HEALTH COMMITTEE

Tuesday 1 March 2005

Session 2

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HEALTH COMMITTEE

6th Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)

*attended

THE FOLLOWING GAVE EVIDENCE:

Margo Biggs (Forth Valley Local Health Council)
Dave Bissett (Scottish Haemophilia Forum)
John Davidson (Scottish Executive Health Department)
Philip Dolan (Scottish Haemophilia Forum)
Keith Foster (Skipton Fund Ltd)
Dr David Love (British Medical Association Scotland)
Alex Matthewson (British Dental Association Scottish Council)
Frank Maguire (Scottish Haemophilia Forum)
Hal Rollason (Optometry Scotland)
Stewart Scott (Borders Local Health Council)
Peter Stevens (Skipton Fund Ltd)
Angela Timoney (Royal Pharmaceutical Society of Great Britain)
Dr Hamish Wilson (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Tuesday 1 March 2005

[THE CONVENER *opened the meeting at 14:02*]

Items in Private

The Convener (Roseanna Cunningham): I bring the meeting to order and thank everyone for their attendance.

I want to deal as quickly as possible with agenda item 1, which is to consider whether to take items 4, 5 and 6 in private. Item 4 will be a discussion of evidence that we have received today. Such discussions normally take place in private as they are, in effect, part of consideration of our draft stage 1 report. Item 5 will be continuation of our consideration of the draft report on our eating disorders inquiry and item 6 is to discuss the arrangements for the workforce planning event in the chamber that we are trying to organise.

There is an issue about the order of the agenda but, before we deal with that, I want to get the committee's agreement to take those three items in private. Is everyone happy with that?

Members *indicated agreement*.

The Convener: I now ask for the committee's agreement to take items 5 and 6 out of order. Due to the weather conditions that resulted in the closure of Edinburgh airport this morning, the witnesses from the Skipton Fund are seriously delayed and cannot get here at the originally scheduled time. Therefore, I propose that we rearrange the agenda by taking items 5 and 6 out of order. Is that agreed?

Members *indicated agreement*.

Subordinate Legislation

Food (Pistachios from Iran) (Emergency Controls) (Scotland) Amendment Regulations 2005 (SSI 2005/70)

14:04

The Convener: Under agenda item 2, the committee is asked to consider, under the negative procedure, the Food (Pistachios from Iran) (Emergency Controls) (Scotland) Amendment Regulations 2005 (SSI 2005/70). The Subordinate Legislation Committee had no comment to make on the regulations and no comments have been received from members. No motion to annul the regulations has been lodged. Are we agreed that the committee does not want to make any recommendation on the Scottish statutory instrument?

Members *indicated agreement*.

Smoking, Health and Social Care (Scotland) Bill: Stage 1

14:04

The Convener: Item 3 on the agenda is continuation of our evidence taking on the Smoking, Health and Social Care (Scotland) Bill. Today we will hear oral evidence on two aspects of the bill. We will consider part 4, which deals with discipline, using the same round-table format as we used last week. When we take evidence on part 5, which deals with infection with hepatitis C as a result of national health service treatment, we will use the standard format of witness panels to which we are more accustomed.

The witnesses for part 4 are already at the table with us. At the outset, I inform them that witnesses who are called to give evidence by a committee are entitled to claim travel expenses. Does the committee agree to delegate to me authority for deciding whether any claims that arise from stage 1 consideration of the bill should be paid?

Members *indicated agreement*.

The Convener: As I said, the first session today will be in round-table format. I thank all the witnesses in advance for participating. I draw everyone's attention to the paper that introduces the round-table approach and sets out how it will work. Members saw it at work in practice last week. The committee papers include background papers from the Scottish Parliament information centre on part 4 and all the written submissions, both from people who are present and people who are not here.

I invite the Executive officials to outline briefly the main provisions in part 4. Dr Hamish Wilson is head of the primary care division and John Davidson is from the workforce and policy division's general medical services team.

Dr Hamish Wilson (Scottish Executive Health Department): At the moment, the National Health Service tribunal is the ultimate disciplinary body within the national health service for general practitioners, dentists, pharmacists and opticians. The tribunal's main sanction is to disqualify a practitioner from membership of the list that the health board holds for his or her profession. It also has a power of suspension, pending the outcome of any case.

I will outline the main changes. The bill introduces a third ground for disqualification, in addition to those relating to efficiency and fraud—namely, unsuitability by reason of professional or personal conduct. Section 22 brings within the tribunal's jurisdiction additional categories of persons, in particular those who assist with the provision of general dental services and general ophthalmic services, dental corporations, persons who perform personal dental services and registered pharmacists. That change follows on from the changes to listing, which were discussed a week ago.

Section 22 also removes the sanction of local disqualification and leaves only national disqualification at the hand of the tribunal. At present, the tribunal can only disqualify someone locally. The view was taken that that was inappropriate and that, if a disqualification were necessary locally, it would also be necessary on a Scotland-wide basis.

Section 22(7) introduces a new ground for suspension, when it is

"otherwise in the public interest".

Section 23 updates the provisions by allowing decisions that are taken elsewhere in the UK to be applied to Scotland.

The Convener: I ask the two patient representatives to comment specifically on part 4. Stewart Scott is the chair of Borders local health council and Margo Biggs is a member of Forth valley local health council.

Margo Biggs (Forth Valley Local Health Council): We welcome the new ground for disqualification. Our primary concern has always been about the linkage of information, so that incidents can be reported timeously and dealt with accordingly. That is my main comment.

Stewart Scott (Borders Local Health Council): We have heard what Dr Wilson said. We are talking about practising 21st century health care. There is no doubt that we need to match that with 21st century legislation that enables clear and unambiguous approaches to dealing with issues of suspension and discipline of all professional groups that are involved in health care. The public expect no less.

