strength of feeling and such panic and anxiety among our members that we abandoned the planned agenda to discuss this issue, which became the subject of our morning conference. I relay the views that our members expressed to the committee. One member stated:

> "I have already been affected by having my benefit cut and feel it has been an awful experience personally. Having a doctor's support could have made a huge difference to my outcome. This is an attack on my right to a fair trial".

Another member stated:

> "Surely this is part of patient care—this is extreme discrimination. What about the Patient's Charter?"

Other members asked over and over where else they could go for evidence and support and said that they feel isolated and vulnerable. Another member stated:

> "I always thought that your doctor would be there to provide support and evidence."

Such concerns were raised again and again by our members. I have not had time to write their comments up into a full report, but I have some of the post-it notes from the conference with me if committee members want to see them later.

Before we even begin to discuss the impact of their stance more fully, I emphasise that we appreciate what the doctors are saying about the extra time that it would take them to write such letters, particularly for people in deep-end practices in areas of deprivation and disadvantage. However, the problem is not of the making of disabled people or people with long-term conditions. We can be part of the solution and can make suggestions, but we cannot be held responsible for the problem in the first place. The situation seems to be unfair and for the solution to be that doctors just do not provide the evidence is an unjust punishment.

Glasgow's disabled people are losing out in a devastating way that has potential consequences for their income, for their participation in society and for their health and wellbeing. That is at odds with the Equality Act 2010 and the Patient Rights (Scotland) Act 2011, which commits to giving patients the right to healthcare that considers their needs; considers what would most benefit their health and wellbeing; and encourages them to take part in decisions about their health and wellbeing, and provides them with information and support to do so. We feel that the issues that we are discussing all fall within those commitments.

What is happening flies in the face of all the rhetoric about preventative approaches. Fundamental to all this is a breach of human rights, specifically the right to a fair trial. The right of access to a fair hearing, including access to an independent and impartial appeals process in the provision of welfare benefits by a state, is crucial to the realisation of article 6 of the European convention on human rights. The European Court of Human Rights in Strasbourg ruled specifically on the issue in Kovachev v Bulgaria in 1998. I can give the committee more information on that ruling, but for now I will point out only that that is the precedent that has been set.

The parallels between the case law and welfare reform in the United Kingdom could not be more evident. Vulnerable people who need welfare have no right to appeal decisions to anyone, let alone an independent and impartial tribunal. That is a clear violation of their right to a fair hearing as laid down in article 6 of the convention. That welfare reform violates human rights is in no doubt but, rather than talk about legislation, it is more important to highlight the home truth that the only way for a disabled person to challenge the decisions that are made against them—the smallest sliver that they can get of what should be a fundamental right—is for a doctor to supply medical evidence. We do not feel that we can do without that.

The only way to challenge a decision that has been made poorly, made wrongly, and made without evidence or the involvement of the person concerned, is by a letter from a doctor. It is clear that there is a crisis facing disabled people and, at times, we feel that our humanity is under attack. Arguments that were made and won long ago have re-emerged. We are therefore tired and dismayed to be fighting old fights about why we should be entitled to dignity and to make choices about the most basic things, such as evidence of our support needs, care needs and medical conditions. A lot of different things are happening that affect disabled people, so the issue is not only about the GP letter, which must be seen as part of the bigger picture.

For example, those of us who receive social support services and have care support arrangements are being asked, “Do you want to get up and have a shower in the morning and get dressed, or do you want to participate in the community? You cannot have both. Which is more important?” Such ridiculous questions fly in the face of legislation that we are signed up to through the treaties on human rights; indeed, article 19 of the United Nations Convention on the Rights of Persons with Disabilities says that disabled people have the right to live in their own homes with the support that they need and to participate fully in the life of their community. However, all these factors are compounding in a way that does not make that possible.

Disabled people face complex and interrelated barriers at the best of times and the lack of a long-term focus and austerity measures such as cuts and efficiency savings, service reform, the charges for social care that in many local authorities have gone up over the past year as well as the usual barriers faced by disabled people have crushed their confidence, self-worth, identity and participation. If we add to that hostile attitudes and propaganda about layabouts and scroungers, we have a perfect storm of the forces that are acting against disabled people and it is all impacting negatively on the mental and physical health and wellbeing of not only disabled people but people with long-term conditions.

For the first time, disabled people are now being asked to provide medical evidence for social work services; indeed, I can give the committee recent case stories and anecdotes of people in Glasgow and other areas who have been asked to do so. What disabled people are saying—and I heard as much on Friday and last night, when I spoke at a conference of more than 200 representatives of the Glasgow and West of Scotland Forum of Housing Associations—is that their last line of defence, their trust in and relationship with their GP, is being eroded. Although they understand and appreciate the pressure on GPs, they feel that the solution does not lie in GPs refusing to send these letters but lies elsewhere.

We know that disabled people in Glasgow are at greater risk from health inequalities and resulting disadvantage than people in other areas, because of the sheer scale of the numbers of people with impairments and long-term conditions as well as the fact that the area has the highest rates of benefit claimants. We also understand that that is likely the very reason why the policy was introduced; the bedroom tax would have a significant impact on the time available to GPs to write letters of support and provide evidence. As I have said, we feel that this is not the correct response and ask that the decision be reversed.

Given the problem’s complex and challenging nature—I believe that Dr Harry Burns calls these things “wicked problems”—we are surprised and confused that GPs and their representative bodies have come up with such a simple solution. We think that such issues require more thinking through and a more strategic approach than this one. We also feel that this approach will make the situation much worse.

We are here today to ask for assistance in persuading the Scottish Government and the national health service to take seriously and implement with integrity their duties under the Equality Act 2010, the Patient Rights (Scotland) Act 2011 and the Human Rights Act 1998. Through their national voice, the BMA, doctors have already said that the assessment under the Department for Work and Pensions and Atos should end immediately and the General Medical Council has stated unequivocally that doctors must take action to prevent harm from happening to their patients. At its core, the Patient Rights (Scotland) Act 2011 is about providing an NHS that considers people’s needs and the European convention on human rights and rulings from the European Court of Human Rights make it clear that the lack of an independent and impartial appeals process for welfare decisions is a violation of human rights.

The only appeals process—that is, the only thing that literally stands between disabled people and far greater harm, either destitution as a result of the removal of their benefits or serious deterioration in their mental or physical health through being forced to work when they are not fit to do so—is a letter from the GP, and that such a letter is being refused is professionally, legally and morally wrong.

The Convener: Thank you.

Bob Doris (Glasgow) (SNP): That was a lengthy presentation, but there was a need to put it all on the record on behalf of the people you represent. I was certainly listening very carefully to what you were saying.

I was keen to have doctors' representatives and you at this meeting because of representations that I received not only from Inclusion Scotland but from individual constituents about a certain poster that has been going up in Glasgow surgeries. The poster says:

> "GPs provide General Medical Services to their patients and we are not in a position to administer nor to police the Benefits System. The LMC considers that it is not appropriate for the GP to be asked for letters of support or letter to confirm care needs."

Further down, it says:

> "Therefore we cannot respond to your request for a letter."

It is not even that some doctors are refusing requests for letters; the poster basically says, "Don't ask in the first place."

10:00

I have fundamental concerns about that, which relate to what Ms Burke said—she used words that I had already written down. I think that my constituents will think that the approach reflects a lack of compassion on the part of GPs—the people in their communities whom they most trust. That will have a corrosive effect, eroding trust in some of the people who are most important in helping vulnerable people in our most deprived communities. I should say that I do not think that any GP lacks compassion. However, the question is how the poster will be interpreted by some of our most vulnerable people.

As it happened, I was in a health centre in north Glasgow on Friday for a completely unrelated reason, and GPs told me that the poster has been taken down. I do not know whether it has been taken down in just one health centre or throughout Glasgow, and I do not know why it has been taken down.

Dr McDevitt, I know that you are not here to speak specifically about Glasgow. Have posters been put up throughout Scotland? You said that three of the 16 patients you saw yesterday asked about further medical evidence. Did they walk past a poster that says, "Don't ask"? Has your local area taken a different decision about deterring patients from asking? What is the situation for patients in Scotland? Can they ask for a letter in some parts of Scotland but not others? Can they ask in one health centre in Glasgow but not in others? Can we get to the bottom of what GPs are doing across the country and what is happening to my constituents in Glasgow?

Dr McDevitt: Let me start by talking about some of the problems with such letters in the first place. We have argued that the system should ask us for the information up front. A citizens advice bureau survey suggested that only 8 per cent of ESA applicants have a report that is requested from their GP.

I have brought the document that shows what we are asked to do for such a report, if members want to see it. We are asked for factual information with regard to people's health. We are not asked for an opinion on whether the person is fit for work or on the nature of the disability; we are asked for a factual report on what we can testify to with regard to the patient.