The proposals in part 4 provide a good basis for proceeding to amend and strengthen the disciplinary powers of boards and tribunals. Gone are the days when the majority of patients were passive recipients of health care, and there is a need for more active involvement of the public in decisions about disciplinary matters. I do not come from a medical background, but I wonder whether appraisals of general practitioners and others might be a good way of highlighting any shortcomings in their clinical skills or methods of practising. I do not see any mention of appraisals in the papers, but GPs are taking on board that new approach and they might well be a useful way of picking up on problems much earlier and allowing earlier progress to be made, rather than picking up on them later, when the damage has been done. We all know the benefits of that.

The Convener: We move on to the witnesses from the various professional bodies. Dr Love might be the appropriate person to respond to Mr Scott's comment on appraisals. With us are Alex Matthewson, who is north branch representative from the British Dental Association Scottish council; Dr David Love, who is deputy chair of the British Medical Association Scotland; Hal Rollason, who is chairman of Optometry Scotland; and Angela Timoney, who is chairman of the Scottish executive of the Royal Pharmaceutical Society of Great Britain.

I ask the four professional representatives to make specific comment on the bill, and I ask Dr Love to address Mr Scott's specific concern.

Dr David Love (British Medical Association Scotland): Generally, the BMA has no objections to the Smoking, Health and Social Care (Scotland) Bill. We acknowledge the need for the new category of professional or personal conduct to be introduced. There have been instances in which persons who were clearly unfit to practise were not covered by the existing categories, so we accept the need for the new category. We also accept that it is common sense to drop the option of local disqualification and to ensure that disqualification applies nationally.

We have only one major concern, and that is the lack of a definition of professional or personal conduct. The policy memorandum states that the ground will apply if

> "a practitioner has been convicted of an offence, the nature of which suggests he or she no longer deserves the trust which is necessary".

That is quite right, but the way in which the bill is written makes the ground a wide-ranging catch-all that could be abused and misinterpreted. It is terribly important for subsequent regulations and guidance to make it clear to both the profession and the tribunal what sort of professional or personal conduct could lead to disqualification of a GP's right to earn a living, which is a severe sanction.

We also note that there is no reference to the professional regulatory body of GPs, which is the General Medical Council. It would be sensible for subsequent regulations and guidance to be compatible with current GMC guidance on what constitutes unsatisfactory professional or personal conduct, which I realise might change in the light of the review that is taking place following Dame Janet Smith's inquiry into Shipman.

In response to Mr Scott's particular question, GP appraisal as it is currently modelled and practised in Scotland is a formative educational exercise between the appraiser and the appraisee in which a doctor identifies priorities for learning in the following year and the appraiser assesses progress and compliance with that learning plan in succeeding years. It is not primarily a method of detecting poor performance or underperformance. If poor performance is thought to be an issue during appraisal, the appraisal process stops and the GP concerned is referred to the performance procedures that are in place at health board level, which might lead to referral to the tribunal. Therefore, appraisal is not the vehicle for instigating disciplinary procedures.

I say that with the large proviso that the whole business of appraisal and revalidation is being re-examined on a United Kingdom basis. The chief medical officer is examining the matter in England, as a result of the Shipman inquiry, so the GMC might change its position on the requirements for appraisal and revalidation in future.

14:15

The Convener: Mr Scott will have an opportunity to respond, but first we will hear from the other three professional representatives.

Hal Rollason (Optometry Scotland): I apologise for not submitting comments on tribunals earlier. I submitted a response from Optometry Scotland yesterday, but I understand that the committee will not have had a chance to consider it yet.

Optometry Scotland and the General Optical Council replied to the Scottish Executive consultation last June and broadly supported the Executive's proposals. In the response that we submitted yesterday, we state:

> "Optometry Scotland welcomes the harmonisation of disciplinary procedures of family health service practitioners, and as you would expect, we are firmly committed to the concepts of improving patient protection and optimizing NHS resources.
>
> In general OS supports the future role envisaged for the NHS Tribunal but thinks that the policing of these proposals may be difficult. Consideration must also be given to the place of trainees and students since these people also have close patient contact.
>
> OS does agree that all the primary care professions should be included in whatever scheme for fitness is produced, but there should be a realistic assessment of a practitioner's risk profile. The various family health service practitioners will have very different degrees of patient contact and opportunity to cause harm to those patients. The Tribunal when assessing any one practitioner's risk to the patient or the NHS must take this into consideration."

The Health Committee might want a copy of the submission that the GOC made to the Scottish Executive consultation. Yesterday I was in contact with the registrar, who has sent a note to the Scottish Executive that it will pass on to the committee shortly.

In our response to the committee, we also say:

> "It might be extremely difficult to decide whether a person is a fit person following a conviction that does not result in a successful prosecution. It may be more appropriate for the National Regulatory bodies to be the arbiter and take responsibility for the character of their registrants. It may be more appropriate for Health Boards to refer suspected people to the regulatory body rather than to a whole new system of investigation. This would give a consistency of approach throughout the UK."

We have some specific reservations. One relates to paragraph 107 of the policy memorandum, which suggests that, while a practitioner is suspended, they will continue to be paid. However, if an optometrist is unable to work, he cannot generate any income and so cannot be paid. That is a slight difficulty.

Another reservation concerns paragraph 114 of the explanatory notes, which states that a body corporate may be suspended or disqualified on the grounds of fraud or unsuitability. I understand that that is already the case, but we think that it is slightly unfair. In our response to the committee, we disagree with the proposal and argue:

> "Each situation would need careful investigation before making a decision, as it would be unfair to punish an entire organisation for the act of a single individual"

in that organisation. The submission continues:

> "A corporate body may have a large number of practices"

and a few directors,

> "but could be disqualified in total, based on the actions of one or two people. The actions of one individual may be unknown to anyone else"

in the company

> "or may be malicious in their intent."

In conclusion, we state:

> "OS would not support an extra layer of administration if it duplicates tasks already performed by the National Regulatory Bodies, or which such bodies could easily assimilate."

However, we understand that the tribunal is concerned specifically with NHS issues and that the regulatory bodies deal with all issues.

As Margo Biggs said, there need to be clear lines of communication between the national regulatory bodies and the NHS tribunal. We think that it is important and advisable that the family health service practitioner groups are closely involved in any policy development or review that follows on from this.

Angela Timoney (Royal Pharmaceutical Society of Great Britain): This is a good time for pharmacy. A lot of changes are happening in the profession. "The Right Medicine: A strategy for pharmaceutical care in Scotland" has been in place since 2002 and the profession supports that strategic direction and the new services that are now being delivered.

It is the view of the Royal Pharmaceutical Society of Great Britain that parts 3 and 4 of the Smoking, Health and Social Care (Scotland) Bill are inextricably linked.

The society is the professional and regulatory body for pharmacists. That dual role is unique in the health care profession. It means that we have responsibility for pharmacists' undergraduate training, their entry onto the register, standards of practice and assessment of competence. If things go wrong, we are able to identify that at an early stage and provide support, which picks up on the point that the Borders local health council representative made. Where that is not successful, disciplinary proceedings and the ultimate sanction of removal from the register might result. The society has more than 150 years' experience of providing both regulatory and professional input.

As I have said, our view is that parts 3 and 4 of the bill are linked. Last week, when the committee discussed part 3, which deals with pharmaceutical care services, many people around the table stated that there is a need for nationally agreed standards to ensure that there is not inequity in the provision of services across Scotland. The society has extensive experience of setting standards and of developing practice guidance, and we would like to be involved in that and in developing and commenting on the regulations. It is our view that the next stage is then assessing competence against those standards. Part 4 would apply where there are problems with monitoring those standards, as it relates to the disciplinary proceedings that might be involved.

The society is totally supportive of the intention to protect patients from health care professionals who are unfit to practise. We endorse the functions and responsibilities of a modern regulator that are set out in the Kennedy report and are modernising our disciplinary processes through a section 60 order under the Health Act 1999. The Kennedy report talks about the functions of a modern regulator as being not simply to deal with discipline and sanctions but to deal with proceedings from undergraduate training right through, to ensure that, at every stage, people are fit to practise and that, when things go amiss, corrective action is taken at an early stage.

We feel that the NHS disciplinary procedures that are outlined in part 4 will be complementary to those exercised by the society and that there should be clear links between the NHS tribunals and the regulatory bodies so that those duties can be discharged effectively and efficiently. We have an inspectorate within the society that inspects community pharmacies and checks to ensure that they meet professional standards and have safe systems of work. It also responds to complaints, so we are both proactive and reactive in our responses to problems in the profession.

In undertaking that work, inspectors know at an early stage when something is amiss and can intervene on behalf of patients and pharmacists. It is our view that the regulations that follow the bill will need to ensure that there are two-way links between the NHS and the society, so that we can deal appropriately with professionals.

The timescales involved in such processes are another reason why that is important. It is necessary to have streamlined and efficient processes to ensure patient safety and to protect professionals. The committee might be aware that, last week, the English Minister of State for Health announced plans to tackle the cost of long, drawn-out disciplinary procedures for doctors and dentists in England, following a Public Accounts Committee report that suggested that the cost was around £40 million, because of the costs of legal fees and of paying people when they are suspended. It is important that the detailed and complex disciplinary systems and procedures are effective and efficient.

We have a busy agenda so I will conclude. We express our support for taking forward NHS tribunals, but the society wants to work with the committee on parts 3 and 4 of the bill to ensure that the regulations work effectively for patient safety.

Alex Matthewson (British Dental Association Scottish Council): I promise members that there has been no collusion with the other people at the table, but the committee will see from the British Dental Association's submission that we also agree with the general principles of the bill and the part about discipline. There is no harm in going over the issues again. The reason why we like the bill is that it will strengthen the disciplinary powers, because we have no truck with underperforming dentists or people who are a disgrace to our profession. We realise that there are some anomalies just now that the bill will iron out.

We are unhappy about one or two things. The professional conduct committee of the General Dental Council is already looking into areas where discipline is necessary. There should be some mechanism whereby the tribunal and our professional bodies can work together in harmony.

We are pleased about the removal of local disqualification. We feel that disqualification should be national.

The power of suspension is an interesting one. The policy memorandum refers to

> "protection of the public interest".

There is a need for a definition to go along with that. We know that the General Dental Council has a strong definition on that area of indiscipline and malpractice. Some extra words are necessary in the bill.

One or two witnesses have referred to the fact that, according to the policy memorandum,

> "Any practitioner subject to suspension proceedings will have the right to a hearing"—

which is fair—

> "and, if suspended, will continue to be paid."

General dental practitioners are paid on an item-of-service basis. If they do not work, they do not earn, so that has to be clarified.

We understand the measures on removal from dental board lists. However, we are concerned that the confidentiality and accuracy of reports should be maintained and ensured in case of innocence. We are almost talking about people already being guilty. We want to ensure that when a spurious allegation is made against a doctor or a dentist and the matter is all cleared up, no aura of suspicion hangs over them.

The Convener: Before we move on to the open session, I ask Mr Davidson whether he has anything to say about the payment of opticians and dentists while suspended because, clearly, both professions have an interest.

John Davidson (Scottish Executive Health Department): Suspension was introduced for doctors, dentists and so on in about 1996. At that time, we introduced the principle that, if a practitioner was suspended, he would continue to receive his net income from the health board. The provisions for that applied only to the classic example of a principal GP but, clearly, we can build on that principle and try to ensure that anyone who is suspended receives their net income. We will consider that.

The Convener: The issue comes down to who pays the net income.

Hal Rollason: There is no net income if we do not work. There are no capitation fees or anything like that for optometrists.

John Davidson: We stated that a GP's income would be preserved as far as possible. We would take into account the fact that he did not have any practice expenses during the time he was suspended. That is why we used the expression "net income". We consider that the health board will ultimately pick up the cost, because it is the health board that decides to suspend.

The Convener: Does that clarify things for the dentists and opticians?

Alex Matthewson: Not really, because "net income" does not carry much meaning for me. As a general dental practitioner, I have vast expenses that I have to continue to pay, even though I am not working.

Hal Rollason: The same applies to me. I work with a pre-registration trainee optician—if I do not work, they do not work and nor do any of the other practice staff.