We want to provide more of those reports—out of interest, we are not paid additional money for them; producing them is part of our contract, so if the volume goes up, there will be no financial benefit to GPs. We want to encourage the system—indeed, we have urged the system—to ask for the information in advance of making a decision on ESA for a patient, because we think that that is the only fair and equitable way for medical evidence to be sought and to be provided by us.

The problem with further medical evidence is that the current system puts me in an invidious position. If I provide further medical evidence only for some people, I am being partial. I might provide a letter because I am sympathetic to the patient—I might like Mrs Smith or feel particularly sorry for such-and-such a person. We therefore end up with a situation in which my decision to provide additional information, which is private, because it is not part of the assessment system, is based on whether I prefer one patient over another one.

Therefore, if I were to give reports, I would have to give them for everyone. That is just not tenable, given the volume and frequency of the reports that would be required. It is fair to give extra, additional information either to no one or to everyone. Therefore, we have said that it would be more sensible if the system got information up front, through the normal processes and in a standardised and fair way, so that the information could be used by an independent body to decide whether a person was entitled to benefits.

That is why we have the all-or-nothing scenario. Otherwise, we are being partial and I am put in the position of having to decide who deserves an additional medical report that will help them to challenge a decision that they cannot have benefits. For some patients, their doctor will not disagree with a decision not to continue to pay benefits. There is also a huge range of opinions among doctors about how the benefits system should work. However, such views belong in the political not the professional arena. We should be fair to everyone, so we encourage the system to ask for the information up front in a fair and standardised way.

The Glasgow local medical committee is not the BMA and I cannot speak for it. I am rather embarrassed at having to say that I did not see the poster, but it would have gone up in my practice, because it is advice from our local medical committee. The poster has been taken down in response to comments that were made to the LMC, and the committee is reconsidering whether that is the right approach.

However, the problem remains. Should everyone get an additional report, or should only some people get one, when I decide to grant them that favour? The poster was one response to that issue. As I say, it has been taken down, but that does not mean that the problem has gone away. Because of the negative response and the way in which patients perceived the poster, it was decided to reverse the decision while the LMC reconsiders how to deal with the problem. That comes back to our point that we should encourage the system officially to ask for fair and equitable information up front from us, which would be at no additional cost to the state or the patient.

Bob Doris: I want to come back to that point and consider it in more detail but, just for a bit of clarity, you say that your local medical committee initially had a policy of putting the poster up in all GP practices and it has now—

Dr McDevitt: —actively requested that it be taken down.

Bob Doris: When did that happen?

Dr McDevitt: I think that it was about two or three weeks ago, but I cannot be precise. I can get you that information, because it is in a letter from the LMC.

Bob Doris: That would be helpful.

Did every local medical committee have posters put up in their surgeries across Scotland or was it just some of them?

Dr McDevitt: I think that it would just be some of them. The poster that we discussed was specific to Glasgow, because the LMC made that decision. I suspect that some other committees might have done something similar, but I have not heard of that.

Bob Doris: I am delighted that the LMC is reconsidering its position, because when it responded to my representations on 9 May, it said that it would not do so—it said that it had to put up the poster and would continue with that.

I want to explore the issue a little further. You said that three of the 16 patients whom you saw yesterday requested information on benefits issues, despite the fact that the poster was up in the surgery. Do you think that more patients wanted to see you about that information but were deterred from approaching you or other GPs because of the poster?

Dr McDevitt: Because of my prominence in the area, some of my patients have seen my comments on additional reports and have mentioned the issue to me in discussing their requests. Patients are certainly aware of the dilemma that doctors face.

Bob Doris: The point that I am trying to get to is that the most vulnerable patients, after seeing the poster, will be the least likely to say to their GP, “I know about your policy, but I still need the information.” The policy therefore means that the most vulnerable people are least likely to ask for the support that it might actually be appropriate for GPs to provide. Is it the thinking in Glasgow now that that blanket approach was just wrong?

Dr McDevitt: I would say that it was a committee decision. Like this committee, the local medical committee decides, as a group, on the right thing to do. In any committee, there will be a balance of opinions. There is no doubt that the negative impression that patient groups had of the decision has made the LMC review its decision—opinions have been swayed. That is how I would explain it.

Do people change their approach? I think that they do. The intention of the poster was to discourage anyone from asking for further evidence so that we did not have to be partial in deciding who to provide that for. I would have to think very carefully if someone asked me to provide that additional evidence, because I have to be fair to everyone. I can give it either to everyone or to no one—that is the only fair and equitable approach. Someone’s right to an appeal should not be based on whether I feel kindly or sympathetic towards them.

The system should be fair and just. From our point of view, we need the systematic application of a fair system for gaining medical information. The process is there, so that could be done right now. The DWP could change the frequency with which it asks for information in advance of making a decision, so that every patient has the right to the factual information being available when their case is considered. Further information should not be necessary in those cases.

Bob Doris: For the record, I point out that I have spoken to a couple of GPs in Glasgow who continued to provide such letters, which meant working late or taking work home. They just got on and did that. They had concerns about the LMC decision, so I am delighted that it has been reconsidered.

On the wider issue, my understanding is that the BMA's concern is that the structure for passing on the information that is requested by the United Kingdom Government or Atos is flawed; that the information is not always used in the most appropriate way when decisions are being taken; and that, unless Atos specifically requests additional information, there is no contractual obligation on GPs to provide it. Is that the situation?

Dr McDevitt: That is absolutely correct.

Bob Doris: Putting to one side the workload issues, which I will come on to in a second, should the contractual obligation on GPs be widened so that they have to provide more information than at present?

Dr McDevitt: No, because we already have a contractual obligation to provide whatever is requested by the DWP or, in this case, Atos, working on its behalf. So, right now and without changing any contract, the DWP can ask for any information that it thinks is relevant to the process. In fact, it has changed the process, because it has changed the forms. It has also changed the timing and how quickly it wants us to respond. It is entirely in the DWP's gift to do that; it is entirely up to the DWP and Atos to decide what information they wish to receive from GPs and in what format.

Many doctors have commented on the process and the handling of information and data, and you will find a variety of views on whether that is appropriate. In the first instance, it seems that we are asked for that information on only 8 per cent of occasions. Until recently, I had never had any figures or comments on issues such as how frequently GPs return the forms and whether they come back on time; no one had ever provided information to show that the system was not working well and that there was a problem. It is probably of use to hear that 60 per cent are done within two weeks, 80 per cent are returned and 20 per cent never appear. I do not know whether they do not appear because of the post, because they go to the wrong doctor or whatever, but until the recent freedom of information request, no one had ever pointed out that there was a problem with the system.

As a professional organisation, the BMA Scotland is more than happy to provide encouragement so that the system works correctly and, if there is a problem, to hear the information on that and to work on ways to make the system work better. That information is important, but it has only lately come to my knowledge, and I will certainly consider the issue. We accept our professional obligation to provide the information that is required in a contractual sense. However, it is entirely up to the DWP to determine the right method of asking us and what information to ask us for.

Once again, I point out that we are asked only for factual information and only to attest to that which we have witnessed or we know—the reports are not usually opinion based. That is the difference between the welfare system and what happens normally when someone asks for a medical report. I am usually asked for my opinion on something and what evidence I have for it. The DWP—rightly, I think—asks for factual information that I know about the patient and to which I can attest personally. In fact, medical records are often poor at saying what functions people can and cannot do. That is because I do not see people doing things and I do not ask them to do them in my surgery. I can mention things such as walking, but I cannot cover many other things.

Therefore, it is right that patients are asked to describe what they find difficult in their lives functionally, because I am not there to see it. In fact, sometimes patients who know that they are coming up for a review deliberately come to see me to tell me, "I can walk only 50 yards and I can't bend to lift more than 2kg." That is slightly absurd, but they do it so that I write it in the notes, because they know that those are critical points of information that will determine whether or not they get benefits. In fact, according to the DWP, I am not supposed to report that, because that is hearsay evidence and I have not seen those things happening. It is a sign of how desperate people are to ensure that they meet the criteria that they come to me to provide evidence in the hope that I will pass it on and it will have an influence.

Bob Doris: Is there variation or inconsistency in the quality of information that GPs provide on the forms? Some GPs have told me that they can answer some questions but not all of them so, if they are not sure, they leave the spaces blank, whereas other GPs try to fill in everything. Do we need guidance for GPs in order to achieve consistency in how GPs fill in the forms? If we get that right, it might reduce return visitors, when claims have not been properly assessed.

Dr McDevitt: That is interesting. It is partly just in the nature of different characters that their responses will be either voluminous or brief. When I was researching in preparation to come to the committee, I found a paper on the DWP website that said that, because there were concerns that GPs were sometimes too brief in their responses, a pilot was carried out that used patients' records to decide on their evidence. The pilot found almost no difference in decision making. We could take that to mean that, although GPs might be brief, they are giving the information that is critical to the decision and that, in fact, having all the evidence does not appear to change that.

There is already guidance. There is no doubt that, as various patient groups have said, the way we present evidence might influence a decision. That is something that GPs might wish to consider. However, that has been highlighted only because of the failure to gather medical information in the first place. In most cases, the DWP is not getting anything. By all means, we should consider the effectiveness of the information that is provided, but in fact that study of having all the information versus what we currently provide found that what we currently provide appears to have the necessary effect on decisions.

10:15

Bob Doris: Finally—my colleagues want to get in—there is the overall workload of GPs. As I said earlier, I do not believe that there is a lack of compassion on the part of GPs. I think that GPs in Glasgow got the policy badly wrong, quite frankly, but that was not because of a lack of compassion.

GPs are seeing a significant increase in their workload because of welfare reform. You said earlier that you believe that that leaves less time for other vital medical work that you have to do for your patients. First, can you give me an idea of some of the work that you think is not being carried out for patients—for my constituents in Glasgow—or is not being carried out as timeously as it otherwise would, because of welfare reform? Secondly, how can that be remedied? In other words, does more money need to be invested in locums or in more GPs? Who would be responsible for funding that?

Dr McDevitt: First, it is important to say that it is not just through forms and documentation that austerity and welfare reform impact on my workload. Patients who are poor and getting poorer suffer more ill health. They are more depressed, they are more stressed and they may engage in more self-harming behaviours through alcohol and drugs, and in other dangerous behaviours. Their illnesses get worse, their chronic pain gets worse and they are more likely to end up in hospital. The weight of austerity and the changes in the welfare system create the real workload.

As I said earlier, we put the paperwork to the bottom of the priority pile. We deal with the human consequences of austerity and the welfare changes first, because that is the real workload that we need to address. That is why we object to the paperwork. I could, at the end of the day, phone someone and try to explain their latest blood result and reassure them or try to get them to engage in some healthcare activity, or I could fill out another form for a process that I think is fundamentally flawed and that is distracting me from the real business of looking after people's illnesses and improving their health.

Overall, I put the issue back to politicians. The welfare system is a political agenda and it is for politicians and pressure groups to decide how the system works. Our role in that has clearly changed without any input from us. We did nothing to change it, yet somehow we seem to be blamed often for its going wrong, which is a strange position to be in.

Nonetheless, in general terms, general practice tends to have a workload because of what we deal with and how we deal with things—there is much more that we can do for people. The effects of austerity and the welfare changes mean that the clinical work that we need to do with patients is getting to the level at which many young doctors do not want to be me. That is a serious problem for the future of the NHS and it will be down to the NHS and to the Government to decide how that should change.

We would argue for an increase in resources; we need to increase massively the resources in primary care, not just GPs, but district nurses and health visitors, in order to meet the demands of the population—particularly the ageing population but also the population that is living under austerity and welfare stress.

Bob Doris: Okay. I will haud ma wheesht on that and give my fellow committee members time to come in, but I may come back in later.

The Convener: Ms Burke, do you have any comments on GPs' workload before we move on to the next question?

Tressa Burke: Disabled people and our organisations in Glasgow and in Scotland as a whole support the need for more resources. One suggestion that came up last night and last Friday from disabled people was that if agencies want the evidence, they could pay GPs for it, which would create more resources to bring in more GPs. We accept that that would be a piecemeal and quite fragmented approach to allocating GPs, so another suggestion was that more GPs need to be allocated in deep-end situations to deal with poverty in disadvantaged areas where there are more benefits claimants and where welfare reform is having more impact.

It was also suggested by disabled people that no one knows the disabled person's condition better than they do themselves, but unfortunately we are in a time of cynicism when people will not believe a disabled person. I believe that people trust me and have confidence in what I am saying today, but I have multiple sclerosis and I cannot be confident that, if I became very ill tomorrow, anybody would believe anything that I said. The one thing that I know I can cling on to is the fact that I have a good GP, but I would be worried that I might not be able to ask the GP for support now. Asking the disabled person or the person with the long-term condition is an obvious starting point, but that is not necessarily the view to which the DWP would listen.

People have also suggested that good health professionals such as nurse practitioners could have a role, as could people in the voluntary sector. In this time of post-Christie commission recommendations, we know the role that the third sector could play, whether that involves community-based organisations, citizens advice bureaux or organisations that are led by disabled people. If their accounts could be taken seriously, those people are committed and well placed to provide support and to give evidence.

The reality is that doctors often just go on what their patients tell them, because the patients do not present regularly. I have an incurable disease, so I rarely present to my GP. If I did, I would be going there to say, "Here's my list of symptoms. Can you write me a letter for access to work?" or whatever it might be. My GP trusts me on that, but I appreciate that there is a certain irony in the situation. A range of measures, including increased resources, are needed.

One thing that Dr McDevitt has said with which I must respectfully disagree is about an approach to treating everybody fairly that results in giving nobody the help that they seek. That is not a particularly good solution, and it is a naive reaction to take that approach, although I completely understand where it has come from. The pressures on GPs are phenomenal, but we all have responsibilities under human rights law to ensure the right to a fair trial and a fair appeals process, and the response that Dr McDevitt described would be unhelpful, so I am delighted if it is going to be reversed. Even the temporary suspension of such an approach would be a good thing.

The Convener: We may return to those points.

Drew Smith (Glasgow) (Lab): I listened carefully to that exchange. Dr McDevitt mentioned the FOI request, which is now in the public domain, about the return of information to the DWP. I should state first of all that, having met the deep-end group on a number of occasions, I am sympathetic to issues about the GP workload and improving that balance. Would GPs be in a better position to argue their case if the numbers for the information that they are statutorily required to provide were a bit better than the FOI results suggest? The national average figure for GPs responding within the timescale to direct requests from the DWP or Atos—the stuff that they are actually paid to do under the current contract—is only about 58 per cent across the country, and in some parts of the country they return the information appropriately only on a minority of occasions.

I accept that there will be a range of issues, and some of that might be the DWP's fault, because it might not know which GP to contact, or things might go missing, but the overall figure is quite stark. Would it not have been better for GPs to get their own house in order on those issues before expecting people to be understanding about the extra letters that they are being asked to provide?

Dr McDevitt: We do not get the letters, so I have no idea how many GPs returned them, because I do not have that information. Until the FOI request was published, I had no idea that there was any issue. The first thing you do when such a matter is raised is ask and find out what the cause is. If it is because of us, we must look at how we deal with requests for letters.

I should point out that the new form, the ESA113 for employment and support allowance, has to be returned within five days, but it does not tell me when the patient is going to be seen or assessed. Returning a form within five days may seem to be straightforward, but I work Mondays, Tuesday mornings and Fridays. If a form comes in and goes into my pile on Monday night, and I do not get back to it on Friday, I have already missed the deadline. Coming before a parliamentary committee does not help.

A five-day deadline means that the form must be sent back almost by return of post. That seems strange to me, because I presume that the date for the assessment would have been made in advance, so there should be plenty of time to seek evidence and allow a reasonable timescale for response. However, if every GP must answer those requests by return of post, inviting even more could well break the back of the system, because we would have to do them on the day that they come in, in order to get them back within five days.

If there is a problem—it is the first time that we have had a hint that there may be—some of it might be GPs' fault and some might not. However, as I have said, we are happy to consider ways to enhance and improve the system. I say to the DWP and the committee that we are inviting more work, but for no extra money, in order to try to solve the problem because we think that that is fair and the right way to do it.

We will also consider how we can improve the response times and the quality of the response. Pressure groups can help us with that by knowing the right words to use. How we say something can matter a lot and many welfare rights officers tell me that it matters whether I say that something could be a problem for someone or do not mention it. I am no expert on the system, but welfare rights officers are. They teach me about the language to use, but I have to admit that that coaches me to encourage my bias in favour of the patient.

We almost end up in a situation in which professionals are being asked to go against the state because the state has decided on a system to determine who will reach the threshold for getting benefits. Welfare rights officers rightly tell people within the law how best to answer the questions so that they are more likely to be successful.

We need to be clear about the type of second report that we are often discussing. The first one is factual and standardised; the second report is someone asking me to provide counter-evidence to the Government's assessment of ability and disability. Therefore, we end up with two opposing views: mine as a GP and the other from the independent and supposedly unbiased doctor providing information as part of the state's assessment.

That will just lead to an impasse. If, every time the state makes a decision, I question it and provide an alternative view, it will ignore my view all the time or will have to change the system. However, that is all on a necessary addition. The proper, independent system should get it right.

We argue that the concentration should be on getting it right. If that happens, there should be no need for us to fight against the state's assessment because it should be fair and independent in everyone's eyes. If it is not, patient groups and politicians rightly complain about that.