14:30

Dr Wilson: There is no disagreement about the principle that while somebody is suspended, they should continue to receive an income. The practical problem that we face with some contractors is determining what exactly the income should be, because normally they earn their income in a particular way. One can consider a practitioner's historical earnings to determine their average earnings. As with some other issues, practical work needs to be done to follow up the matter. We need to work out with the individual professions a fair way of remunerating suspended practitioners.

Angela Timoney: I am pleased to hear what Dr Wilson says because pharmacy has a particular problem. As the committee discussed at its previous meeting, we have pharmacists who are contractors, but who employ pharmacists within a pharmacy. For instance, Boots has employee pharmacists. If an employee is suspended by the NHS, it would not seem reasonable in many situations for Boots to pay. We need discussions about appropriate remuneration for such people.

The Convener: Clearly, the issue needs to be resolved.

Members have more general questions. Shona Robison wanted to ask about professional conduct.

Shona Robison (Dundee East) (SNP): I am particularly interested in the comments from Margo Biggs of the Forth valley local health council, who is sitting beside me. Her written evidence mentions the

“need to get away from the ‘old boy network’”

and states that

“patient safety should be the main concern.”

I am sure that we all agree with that.

Margo Biggs continues:

“If something which raises suspicion is noticed by anyone from domestic staff to consultant that person should feel able to report it, therefore a culture of ‘whistle blowing’ should be encouraged.”

Obviously, the bill has limits and it may not achieve that culture, but will it go some way towards allaying those fears? More generally, what needs to happen beyond the bill to achieve that aim?

Margo Biggs: The bill will improve matters by helping to create a culture in which causes for concern are shared and in which it is not felt that, by bringing concerns to public attention, a person is in some way being disloyal to their profession. Dr Love mentioned Dame Janet Smith's Shipman inquiry. One of her suggestions was that patients should be asked to comment on their level of satisfaction at various stages of their treatment. That would improve matters further. It is all very well with hindsight after Shipman to raise issues such as the concerns that relatives may have felt at the time, but patients and carers must be more involved throughout treatment.

We also need more robust record keeping, to which I alluded previously. Another suggestion in Dame Janet Smith's findings was that health boards should have robust databases through which people, including patients, would be able to access practitioners' track records. That sets alarm bells ringing because it is similar to league tables in education and because people may make judgments on false basis, but we must have more transparency and more of a culture in which concerns are not seen as a betrayal of colleagues.

Shona Robison: What do the representatives of the Executive say on the general point about how patients and the public fit into disciplinary matters? I know that it is a difficult area, and that there is a balance to be struck, but the same point was made earlier by the representative from Borders local health council, who was talking about the involvement of the public in disciplinary procedures. Is that something that the Executive has considered? If so, what form could that take?

Dr Wilson: I would separate complaints from discipline as the two procedures are separate in Scotland. You will be aware that a revision of the complaints procedure in Scotland is already under way, which would strengthen the role of organisations such as the successors to health councils in the investigation and pursuit of complaints. That may itself be subject to review, depending on the outcome of Shipman 5. Work is already under way on modernising and making more effective the complaints procedure.

If a case comes to discipline at health board level, the discipline committee that hears the case—which will be heard at a health board that is not the health board where the offence may have taken place—will consist of lay people as well as professional people. There is already involvement there. On an NHS tribunal, one of the three members is a lay person: its chairman is a legally qualified individual, there is a member of the profession and there is a lay member. Lay members are actively involved in the formal procedures. As Margo Biggs and Stewart Scott said, significant effort is made at local level to catch problems early, so that we avoid going down the discipline route wherever possible.

As Dr Love will know, work was carried out two or three years ago on poorly performing doctors, which resulted in a procedure that allowed for earlier identification of problems, much of which comes from information provided by patients. That procedure is implemented in such a way as to avoid going down the discipline route and to provide help and support to the individual practitioner, so that problems do not escalate and become disciplinary matters.

Shona Robison: Does that happen routinely, or were you referring to a specific case?

Dr Wilson: A procedure is now in place.

Shona Robison: Will that be applied consistently in every case?

Dr Wilson: Yes—where poor performance is identified. Dr Love referred to that in his remarks on the appraisal system, which is separate but parallel.

Hal Rollason: Optometrists probably work at the most retail-oriented end of the health service. Many optometry companies send out questionnaires in which one is asked to gauge on a 1-to-10 basis how good the test was, what explanations were given, what happened and what the handover to the dispensing optician was like. We might not want to go down a wholly formal, league-table version of that with information being collated by the health board, but I see no reason why doctors, dentists or other health professionals could not do the same.

The Convener: Surprise, surprise—Dr Love wishes to come in at this point.

Dr Love: One of the major requirements under the new GP contract is to carry out a patient survey, part of which involves feedback on the doctor's performance. The surveys solicit feedback from, on average, 50 randomly selected patients who are seen in normal surgeries. A validated questionnaire is used—it is independently analysed—which is retained by the GP and put in the revalidation folder, after which it will be examined as part of the appraisal and revalidation procedures. It is all beginning to happen.

A point was made about information on individual doctors being more readily accessible. That recommendation was about the General Medical Council's database, not health board databases. It was felt that the GMC should make it much clearer what doctors' past records were and what information the GMC holds on them.

Alex Matthewson: To put Mr Scott's mind at least partially at rest, there are already two routes to looking after the concerns of the patient as far as the dental profession is concerned. One is through health boards, which have dental practice advisers who do practice inspections, which could involve an assessment of cross-infection control, of the premises or of record keeping. In other words, anything that

> "would seriously compromise or disrupt the efficient delivery of local health care"

could be looked into at local level.

Secondly, the dental part of the practitioner services division has district reference officers who assess five cases on the basis of the quality of the work that was delivered. Put very simply, patients are asked how the dentist did. If the dentist's work does not pass muster or if there is one bad reference, that triggers a series of five or so inspections. I should point out that the references are graded 1 to 4, where 4 is the worst. If there is a 4, the matter could be referred to the General Dental Council and disciplinary action could result.