That is where the battle should be rather than in a fight between two medical opinions; one from me—a biased individual putting the opinion in ways that will benefit my patient—versus the state's doctor, who acts apparently independently and objectively on the basis of fact. We should get the system right rather than get into the silly situation of simply knocking heads on medical opinion at a later stage.

Drew Smith: I understand what you say. The figures that Michael McMahon has been able to put in the public domain relate to the 14-day period, so we can assume that, if a request is made for a response within five days, the lack of compliance would be even higher. I accept that there is an issue with how realistic that timescale might be, but the fact of the non-compliance remains.

Moving on, from the evidence that you are under contract to provide, to the other evidence that you might be asked to provide, I will ask about the charging regime. What is the BMA's view—or your view, if you are not able to give a BMA view—on whether it is desirable to achieve consistency in the charging regime, and how would we do that? We seem to have a wide variation throughout the country from a few pounds to almost £100 being taken from patients.

Dr McDevitt: When someone asks me for a private report—let us say any private report—I could opt to do it for free as a charitable act. It could be for someone who is going to do a parachute jump for charity, someone who is going for a job or someone who is applying for a loan. A private report that is not part of my job and for which I will not be paid is charitable work that any of us could get involved in. Most GPs are conscious of fairness. They are conscious that they should not just do favours for the people whom they like and, therefore, should do charitable acts consistently or say that they can do such a report, but the person requesting it must pay a fee.

The BMA used to set and recommend fees for different types of activity. However, it is now on its third and final warning from the Competition Commission and the Office of Fair Trading for price fixing and is no longer allowed to advise GPs on how any private work is priced. In fact, it is illegal for two GPs or practice managers to discuss pricing on that issue because it is against competition law. There is no standardisation and we are not allowed to talk about it, so each practice has to have a system to determine what to do if somebody wants a GP to do private work. Everybody needs us to do it, because people would not get mortgages, be able to claim for compensation or go to court without private medical work being done. Most practices have a standardised system that says what it costs to get GPs to do private work. Anyone can ask us to do that.

It also seems to me to be unfair for me to refuse to do such work. I appreciate that there is a dilemma. Some doctors might provide a private report for medical evidence even though they would not do it voluntarily. There is also the issue of whether, if somebody decides that such a report is worth paying for, I should refuse to take money from someone who is on benefits but take it from someone who needs the work done for a legal report. There are all sorts of dilemmas, which is why we want to cut things off earlier and get evidence, in a fair and standardised form, to the right place so that it does not cost individuals money. Fees will always vary because it is not legal for us to fix prices or to give advice on that—indeed, it is not even legal for two practices across the corridor to discuss charges—but things will depend on the volume of private work and how the practice decides to price its time. In most cases, the work will be done in GPs' own time and will be priced accordingly. There is no method that I know of by which you or I could influence that matter.

10:30

Drew Smith: That is very interesting evidence on an issue that I think we will want to come back to.

Finally, on the bedroom tax, which seems to be the impetus for the poster from Glasgow LMC, are GPs really best placed to provide some of the information that is being requested, particularly with regard to underoccupancy? Some of the issues might not be medical, so are GPs better placed than the individual, their carer, the social work department or whoever else the person might be in contact with to indicate their care needs?

Dr McDevitt: Whenever they have to ration a service, organisations—especially state-run ones—are in the habit of saying first, "Get a doctor's letter." Every GP knows the phrase. Patients come in and say that they have been told to get a doctor's letter if they want their gardening to be done in the summer, their wheelie bins taken out, a bath or shower installed in their house, their carpets relaid or their central heating installed. You name it—we have had it. There was a very laudable central heating installation programme, but many people could get it only if I said that they could have it. I remember one particularly daft instance in which a lady came to see me and said, "The social worker says I need a new bath, the district nurses say I need a new bath and I think I need a new bath, but they'll only give me one if you write me a letter and say that I need it." I had never seen her bath; she might well have needed a new one, but why did the issue have to come to me?

The fact is that, as I have said, the first stop for many organisations when they begin to ration a service is to tell people to get a letter from their doctor and then they can have this benefit, that bath or whatever. We are in the same situation with the bedroom tax. We would rather that people self-declared their issues and were believed; after all, they know their situation best. If they are not believed, someone should go and check. That is what happens in housing. For many years in Glasgow everyone who wanted a new house had to get a doctor's letter because they did not get priority without one; they had to get medical points to have any chance. As a result, every single person who applied for a house had to get a doctor's letter and their success seemed to depend on how well the doctor wrote it. It was an absurd, irrational and unfair approach; after all, whether or not a person gets a house should not be up to me but should be an independent and fair decision.

After many years, we agreed a system with Glasgow housing in which patients self-declared their problems with regard to housing—for most people, it is usually not the diagnosis but function that matters—and only on the occasions when the applicant was not believed or when the matter was felt to be too complex was a GP's letter sought. Since that system was introduced, almost no GP reports have been required and patients' self-declaration has been found to be an effective and fair way of getting prioritisation in housing. If such an approach can work there, why not elsewhere?

Often it comes down to a matter of trust. In some ways, my saying what a patient has told me is seen as being more believable than the patient saying it. That is absurd and a waste of everyone's time, which is why we frequently say that the first approach should be self-declaration, then if there is reason not to believe that information or objective evidence is needed, someone should be sent to look at the bedroom, to see what it is being used for and to find out who else is living in the house. After all, I do not know that sort of thing.

Likewise, with the wheelie bin letter, I am asked to declare that there is no one else in the house or no other neighbour who could put the bin out for the person. How am I supposed to know that? However, that is the norm of rationing in many state-run systems. I could entertain you for hours and give you a whole book of cases in which we have been asked to discern need and to ration services, particularly state services of one sort or another.

In short, we think that asking the patient is an effective and trustworthy method; if it is necessary to check a fact, someone should be sent to do so. Occasionally, more detailed medical evidence might be needed, but in most cases it will not.

Drew Smith: What is Ms Burke's view?

Tressa Burke: Can you repeat the question? [*Laughter*.]

Drew Smith: It is being argued that in Glasgow a whole part of GPs' workload, of which this work is just one function, is being caught up in officialdom, but the disabled person is the one who is losing out. The poster goes up and suddenly they think that they cannot ask for this or that any more.

Who do disabled people feel is the appropriate person to be involved in their applications? Do they think that a GP should be involved or would they prefer that they were believed or that the opinion of their carers, their neighbours, their social worker or whoever else was taken into account? If someone has a long-standing condition that means that they have a care need, that is not really a medical matter, and they should not have to involve their GP in declaring, for example, who stayed at their house last night and how that person helped them.

Tressa Burke: Ideally, disabled people and people with long-term conditions want to be believed and would prefer not to have to go to their GP with a begging bowl and their tail between their legs to tell their GP their life story, particularly if they have not been presenting all the time. However, that is not reality; it is just not where we are.

Disabled people are simply not believed. In the past few weeks, a colleague and friend of mine has taken the first bedroom tax appeal in Glasgow to a judge. The problem with the situation is subjectivity. That case involved a couple in which the woman is a disabled person who receives disability living allowance. If they had just had an extra bedroom, she could conceivably have moved; the DLA and the fact that she is a disabled person would not necessarily have stopped her doing so. However, the couple have a son with autism and the problem was that he could not handle change and therefore could not move. The judge could not get his head around that—it was unlikely that a judge in Glasgow was going to find in favour in such a case anyway; I think that things will have to go further. As I have said, the problem is that we are dealing with subjective matters.

On Alan McDevitt's point about professionals, I would argue that it is not only GPs but social workers who increasingly find themselves being asked to go against the state. The presupposition is that the state is—as it should be—determined to protect the most vulnerable people. However, we are coming up against questions such as, "Who is the state? What is the ideology that is driving welfare reform? Is the purpose of welfare reform to protect the most vulnerable in our society and human rights or to ensure that people can lead a fulfilled or at least semi-decent life?"

Many disabled people would argue that that is not seen as the purpose, so we cannot assume that the view of the state and an independent GP assessment will be factually correct and lead to an appropriate outcome. In fact, the evidence is to the contrary because, as we know, 40 per cent of the cases that are turned down are won on appeal.

We are certain and have evidence staring us right in the face that we cannot rely on the state, which means that, although we know that it is not the best scenario, we really need our GPs and need to be able to work with them. Disabled people in our organisations would argue that GPs need to be resourced in that respect because they are clearly struggling, particularly in disadvantaged areas.

The Convener: The comments from Dr McDevitt suggest that doctors are reluctant to be truly independent. There are times when a doctor—or a social worker—will not want to be the person who confirms a decision to deny benefit. I can understand why they would not want to be put in that position; it means that trust is broken for ever. However, your campaigning point seems to be that doctors should support every case that is turned down. You are saying, "We need our GPs at this time."

Tressa Burke: I am not saying that.

The Convener: What are you saying then? Is that not the point?