Mrs Nanette Milne (North East Scotland) (Con): If I have understood things properly, the witnesses believe that the NHS tribunal and the professional regulatory bodies need to work together in a complementary way instead of duplicating one another's work. In its submission, the Royal Pharmaceutical Society of Great Britain says that such an approach

> "can be secured through development and implementation of formal Concordats or a Memorandum of Understanding between the Society and NHSScotland."

I wonder whether Ms Timoney would care to elaborate on that statement, and whether other witnesses think that that would be the way forward.

Angela Timoney: In my introduction, I mentioned that our inspectors visit every community pharmacy and check the premises and professional standards. That enables us to identify at an early stage whether there are problems.

A memorandum of understanding between the society and the NHS would allow us to have an agreement about what information could be exchanged when moving from a support function to concerns and disciplinary issues. Such an approach would protect patients and allow us to have more efficient processes. Because NHS tribunals rely on patient complaints, other concerns might not come to the surface or result in a complaint. For example, when we investigate certain matters, on the one hand we need to find an appropriate way of feeding into systems and, on the other, the NHS must give us certain information. After all, as other witnesses have pointed out, we are dealing with people outside the NHS as well as people within it.

Mrs Milne: How does that fit with the thinking of the other professional bodies?

Dr Love: I am not certain that most cases will reach tribunals via complaints. Although that might happen, many cases could arise as a result of court convictions. However, the anxiety is that no one knows what is meant by the phrase

"by virtue of professional or personal conduct"

in the bill. The tribunal and practitioners have to know what it means, and we are simply flagging up that most of the professional regulatory bodies already have fairly copious guidance on what constitutes satisfactory and unsatisfactory professional and, indeed, personal conduct. In fact, the GMC produces a constant stream of booklets that we are all meant to read. They are usually very helpful and set out a clear framework of what is or is not acceptable. We need to link that guidance with the regulations that will guide tribunals.

The Convener: Perhaps the Executive officials can tell us about the definitions of misconduct.

Dr Wilson: I confirm Dr Love's point that we see the need to be more specific in guidance about some of the words that are used in the bill. That said, I must point out that some of those words are consistent with the text of legislation south of the border. No definitions have been needed in that regard; moreover, professional regulatory bodies also provide a good deal of background information. We intend to produce guidance that will follow through the bill's enactment and provide clear examples of professional and personal misconduct, public interest and so on.

14:45

Mrs Milne: I would have thought that the last thing that we need is duplication of all the books that the British Medical Association brings out. It will be good if the regulations make the system simpler so that there is clear understanding and no duplication. Have the other witnesses anything to say?

Hal Rollason: I agree. We want to avoid duplication of tasks, and it is important to share information. Optometrists think that they are onerously dealt with by their regulatory body, compared to some of the other professions. That is just a personal opinion, which the body knows about. The most important things are sharing of information and protection of the public.

Alex Matthewson: There is a burgeoning industry in all things concerned with standards: NHS Quality Improvement Scotland has just brought out a draft standard of dental practice. The re-accreditation and revalidation that is required every year to be a practising dentist is getting more and more onerous. Various amounts of postgraduate work—far more than used to be the case—must be done every year and we still have practice inspections that examine everything from our hepatitis B status to the nature of our toilets. We are being examined all the time and, a bit like the optometrists, we feel that we are being spied on on every corner and that it is not possible to get away with anything nowadays, although that is as it should be.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): There is a crossover in what you were talking about. I was going to go into the details of the provisions on unsuitability by virtue of professional or personal conduct, but we have discussed that. The Scottish Pharmaceutical General Council suggests in its submission that

"unsuitable to be on the list"

would be a better phrase. In some ways, that seems to me to be vague as well, although the SPGC's criticism of the other wording was that it was too broad and open to interpretation.

How much are the witnesses worried about the workforce? Perhaps enough optometrists are working to cover all the hoops that they have to go through nowadays. How concerned are you about having sufficient people to cover all the extra postgraduate work that has to be, and is, done and about the fact that young doctors and pharmacists who are in training will be open to disciplinary proceedings and might be making mistakes? Will you elaborate on that? It has a bearing on future recruitment, because people might be scared to work in a profession that is unclear about how it labels people as being unsuitable. How would that work out?

Hal Rollason: There is no workforce problem with optometry, which is attracting a good number of entrants to all the universities that provide the course. Optometry Scotland has felt for some time that students and pre-registration trainees should be covered for their own and patients' protection as much as anything else, so we have no issue with that. We are pretty well regulated. Optometric advisers—who do regulatory work on the submissions that we make for payment—work locally for health boards and NHS National Services Scotland, which used to be called the Common Services Agency. Workforce and regulation are not problems.

Angela Timoney: I will speak on behalf of pharmacists. We do not have a problem with people being interested in becoming pharmacists or with recruiting to the profession, and the calibre of people that we want to recruit should want to be regulated and to practise to the highest possible standards. I have no concern about that, but the RPSGB has codes of ethics and practice, and I would be concerned about duplication. I would like it to be the case that what the RPSGB considers to be appropriate personal and professional conduct meets the standards that the NHS tribunal sets so that pharmacists do not have to go down parallel tracks and so that there is no dubiety between the two sets of standards. Therefore, we need to work together on developing the regulations to make them efficient.

Dr Love: Can I comment on doctors and training? There is an issue about the regulatory process in respect of weeding out unsuitable people before they do damage. There is also a debate about whether the GMC should extend its remit to undergraduates; however, clearly that is nothing to do with the bill. There is a workforce issue about increasing appraisal procedures, which involves a large number of doctors taking time away from patient contact and carrying out appraisals on another large number of doctors who also have to take time out from patient contact. Appraisals are worthwhile exercises, but there is a service delivery problem that has not been played into the workforce calculations—certainly not for GPs.

The Convener: There has been quite a lot of discussion about the existing regulatory bodies and the new system. I wonder whether Dr Wilson or Mr Davidson can tell us what are the links between the new system and the regulatory bodies.

Dr Wilson: It is an opportune time to consider the matter. All the national regulatory bodies have been reviewing their own procedures and how they operate—not just because of Shipman, but because of a series of other factors. We want to ensure that the system is fair to patients and to practitioners, so the proposals that have come from all the professional bodies for harmonising procedures and making them complementary to one another are important. We will want to pursue those proposals, following the passing of the bill.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): We have concentrated on discipline and referral not being specific, and we have heard it conceded that referral will be more specific when the time comes. What concerns me is the alternative that has been proposed. On the use of the power to refer someone to the NHS tribunal, the SPGC‘s written submission states:

> “SPGC suggests that only those carrying a six-month prison sentence i.e. those offences of a serious nature should be reported.”

Does that mean that it is okay for a drunk driver, someone who beats his wife or someone who abuses a child to be a family health service practitioner? What does that mean? Would that power be triggered only by a six-month jail sentence?

Angela Timoney: Those comments were made by the Scottish Pharmaceutical General Council, which is a separate body from the Royal Pharmaceutical Society of Great Britain.

Mr McNeil: Oh. I am sorry. It was not you.

Angela Timoney: As a regulatory body, we may take a different view from that.

Mr McNeil: Nobody supports that view.

The Convener: Ms Timoney is saying that the regulatory body takes a different view.

Mr McNeil: It is here, in the evidence that is in front of us.

The Convener: I appreciate that. Unfortunately, we do not have somebody from that organisation present.

Mr McNeil: What a pity.

The Convener: Perhaps that is something that we could explore in writing. Do members have any more questions for the witnesses, or do the witnesses feel that anything has been missed out?

Margo Biggs: This is possibly not totally relevant to today’s meeting. In general discussion, possibly because of the last week’s media coverage, particularly the campaign in *The Herald*, the regulation of NHS 24 sprang to mind. I wonder how it feeds into the system whereby people are acting in some ways independently. I do not know whether that is relevant.

The Convener: It is quite a good question.

Dr Wilson: NHS 24 is not covered by the provisions that we are talking about. I am unable to comment further on the issues surrounding NHS 24; all I can say is that the provisions we are talking about refer to those who are on the list to provide medical, dental, pharmaceutical and optical services.

Margo Biggs: I realise that. However, the thought processes that were engendered by discussion made me wonder about the vulnerability of patients in relation to some of the concerns that have been raised over NHS 24. Perhaps that could be considered in another forum.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): That is a legitimate question and I am glad that it has been raised. NHS 24 does provide a medical service in the form of advice, which may be wrong or damaging, so perhaps it should be included. Would the Scottish Executive consider bringing it in at a future stage?

The Convener: Why was it not considered appropriate to bring NHS 24 into the ambit of the bill?

Dr Wilson: If we may, we shall take that question away and write to the committee about it.

The Convener: That was a nice late lob from Forth Valley local health council, but that is the beauty of sessions such as this.

Alex Matthewson: As a matter of interest, I have been in the dental profession for 40-odd years, and I can remember only two tribunals during that time. Could the Executive give us an estimate for how often a tribunal would sit? Two in 40 years does not seem to be an awful lot from a dental point of view. Does it happen more often with the other professions?

John Davidson: Until 1996, there was a long period without any tribunal cases and then there was a case concerning a dentist. I think that the last case before then was in 1984. Since 1996, we have had about one case each year. Recently, we have had two cases running at the same time, so there is an indication that the workload has increased.

Alex Matthewson: Is that to do with dentistry or with other areas of medicine?

John Davidson: It is spread across the professions.

Mr McNeil: We need to understand what is going through the system and how that case load compares with official complaints to give us some balance in understanding which complaints arrive at a tribunal and which are settled through the process.

The Convener: Perhaps we could get some information from the Executive about tribunal history, so that we know what that position is. We shall also endeavour to get information about the complaints.

Alex Matthewson: It seems that complaints progress far down the line before tribunals kick in. I just wanted to know what the importance of the tribunal was, because many matters are sorted out before a complaint reaches that stage, although perhaps not to the satisfaction of patient representatives. It would be good to find out.

Hal Rollason: I have some paper copies of our submission if you would like me to leave them for members.

The Convener: That would be helpful. Thank you.

Mrs Milne: As the question has been asked about how many tribunal cases take place, I just wondered how many cases, by comparison, had been dealt with by the professional disciplinary bodies in the same 20-year span.

The Convener: No doubt the clerk can contact the appropriate regulatory bodies and get some background information on that.

14:58

Meeting suspended.

15:01

On resuming—

The Convener: Part 5 of the bill deals with infection with hepatitis C as a result of NHS treatment. In taking evidence this afternoon, our focus is on the bill, which proposes a legal basis for the existing system of ex gratia payments. The committee will hold a further separate evidence session to examine the case for a public inquiry; that session, of course, will involve representatives of the Scottish haemophilia forum and the Minister for Health and Community Care. I remind witnesses and members not to stray into that area today, because we are dealing specifically with what is in the bill.

I welcome Philip Dolan, chairman, and Dave Bissett, vice-chairman, of the Scottish haemophilia forum and Frank Maguire, who is the legal adviser to the forum. I invite Philip Dolan to make a brief introductory statement, which I ask him to confine to five minutes.

Philip Dolan (Scottish Haemophilia Forum): Thank you for the opportunity to speak to the committee. This is the first forum at which we have been able to discuss our concerns about the Skipton Fund. The committee has received our submission, which I do not intend to go over, other than to highlight a few points. We have concerns about the Skipton Fund.

Frank Maguire will speak on the legal aspects of our concerns about the bill, of which you have given us a copy. He is much better equipped to deal with the legal aspects than we are.

It seems that the minister will have the opportunity to lodge amendments. Perhaps I am misreading the information that I have—no doubt you will put me right about that. We have always expressed our concern that the Skipton Fund seems to discriminate against the dependants of the people who died prior to 29 August 2003. We think that that is unfair and we do not know why the decision on it was reached. I am the only person here who attended all three of the meetings about Skipton that were held in London and there are no minutes of the meetings. We are concerned about how a record is held of how Skipton has come to decisions.