Tressa Burke: I have not heard the point being made in the way that you suggest. If it is being said that GPs have taken a decision and put the poster up because they do not know whether their patients are telling the truth, that is a different matter. I am not advocating that GPs should provide false evidence—not at all. If a GP has reason to believe that a patient is lying, if there is a pattern of behaviour or if there is some sense that the symptoms cannot relate to the condition that the patient has been diagnosed with, we are not saying that the GP should provide false information—absolutely not.

The Convener: No. We have discussed the poster for quite some time but, given your campaign and your good representation, I think that we have moved on beyond the poster. Maybe the committee will decide in a couple of weeks that people will have to account for all that. We appreciate Dr McDevitt's appearance at the committee, although the people who were responsible for putting up the poster are not here.

We have moved on to how people can be helped and how they look to people whom they trust, whether they are in social work or in their GP practice. Inevitably, sometimes GPs cannot support such an appeal. That is another difficult aspect for GPs. They do not want to be in a position of saying, "No, we cannot support you." Does that reflect some of what Dr McDevitt said?

Dr McDevitt: That is very true. We have to look after people throughout their lives. Hopefully, most people will not be on benefits all that time but, sadly, some people will be. It is important that I can help them with their illnesses and help them to cope with life. I help people to make the decisions that will make their lives better and I help them to stay healthy. It sours that relationship if, suddenly, they lose a lot of the money that they use to survive. To make a personal statement, it is ironic that, in the middle of a time when jobs are at their least available, people are suddenly being put out to try to find jobs.

I believe that work is good for people. Staying endlessly in poverty or on benefits, with illnesses, is not good for my patients. It is also true that diagnoses do not always stop people working. I have patients with cancer who work; I have patients with MS who work; and I have patients with spina bifida who work. With the right support and the right type of work, even people with quite severe disability can work, which enhances their lives and significantly improves their health.

I believe in getting people into work. From a GP perspective, the problem now is that my patients are faced with getting a cut in benefits and with increased stress in trying to find jobs that might not be there. That is not good for them, so I find it hard to say that someone should not get benefits. If I said on medical grounds that they should not get benefits, that would give them less money and more stress, which is not good for them. I do not want to be responsible for that decision. That is not my role in relation to such people. My predominant role is to be their doctor, not to say that they cannot get benefits.

Members must remember that, because of my professional obligations, if someone asks me to do a report—whether or not they pay for it—I have to give the facts, and the facts might say, “You shouldn’t get the benefit.” People cannot assume that, because they pay me for a report, it will say definitively that they will get the benefit. It might definitively say that they will not, because all the evidence that I have suggests that they do not meet the threshold. Professionally, I have to be honest and truthful and I have to put what I think is the case and defend it.

People need to remember that. Getting my letter or report will not always definitively mean that someone has absolute support for their case, because I will just tell the truth—the facts—albeit, perhaps, in words that are more inclined to support the patient than not. However, it is important to realise that it should not be my decision to give an additional report because I feel sorry—as I do—for the patient.

In the past, if I felt that the state had made a manifestly unjust decision, I would always write a report for free to give my view as an advocate for the patient. I am sure that members of the committee have done exactly the same thing for their constituents. I have always done that, but that should be the exception. However, it seems to be becoming the norm for people to be given harsher decisions—the threshold to get benefits appears to be much higher. As a non-expert, I am getting that impression from patients. Patients are being distressed by that change and it is almost the norm now that many people are distressed by the process and the decision.

That is the country’s decision; it is a political decision to change the thresholds for benefits. When it becomes normal for people to have to appeal to me for additional information, the system is wrong—it is not working correctly. We are trying to get back to a rational position of fairness and equity for all. We are volunteering to do extra reports for nothing extra to us and, if the system asks for them, we will do our best to get them done in time. That has a cost to the system, as it means that I will spend less time on other things that patients need but, if it is necessary, it is necessary.

10:45

The Convener: In this adversarial system, where GPs are caught in the crossfire and are sometimes wrongly blamed because people shoot the messenger, is there an opportunity to do something other than to put up such a notice? Even if we resolve the other issues—about allocation of houses and the legal or employment requirements—there must still be general guidance for GPs. I presume that, for insurance, legal or employment purposes, GPs will not do their own thing but use a standard model. For example, a standard form might ask them to address questions 1 to 5, which would not be burdensome on individual practices. That is not dealt with individually, is it?

Dr McDevitt: Unfortunately, it is. Each practice is an individual unit or organisation with a separate contract and legal status. For example, neither the BMA nor the LMC can make practices do anything, although we can provide advice to help people to make a decision. If every practice had to have the debates that we are having, patients would never be seen, so practices need to make a decision when faced with the situation.

The Convener: Is there no standard report to comply with legal, insurance or employment requirements? Are there no standard elements at all?

Dr McDevitt: There are different bits. Most organisations that do a lot of this—such as insurance work—provide a standard report. If they are sensible, they will have discussed the issue with us and will use a standardised form. In many cases, a legal letter of this type requires someone to ask me a question, which I need to answer using the medical evidence. That is what a medical opinion report is.

The Convener: If, over time, we can resolve the issues about the allocation of houses and the other reasons why people write to GPs—I see that food banks now do that—to ask whether an individual is a deserving person—

Dr McDevitt: Am I going to say no to that question? Just ask yourself that.

The Convener: Rather than a local medical committee coming up with a reactive response and putting up such notices, which puts a barrier between GPs and patients, if the BMA had made an effort to have a round-table discussion with campaigners, we could have created guidance and a standard form that would have been available to GPs. It mystifies me that we have the current approach when there is no basic disagreement between campaigners on behalf of the most vulnerable and GPs, who want to help their patients. Why have those people not come together to provide guidance about the language, about the questions that people would self-answer and about how to be proactive in providing information in a pro forma? Is any of that work taking place? Could it take place? If not, why not?

Dr McDevitt: I think that the answer is that such work could take place. Following a decision last year, the BMA as an organisation has met disability groups and plans to meet them further. People might disagree on whether that has happened quickly enough and whether the timing has been right, but the BMA is taking action.

In a sense, the BMA is acting politically on behalf of doctors who have made such statements. We have also been clear—this happened at our LMC conference in Scotland this year—about how we think that the issue should be solved. As I have repeated today, we think that the DWP should use its ability to get such reports up front. That is the answer to much of the issue.

We have done all those things, but the issue is probably the pace of change. The building swell of distress in the community has overtaken our activities. The BMA is just one among many political pressure groups that face the same task. In many ways, the issue is the main reason for being for groups such as Tressa Burke’s, whereas the BMA has had to deal with the UK Government on other issues recently, so this is not our only business. Work on the issue has been going on and work is planned to continue. We have responded to quite a number of reports on how we think that things should change.

Glasgow was bound to be the place where the heat rose on the issue, because of the volume of patients who are on benefits and the volume of need. Glasgow was probably where the pressure first arose. When the LMC was faced with the people in a practice saying, “I don’t know how to decide this—what do I do for these poor people?”, the policy that it produced was the answer.

We could say that that came across as insensitive, and that is certainly what many patients might feel. However, if I told the committee today that I do additional reports, even only on extreme occasions, that would distress all the patients for whom I had not done them. The Glasgow LMC could say that all GPs can provide such reports, but not all of them might be able to do it. The LMC is in a dilemma and there is no right answer. It could shut up, stop saying that and leave the decision entirely up to individual GPs—

The Convener: The BMA must have expected the increase in workload from the welfare changes. Did the BMA believe that the issue was resolved because it had a contract in place with, I presume, remuneration at some point for what GPs are contracted to do? Was it the BMA’s sole concern that the contract was in place?

Dr McDevitt: No. Nothing has changed. To be honest, that requirement is an age-old part of the contract and it is almost vague—it is not specified. It has always been there since the NHS contracts started.

The Convener: So the BMA did not envisage an increased workload or increased time or cost implications for GP practices as a consequence of the welfare reforms.

Dr McDevitt: We could argue that, if GPs are providing the standard form in only 8 per cent of cases, the impression might be that we have less work, because the DWP is not asking us to perform our contractual role as often—it is not asking for the information as part of the system. I do not know about that, because I do not have the statistics but, if the standard form is requested for only 8 per cent of reviews, the volume of work might be less than I used to have with the old IB113 forms, because the DWP has decided not to ask me for the information. Bizarrely, in contractual terms, I might have to do less work than I used to do, although I do not know.

The Convener: So the work comes from the appeals.

Dr McDevitt: The work now comes from the appeals, which involve a private collection of data to contest the state’s view, as the state has not asked me for a view.

The Convener: What information does the BMA have on the volume of work for GP practices? We heard about your experience yesterday, but how many GPs in Scotland are being buried under such work?

Dr McDevitt: To be honest, we have been saying that general practice is now maxed out in all areas, not just in the welfare work. We cannot make any more hours in the day and we are having to make difficult decisions, about not just paperwork but clinical work that we might do for patients.

We are at a time in which the nature of our work is changing. The Government rightly wants us to do anticipatory care planning for the elderly and to look after sick people in their homes. That is the right approach and we have to do it. We are not waiting for that to happen—we are already in that change. We are under maximum pressure, and that is not just to do with the welfare changes.

We are trying to gather data, because people like figures. One GP in Glasgow told me that she had calculated that 12 per cent of her work is based on additional information requests for welfare purposes. That is a huge—

The Convener: That will not be uniform throughout the country.

Dr McDevitt: I do not think that it will be. We should remember that the reviews will go on until 2014 and that they are usually done in batches. A GP might get enormous pressure one month and nothing the next. I do not know how the DWP will do that. It might do a whole area in one six-month period, or it might spread out the work. The pressure will vary depending on the DWP, which leads the workload.

The Convener: So we do not know the extent of the problem across GP practices.

Dr McDevitt: No, we do not.

The Convener: Does Ms Burke have any facts and figures about individuals across the country that would help GPs to understand the scale of the problem? Is there any factual information or is it anecdotal?

Tressa Burke: We know that eight out of 10 people who are affected by the bedroom tax have a disabled person in their household. Is that the kind of thing that you mean?

The Convener: No—we are aware of those general facts. I am discussing the impact on GPs.

Tressa Burke: We do not have that information.

The Convener: So you do not have it and the GPs do not have it.

Dr McDevitt: The problem is that measuring workload takes time. Should I spend time on counting my workload to defend myself or should I spend it on patients? However, you raise a valid point.

The Convener: Has the GP contract been renegotiated? Is that negotiation still taking place?

Dr McDevitt: We could say that that has been going on every year, for ever. The GP contract is constantly changing. This year, we have a Scottish variation of the UK contract—it has a significant Scottish element. However, the contract is almost irrelevant to the issue that we are discussing, because the state already has the power to request all the information that it requires from us at no additional cost. That is built into the core contract from years ago.

I do not get £5 more for doing another form; I just have to do whatever the state asks of me. Whether the state requests the information in 8 per cent or 100 per cent of cases, my income does not change. The contract is irrelevant to the question, because the DWP has the power to ask me 100 per cent of the time for the information at no additional cost. Therefore, it is not a contractual issue.

The Convener: What does it pay—

Dr McDevitt: Nothing is specified in the contract to pay for this. It is just a condition—

The Convener: So it comes under the overall—

Dr McDevitt: If someone has an NHS contract, they must respond.

The Convener: Have you raised with the Scottish Government the additional workload that you have as a result of the welfare changes that you have outlined, the other pressures on you and austerity?

Dr McDevitt: We have raised in general terms the overall pressure.

The Convener: You have explained that you are so busy and that the Government will need to pay more if you are to do other things.

Dr McDevitt: Yes.

The Convener: Although you cannot quantify that in any terms, that is part of your negotiations with the Scottish Government.

Dr McDevitt: It is certainly part of our discussions with the Government at all points. Publicly and in our negotiations, we are pointing out that general practice is maxed out and that we need to build capacity.

I emphasise that this is not just about GPs, because we do not work in isolation. We need more social workers, district nurses, health visitors and even pharmacists. This is about community capacity to deal with what is needed for healthcare in Scotland's communities. The capacity needs to be improved and we need to start investing in community healthcare. That is part of the overall picture. As soon as any of those workers is given a new task, it takes away from something else. There is no capacity to say, “You can just add a bit more,” because there are no more hours in the day.

Nanette Milne (North East Scotland) (Con): You mentioned the form that you have to fill in, which might arguably give you a little less work than the previous form. You also said that you would like the full amount of information to be asked for up front. I presume that that would mean a fundamental redesign, or a redesign, of the form that you fill in to allow extra information to be included. How would that affect your workload? Would it take you anywhere near the extra workload that you are currently facing?

Dr McDevitt: It is possible that I might not be here next year because I am saying this, to be honest. My job is to represent people, and I am offering to give them more work for no extra money. That is, in effect, what I am doing here, and it is not a good position for a union representative to be in. However, the reality is that it is the only rational, fair and undistressing way of resolving the situation and getting us away from being to blame for the situation and towards having a rational system. It is the politicians’ and pressure groups’ job to fight over how the DWP standards and processes work. Technically, that is not my job, except as another person with a political view. If I am asked about how I relate to my patients and how I ensure that I am fair and equitable, the answer is that I fill in the forms when requested.

It is not the form that needs to be changed. It is the frequency with which the information is requested. I am happy to look at the content and how we can improve on that, but that is a separate issue once we know whether there are problems with it. I am not saying that the form needs to be redesigned. It is broadly sufficient for us to give the necessary information. It does not allow the inclusion of all the information that patients may think is relevant to the case, but it is certainly sufficient for the information that I have to hand and which it is reasonable and right for me to provide. I think that the form is okay in that regard, but the frequency with which I am asked to fill it out is one of the fundamental flaws in the current system.

Despite the statement that I have just made about pressures of work, I am inviting more work by doing that. I have to say that the five-day deadline is madness. I did not even notice when the deadline was changed. I cannot meet a five-day deadline, and it does not say when the patient will be seen. I can see that things are going to get worse. However, that is outwith my hands. The DWP can change things on its own, because that is what the contract says.

Bob Doris: Just for clarity, there is a contractual obligation to fill out the form at the first time of Atos and the DWP asking. That had to be done within 14 days, and now has to be done within five days. The additional workload comes when a negative decision is reached by the—to use your word—apparently or supposedly independent doctor. Individuals then go back to you, or come to me, and say, “This is the decision. I have a fluctuating health condition, and in general it has deteriorated.” I quite often write letters to doctors saying, “Can you reflect this in a letter to me so that I can give it to the DWP?”

Members of my staff have volunteered to accompany individual constituents to an appeal, because the advice agencies are overwhelmed. My staff are willing to do that, although they cannot do it often. There is no statutory obligation contractually to supply information for the appeals process unless it is requested by the DWP or Atos—is that the situation?

Dr McDevitt: Yes.

11:00

Bob Doris: Okay. Let us deal with it as a workload issue. You said that you have not quantified across Scotland the number of forms completed in the first instance, or how many requests there have been from members of the Scottish Parliament, CAB, Inclusion Scotland or whoever for doctors to do letters. I suppose that the no-brainer for any trade union would be that you must quantify the increased workload before you can make effective representations to your employer for greater recompense.

In the case of Atos and the DWP, the UK Government element of the GP contract and the Government’s UK-wide policies are putting additional pressures on individual GPs. It is important that the additional workload is quantified, rather than a guesstimate being made that, for example, a GP’s work has increased by 12 per cent. Are you doing a proper trawl? That would be time consuming, but it could be done. You must have the data and evidence in order to be able to say to the DWP, “This is the increase in the workload. We don’t believe that the GP contract reimbursement adequately reflects that and we want to renegotiate.” Where are we on getting figures rather than anecdotal evidence?

Dr McDevitt: The first point is that the DWP has the figures. The people in the DWP determine how much they want and they get the responses, so they are the only people who have the data. The BMA would not—and does not—have such figures. Presumably, the DWP has all the data on response times and could provide it on an FOI request. Clearly, the DWP can say how many requests come in.

I do not want to argue the DWP's and Atos's case, but to an extent the additional reports are not part of their process. Their letter invites people to find new medical evidence, which we think is wrong; our view is that, if they think that that should be part of the process, they should seek it. However, they ask people to go and find additional medical evidence, but that is not formally part of their process, so it is completely independent. In fact, they invite the patient to find an alternative medical view to contrast with the official view of the organisation regarding their assessment.

I do not envy the task of the doctors who do the assessments. One of the questions that have to be asked is whether you want doctors to be involved in this at all. If you do, you want a doctor who does not have a personal therapeutic relationship with you, because that is very difficult. However, that doctor has to apply the standards and processes as set by the DWP. They have to follow that guide, so they follow it faithfully.

I questioned the independence argument because lots of patient groups have said not that the doctors are not independent, but that the process is slanted against the patient. However, in fairness and professionally, the doctors have to follow the process that is outlined by the DWP; for them to do anything else would be for them to be unfair and not independent as a result of doing it for some patients but not for others. The process should be set out to be transparent, clear and straightforward so that people either meet the requirements or they do not.

Patients have said—quite rightly—that the system is inadequate in gathering information and that it does not gather the right information: it fails to do the job that it sets out to do. That is a legitimate challenge to the whole process, which I think that patients are right to make.

Bob Doris: I am deliberately trying to steer away from the rights or wrongs of welfare reform. Most committee members are on record as being deeply concerned about the brutal reforms that are affecting the most vulnerable in society. However, I have steered away from all that because the situation is that the reforms are happening. The question for the Health and Sport Committee is what we can do to meet our constituents' health needs that are going unmet because of the reforms.