We have concerns about the fact that the appeals panel will lack any involvement from haematologists, who are the people who have been most involved with all those who have developed hepatitis C as a result of receiving blood products or blood transfusions. That is a concern, especially given the fact that the Skipton

Fund deals only with those who acquired hepatitis C through NHS blood products or transfusions.

That is all that I will say at this stage, but I am happy to answer questions. Mr Maguire will be able to deal with the legal aspects.

The Convener: I do not want extensive or lengthy opening statements. If Mr Maguire can restrict his statement to no more than a minute or two, we can bring out the other issues in questioning.

Frank Maguire (Scottish Haemophilia Forum): As a general point, let me state that we welcome section 24 of the bill, which will give Scottish ministers the scope and power to provide for a scheme that is more amenable to people in Scotland. I have a lot of experience of how the Skipton Fund has operated for people in Scotland since it started in July last year. First, the scheme is based very much on written applications. Many people, including many of my clients, find the forms intimidating and difficult to complete, which is a big disincentive. However, I think that section 24 will give Scottish ministers the scope to provide for claims to be presented orally. It should also mean that the scheme can have a presence in Scotland so that people can have a face-to-face discussion if they want to inquire what they should do with their form and what information they need to provide on it, or if they do not understand the scheme's requirements. At the moment, the fact that the Skipton Fund is based in London makes things extremely difficult.

Secondly, no appeals procedure has yet been put in place for the scheme. Applications have been refused, but there is no mechanism whereby my clients and others can appeal those decisions. Another problem with the appeals system concerns the question whether lawyers and others will need to travel to London to make their case or whether the appeals panel will sit in Scotland. Either way, there is a difficulty. Obviously, it would be difficult and impractical—and, indeed, costly—for many of my clients to travel down to London for an appeal, but requiring all those lawyers to come up here will also have a cost implication. However, there is something to be said for having an appeals procedure in Scotland. Section 24 will give Scottish ministers scope to do that.

As well as those general points about section 24, I hope to be able to highlight, in response to questioning, some specific points about the terms in the bill, some of which are contradictory, inconsistent and inaccurate. I will go through those issues as and when we are asked questions.

Janis Hughes (Glasgow Rutherglen) (Lab): The appeals panel is dealt with in some detail in the Scottish haemophilia forum's submission, which highlights a concern about the absence of a requirement for a haematologist on the appeals panel. I think that the stipulation is that the panel must have a GP and a hepatologist. Given the issue with blood transfusions, I can understand why people might see a need for a haematologist to play an important role on the appeals panel, but could not a GP play that role, given that GPs look after patients throughout their illness?

Philip Dolan: Very few GPs have had direct involvement with hepatitis C. Some GPs will have been involved, but that is not true of the majority. For most people with haemophilia, their first application form to the Skipton Fund will have been filled in by the United Kingdom Haemophilia Centre Directors Organisation. Often, a haematologist will have been involved in that process, because virtually everyone who has developed hepatitis C got it through a blood transfusion. Therefore, the process generally involves some contact with a haematologist.

There is a question over whether a GP could deal with stage 2 applications to the Skipton Fund, because even haematologists find it difficult to work out the equation that determines whether someone reaches that stage. Therefore, there is a role for haematologists. One GP to whom I spoke recently was completely at a loss when they were asked by a patient to fill out the form.

The United Kingdom Haemophilia Centre Directors Organisation says that it has been involved in little or no discussion during the process even though it is the main organisation and most people who have developed hepatitis C are people with haemophilia. We have no idea why a GP was put on the appeals panel; I have also raised questions about how the other members of the board are recruited.

Dave Bissett (Scottish Haemophilia Forum): As haemophiliacs, we do not have a lot of contact with our GPs. We go straight to a centre for treatment. When I go to see my GP about anything we usually have a discussion about how things are, but GPs are not really up to speed on what is going on.

Shona Robison: The first of my two questions is on the point that is made in your evidence, and the evidence from the Royal College of Nursing, that the committee should examine section 24(1)(c) of the bill, which refers to those who

"did not die before 29th August 2003."

You suggest that that cut-off date disadvantages families and partners, who have no access to compensatory payments from any fund or legal process. Will you confirm that the Scottish haemophilia forum is calling for that provision to be amended or deleted from the bill to avoid the arbitrary cut-off date for those relatives who will miss out because the person who died of hepatitis C happened to die before 29 August 2003?

Has the Scottish haemophilia forum done any work on the number of families who are concerned about or caught up by that arbitrary date and who have therefore missed out on payments? Have any costings been done on what it would cost to include those people? That is my first question.

The Convener: We will deal with that question first.

Philip Dolan: We do not know the figures because of the need for confidentiality and so on, but hepatitis C has been an issue since the birth of the Scottish Parliament in 1999. Why choose 2003 and not 1999? Why discriminate, given that there are only a limited number of cases? It is complete discrimination against us.

Perhaps I am just a maverick, but I have not registered with the Skipton Fund. I hope that a public inquiry will address the issues at a later date. If I walked out of the Parliament today and got knocked down, my dependants would get nothing because I am not registered with the Skipton Fund. The fact that one has to be registered is another example of discrimination.

Initially the forum was concerned only with haemophilia, but in the course of our work we have taken on board other people who contracted hepatitis C through blood transfusions, who do not have an umbrella organisation to represent them. Frank Maguire has had more dealings with that group.

Frank Maguire: I will give an example. I have two death certificates here. On the first, the cause of death is hepatic failure and septic shock and the date of death is 7 May 2003. On the other, the cause of death is hepatitis C-related liver disease and the date of death is 4 September 2003. I see no difference between those cases. The date of death is pure chance and nobody has any control over it, but in one case the payment was made and in the other it was not. That puts the matter in stark contrast.

I have handled nine fatal cases; four of the people in those cases died in the period before 29 August 2003. It is quite hard for some of my clients to accept that they have gone through all the suffering because they were infected by the hepatitis C virus through a blood product or a blood transfusion and that because Parliament has only just got round to dealing with the issue, they are disadvantaged even though their pain and suffering are exactly the same as someone else's. That is the injustice. If we are dealing with numbers, and I have nine fatal cases out of 130 cases, and four of those people died before the date, we are not talking about an awful lot of money.