I am concerned about whether the BMA can quantify the additional workload on GPs and practices, and whether that will require another FOI request or constructive discussions with the DWP. At the start of this evidence session, I asked what is not being done as a result of the additional workload. That puts the matter in a Scottish Government context, because Scottish healthcare priorities might not be being met because of the additional pressures that are created via a UK welfare reform agenda that has financial implications for GPs' ability to do things that are negotiated at Scottish level.

If you could quantify that workload, that would strengthen GPs' hand with both the Scottish Government and the UK Government and perhaps drive change around the allocation of resources. Have any steps been taken to quantify the work that has not been done as a result of your doing the welfare reform work? You said that the decision to put up the posters was perhaps ill considered and that you are reviewing that, having taken down the posters. You also said that GPs tend, by and large, to complete the forms and that you want to have a more consistent system. You are therefore doing additional work, which means that other work is not being done. Can you quantify what is not getting done? Are you making representations about that to the UK and Scottish Governments?

Dr McDevitt: There are a couple of points to make, one of which is that the question's emphasis misses what a typical day is like for me as a GP, regarding the intensity and number of decisions that I have to make. I do not have time to start recording stuff and I do not finish all my work at the end of the day. However, if I cannot sleep without getting something done, it gets done before I go home.

The intensity is such that we could not sit and start to look at what we did not do because we had done something else instead. The reality is that anything that I did not do today just goes into the pile of stuff that I must do tomorrow. It belies the nature of our work to say that it would be straightforward to assess what we did not do. To be honest, there are other pressures that are at least as large as the welfare reform pressures—for example, early discharge from hospital, multimorbidity or the elderly population—and which create much bigger pressures and more pressing clinical need than the element of welfare reform administration, which is what that work is.

I return to the point about the union aspects. We have not come at the issue from the point of view of asking for more money to do more of the welfare reform work. We do not want to do much of that work at all. We want it to be part of the existing standard, fair system and do not want to get into complex appeal cases and legal medical cases. The process should be fair and transparent, and everyone should be able to say that the system is as good as we can get it. However, we have been focusing on the fact that it is not. We are not arguing for the creation of a system that will generate a lot more income for GPs by our producing reports for the DWP or the patient, who will pay for all the extra reports that come from the system being faulty to begin with.

We are not arguing for more money for doing the work; our point is that we do not think that more work should be done. That should not be necessary, because the work should be done right the first time. We should not create all that additional, false extra work and we are not arguing for more money to come from that. You are right to say that we argue that the work is one of the major pressures in our day job right now, but it is part of the large mix of work that we do. We are looking at different ways of assessing that, because we are often criticised for not producing figures on, for example, how many phone calls we make in a day or how many patients we see. Such figures are quite hard to get because it takes time, resources and money to get them. However, we are starting to do that, because the fact that we cannot just trot out figures for X, Y and Z is a weakness of primary care. Some of that is because our heads are down getting on with the work, but we accept that some of our arguments are weak because of a lack of figures. We are looking at that.

Bob Doris: I get the point that doing a full audit of everything that you do could be rather bureaucratic. However, do you do a national survey of GPs across Scotland in which you ask general questions that would allow them to report some of the stuff that I have referred to? You are thinking that that would mean yet another form, but a one-off exercise could be done to capture some of that information.

The BMA makes challenging but constructive representations to the Scottish Government about all the other matters that you mentioned. My suggestion is that if the DWP welfare reform agenda is an additional pressure that impacts on your ability to do all the other things that the Scottish Government asks you to do, that must be part of the mix for discussion. I am suggesting a light-touch way of quantifying that, and doing it might strengthen your arm in some of your discussions.

Dr McDevitt: I appreciate that. A female GP in a very deprived part of Glasgow did what you described. She decided that that was what she needed. In her view, 12 per cent of her current workload comes from welfare reform work. That is a quick, straightforward description of one GP's experience in a deprived area.

I agree that data helps and I think that we will look at that issue. However, we are talking about data being gathered for a main political objective. The BMA's objective is to get the system to work right and get the form done properly, not to create a tail of additional stuff that needs to be done. That is our focus in gathering data, because that is the direction that we want to go in to find a solution to this complex and difficult problem.

Drew Smith: Dr McDevitt, you have described the whole gamut of problems that exist, for example with adaptations to housing and the pressure of moving people in and out of hospital. I know that we need to look at this in the round. Is it fair to say either that there is, or that we are approaching, a workload crisis in primary care?

Dr McDevitt: Yes—I think that that is absolutely clear. That is happening for a number of reasons. The nature and complexity of what we do have changed and the population and their health needs are changing. The Government is quite right to focus on 2020 and to say that we need to prepare now for the demographic change. We have to alter in a substantial and significant way how people are cared for medically and by carers in the community.

When I started in general practice, when people were sick they came to see me and they went away; broadly, that was it. Then we started to bring people in and to say, “You've got angina or asthma”—as it might be—“and we want to prevent you from getting sick. Let's work on the best package for you and do a plan.” We have been building on that for years and years. Most chronic diseases now have some type of plan and annual review, all of which is intended to maintain health and avoid illness.

We have the health promotion agenda, to stop people smoking, reduce alcohol intake and deal with harm. However, a lot of crises still occur; probably about 30 per cent of every GP's daily work comes from somebody presenting that day with something immediate. The rest may be more planned, when people are worrying about their health, although that can take longer. We deal with acute demand; people who are concerned about their health; chronic disease; and anticipatory care planning.

The nature of what community health does has fundamentally changed, and must change further if Scotland is to survive and the NHS is to cope with what is happening. On that basis alone, we need to increase capacity to deal with that new agenda, given that we have reached capacity for all that we do now. Having one more way of tackling the problem means that less time is spent on doing something else; it is a difficult balance to strike every day.

As a personal comment, I observe that many young doctors do not want to be me any more: they do not want to work with the intensity with which I work. We have a much more feminised workforce, which will change matters further.

People do not want to work the long hours that many older GPs have been used to, yet that is the workforce that we need. We need to ensure that general practice is an attractive profession for young people to enter to service the needs of the NHS and the people of Scotland, and that the capacity is there to do what all of us here, including me, will need to do. After all, we are among the needy group that requires the NHS to be redesigned and primary care to be strengthened and invested in so that we can be looked after as we get older.

The idea that we should all be exercising sufficiently to ensure that we do not need much care is a good idea, but we need to face the fact that many of us will have problems, either through bad luck or by ill behaviour. General practice and primary care have to have the capacity to do that. The way in which we are set up is not ready for that, yet we are now at capacity. I appeal to the Scottish Government and to all politicians to say that it is now time to invest in general practice and community care.

Richard Lyle (Central Scotland) (SNP): Dr McDevitt, I have listened to you intently. I remember doctors in the good old days. I have been lucky in my life and I see my doctor about once every eight, nine or 10 years, although I know that you see people regularly. On the point that you made earlier about self-assessment and housing letters, or letters for a shower or a new bath, I came across such requests in the 36 years I was a local government councillor.

Are you saying that what is happening is driving a wedge between doctors and patients? How did someone get an assessment for benefit in the first place? They got a letter from their doctor. At some point—five, 10 or 15 years ago—the doctor was involved when they were being assessed under the DWP rules at the time. Now the doctor is being asked to reassess. How do you reconcile the start of that assessment process with the new request to go back over what you have already told the DWP?

Dr McDevitt: There is a danger of conflating the different types of benefit here. Predominantly, I have talked about ESA, but we might also be talking about DLA, attendance allowance or the personal independence payment, as it is now called. There are different aspects. With ESA, for example, to begin with we write a fit note for patients. After 13 weeks, the DWP will decide whether the patient is fit for work or for some or any work, so the matter is out of my hands at that point.

11:15

Normally, under the old system, I would expect to be asked for a report before the DWP made a decision about the person’s fitness for work. That is why I said that I am not sure whether the proportion of cases or the number of cases in which the DWP has asked me for a report has changed. My impression used to be that the DWP always asked me before it decided whether someone was fit for work or not in the longer term. Under the new process, it seems that the DWP does not think that that is necessary. You could argue that that may be true, because if the decision is based on function rather than on diagnosis, that may be appropriate, so there are arguments to be had around that.

My general conception is that I will have given fit notes, which give a brief description of the problem. I will usually also have been asked at some point for a more detailed description of the health problem, and the DWP will make a decision based on that report. The DWP used to ask periodically, every two years or so, whether the situation was the same or whether things had changed. That was the normal process.

You are perhaps straying into things such as DLA and attendance allowance. In those cases, there is a more in-depth and extensive form that looks more at function and asks me for more detailed information about that for a patient, which I give when I have it. I will have filled in such forms for a patient at some point. That is paid for separately, because it is not part of the contract. I think that we get £30 for doing one of these reports. I am not obliged to do it, but we do it and we get a payment from the DWP.

There is a periodic review, at which point we may be asked to say again whether something has changed. The difference now is that, although the patient’s condition may or may not have changed, the thresholds have changed, so the DWP will reapply new thresholds to the old information. The DWP therefore may or may not choose to ask me for additional information; it may feel that it already has the necessary information and it will just apply that information to a new threshold and change its opinion.

I have not seen so many requests for review of DLA and AA, but such reviews are happening. I suspect that the process takes place geographically as the DWP works through patients, so I have no doubt that I will be asked for information in relation to DLA and AA. However, I suspect that it will be less the medical information that changes than the thresholds that are applied.

Richard Lyle: Do Tressa Burke and Dr McDevitt agree that all this reassessment has a cost and that that cost nigh outweighs the savings that the UK Government—not the Scottish Government—wants to make? Thousands of people are being reassessed; they are being seen in tranches. Dr McDevitt used the phrase “false extra work”—I will check the record and I will apologise if I am wrong. Would you like to comment on the cost of all that reassessment? Will the process save money or will there be a knock-on cost?

Dr McDevitt: It is outwith my expertise and knowledge to answer that question. I can comment only on what the process takes from medical time; we have talked a lot about that today. The main cost to us is the time spent on the process rather than on doing what patients need.

Obviously, when the figures indicate that about 38 per cent of people make a successful appeal, that means that it has taken a second go to get the right decision, so that has doubled the work required to get to the end result, which is the right decision. At the very least, that will have wasted effort.

If I used the phrase “false work”, it would be in that context. I would be talking about the creation of a system in which the norm is that we get the right decision on appeal and we have therefore spent more of the patient’s time, the professional’s time and the system’s time to get the right decision on appeal, when everyone’s time would have been saved and it would have been cheaper and more effective to have made the right decision at the first attempt. If I said something about “false work”, it would be in the context that I do not want to encourage the creation of a massive appeal system, because that means that we do twice the work to get to the right decision.

Tressa Burke: I absolutely agree. We do not know the figures, but we imagine that millions of pounds are being wasted, because people are having to go round and round and 40 per cent of people are winning their appeals for some benefits. I would go further than say that it is a waste of money or that it is costing the taxpayer money and say that often the outcome will not lead to a disabled person or a person with long-term conditions getting a job, because of the complex interrelated barriers that I spoke about previously.

Even discrimination can have an effect. I know that if I disclose that I have MS, it is much more likely that I will not get a job. The outcome is not necessarily going to be that disabled people get into work, so there are cost implications not just for the process but for what happens to the people and for their health and illnesses.

Last night, at the housing associations conference in Glasgow, we heard that suicides are up to four a week in Glasgow, and one a week in the east end. We heard that if you start at the top left-hand side of the rail map and work down to the bottom right, you lose a year’s life expectancy at every station. Figures such as that were presented to show that the situation has worsened. The costs are not just about money; they are also about people’s lives.

Richard Lyle: I admire what doctors do and I admire what Tressa Burke’s organisation does. Last week, I attended a bedroom tax meeting in Viewpark, Uddingston, and the whistleblower who blew the whistle on Atos was there—I will not give their name. They had a low opinion of Atos, and they talked about the questions that people are being asked, such as how far they can walk and whether they have a dog—if you have a dog, that means that you can walk, because you will be taking the dog for a walk. Do you think that some of the questions that Atos asks are loaded to ensure that it can get people off the system quickly?

The blame has all been loaded on to doctors, and I can see what Dr McDevitt means about that creating a barrier between patients and doctors. What is your honest opinion of Atos and of the questions that it asks? You may not know all the questions, but could you give a general opinion?

Dr McDevitt: I have to make it clear that I am representing the BMA, which is a large organisation with many diverse views. The decision made at the annual representative meeting, and the discussions that have been held in the profession, centre on the fact that many doctors have serious concerns about the current Atos process. That was the basis of the ARM motion that was accepted last year, and of the motion at the Scottish LMC conference this year.

There are many doctors who have serious concerns that the system is designed to reduce the number of people who might benefit from it. That is my personal opinion as a working doctor, not as a medical politician or somebody who has inside knowledge. The impression seems to be that more people are getting harsher treatment and that the threshold for achieving benefits has become much higher. People who were previously thought to be in need of benefit, whose situation has not changed and who are no less distressed, unwell or disabled, are now not getting that benefit and are being asked to enter into a work-seeking situation, which they tell me is stressful, at the very least, and does not seem to help their health. I have to say that the chances of those people getting employment, particularly in the area where I practise, seem pretty remote. Would I, as an employer, employ some of those people? The answer is probably not. I would not expect them to be able to do a good day’s work.

It is a political decision, so it is right that Governments are responsible for that and should argue about whether the system should be in place, and we should all engage in the political process. However, many doctors think that the process that is now being instigated, and which Atos is contracted by the UK Government to provide, is a harsher system that is intended to result in fewer people receiving benefits. That is my view of what many doctors think, and it is not strictly a BMA view. The BMA view is expressed in the reports and the ARM motions.

Tressa Burke: If you are seriously asking me what disabled people think of Atos, am I allowed to swear?

Richard Lyle: With the greatest respect, we have only about five minutes left, although I am sure that you could speak about Atos for the next two hours. However, so as not to alarm the convener, I will ask you to give a short answer, although I do not want to deny you the opportunity to comment. How do you feel about Atos?

Tressa Burke: Disabled people have reported to me that their experience of going through the Atos processes is that it was humiliating, degrading and unfair. Notwithstanding the occasions that Dr McDevitt mentioned when he cannot believe what patients are saying, the statistics from the DWP itself show that zero point zero something per cent of people are committing fraud. We know that the majority of people are telling the truth, yet they find it extremely painful to go through the process.

Inclusion Scotland and the Glasgow Disability Alliance had a day with our members to commemorate Holocaust memorial day. Atos was mentioned time and again. Parallels were drawn with people enduring prejudice, stigma and discrimination. Parallels were also drawn with the fact that Atos staff are just following orders—people asked where that takes us. I will say no more than that.

Richard Lyle: Thank you.

The Convener: We have heard about where the politics lie and where the policy has come from, and we have read Inclusion Scotland's recommendations in its submission. However, I do not know what flows out of this. We have heard that GPs do not really want to be involved in the situation but are caught up in it. Inclusion Scotland mentions in its submission that the Scottish Government has

"a duty under the Equality Act".

What do you mean by that? Another recommendation in the submission is that

"GPs should be supported by Scottish Government and health boards".

What do you mean by that?

The other issue that has not been covered this morning is the use of reports and assessments from the social work arm of local government or instances when social work departments are asked to confirm certain things in relation to the bedroom tax, such as how a bedroom is used. As I said, how does the committee get to the stage at which we bring all the agencies together to manage a situation that we do not want?

It would be useful if Tressa Burke could comment further on the recommendations in Inclusion Scotland's submission. That would help us to develop our thinking about who we need to get together to produce a practical, pragmatic response that improves the situation for people who are facing worry and may panic, so that the appropriate organisations can therefore at least be with those people at such a time.

Tressa Burke: Our reference to the Equality Act 2010 is to the positive duty in the act to promote equality and reduce inequality, particularly for disabled people. However, it is not only about the Equality Act 2010. There is also a duty on Scottish ministers to promote human rights positively and to reduce the inequalities that disabled people experience. That is what we mean when we refer to the legislation and we can give the committee more information on that.

On practical steps that could be taken, I referred to the idea of agencies having to pay the money up front. I refer back to the Welfare Reform Committee's report on the issue. It mentioned Professor Harrington's report, which indicated that the information provided was not being used to its best advantage and that some of the descriptors that the information was being fed into did not take account of what GPs had said in the first place, which meant that cases had to go to appeal. It is important to have discussions and meetings with the DWP and to look at the issue from the front end of the system.

I will use the reshaping care for older people strategy as an example. Although the process has taken time, we have found that it has been positive and productive to bring people together, including the third sector and potentially the independent sector, and to get them working together on solutions.

As I said, organisations such as CABx and disabled people's organisations are already part of the process and may be able to come up with some solutions.

Notwithstanding all that, we cannot get away from the fact that GPs need further resources so that they are enabled, particularly in deep-end practices, to have more time to dedicate to filling in the forms while all the other things are going on.

That is vital, because there is the crisis of dealing with where we are and there is also the longer-term process of sorting the situation out. We must deal with both at the same time, step by step.

The Convener: As there are no more questions, I thank both our witnesses for their time and for their evidence to the committee. We will consider the evidence and communicate with the minister and others.

That brings us to the end of the public part of the meeting. We now go into private session, as previously agreed.

11:30

Meeting continued in private until 13:04.

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