15:15

Shona Robison: The evidence from the Skipton Fund says:

> "Activity in Skipton is now running at a low rate."

Mr Maguire said in his opening remarks that there was a disincentive because the scheme was based on written applications and the form was long. Do you think that the low rate of activity—I assume that that means a low rate of applications—relates directly to the amount of paperwork that a person has to fill out? Are your clients telling you that the process is preventing them from applying? Is the situation as stark as that?

Frank Maguire: I cannot deal with statistics, but I can tell you my experience. My impression is that although a lawyer is helping people, they are still having difficulty with the process. We are helping them with that. A vast number of people out there do not have a lawyer. The Skipton Fund does not like lawyers; it will not correspond with me. It will write to my client and my client has to come to me. I do not understand the reason for that, but that is what the Skipton Fund does. That is a disincentive, even for my clients who are using a lawyer. There is almost a disincentive to use a lawyer, because the Skipton Fund will not correspond with me.

There are several people out there who are struggling and trying as hard as they can to deal with the form. Not only do they have to fill in the form, they have to go and see someone and ask them to do something with the form. A lot of activity is required of the client.

There is a lack of information on the Skipton Fund. Where do people find out about it? How do they know what to do with the long form that they have to fill in? People sometimes find that their GP or medical adviser does not know about the fund either. I have a case in which it has taken from August last year until now to get the form filled in because the GP did not understand it and the consultant refused to deal with it because he was not getting paid; the form then went backwards and forwards to the Skipton Fund. We went to the fund and said that the consultant would not sign the form because he was not getting paid, and the fund said, "That's not our problem. You will have to pay for it." The client had no money to pay for it, so I wrote to the minister and he got involved. There are many bureaucratic systems in place that are potential disincentives.

Philip Dolan: This point might come up later, but I will mention it just now. Paragraph 3 of the Skipton Fund's submission is very misleading. First reading of that paragraph might give the impression that, of the four directors who were appointed to Skipton, two were from the

Department of Health and two were the result of nominations from the Haemophilia Society. I have received an e-mail from the chief executive of the Haemophilia Society who assures members that the UK society was never asked to nominate persons to be appointed as directors.

We have grave reservations about the closeness of the Skipton Fund, the Macfarlane Trust and the Department of Health. The chairman of the Skipton Fund, Peter Stevens, is one of the nominees of the Haemophilia Society to the Macfarlane Trust, but we certainly did not nominate him or any other person to the Skipton Fund. That raises questions about relationships. Mr Steven's term of office as a representative of the Haemophilia Society on Skipton finishes in July this year. A lot of things are going on. I want to be clear on the point that we were neither asked nor invited to make nominations to Skipton.

Dr Turner: I have two questions on the matter of filling in the form: one is on the form itself and the other is on the private nature of the company. I know of at least one person who is having great difficulty with filling in the form. How many consultant haematologists have said that they did not have time to fill in the forms? I understand that, in this case, they pleaded that the problem was one of workforce issues.

We heard earlier about someone who filled in the form as a private service and, because he was paid £200 to do it, the form was filled in a little bit more quickly. Consultants in the NHS do not seem to have the time to do that. From what you said, it seems that the length and complexity of the forms mean that it is not appropriate for GPs to complete them.

Frank Maguire: The consultants have to set aside time to fill in the forms. First, they have to see the person who has brought in the form to have it completed. They then have to set aside time to get out and look at the patient's notes, some of which are quite large. The consultant might then have to go back and talk to the person about their case. Consultants have to go through that procedure before they get down to filling in the form. If they are diligent, they want to get it right; they know how important that is to the patient. All of that has to be fitted into the work of a busy practice.

No one is saying to the consultant, "We will set aside time for you", or "We will pay for you to do this." Some consultants find the lack of payment quite galling. They are doing the work of filling in the forms, yet who gains a saving as a result? It is probably the private company. Skipton wants to keep down costs by making the process simple and by putting the burden of completing the report on to the consultant, who has to do it gratis. That saves the private company money and, in turn, makes it more profitable. That is the dynamic of what is going on.

I agree that the form is difficult to complete. There is also an issue for consultants in terms of the time that they have to take to complete the forms and the fact that they have to make themselves available to do so. I emphasise again the fact that medical records are very large.

Philip Dolan: The haemophilia directors have been fairly helpful in relation to helping people to fill in the forms at stage 1. That said, it depends on the part of Scotland in which people reside. Some directors are pedantic about how they fill in the forms. We know of cases, certainly in this part of the world, in which people's forms went backwards and forwards between the consultant and Skipton and, at the end of it, people got no money. However, because the haemophilia director in another part of Scotland knows the patients, they can say that someone needs a payment and the payment is made.

Greater complications are involved in stage 2 payment applications. As I said earlier, I know from conversations that I have had with the haemophilia directors in Scotland that some of them have a great deal of difficulty in completing the second part of the application process, partly as a result of their trying to get meetings with hepatologists. I know of one case in which both the professionals work in the same hospital and yet an e-mail that was sent in November says that one can meet the other to discuss the filling in of the forms in February. I am talking about people who walk by each other in the link corridor of the hospital in question.

Dr Turner: I am concerned about the fact that a private company should have been formed in order to distribute the fund. I think that it was the Scottish haemophilia forum that went into detail about the private nature of the company. I do not understand why that had to happen. My understanding is that, under the Freedom of Information (Scotland) Act 2002, it is very difficult for a private company to give out information.

The Convener: Perhaps Mr Maguire can respond in respect of the difficulties that arise simply because Skipton Fund Ltd is a private company.

Frank Maguire: Questions arise because of the fact that it is a private company. What is in it for the private company? We do not know how much the directors are paid, how profit oriented they are or what their profit motive is, and whether they are being efficient because the company provides a public service or because they want to save money.

If I were to be cynical, I would say that—given the requirement for written applications, the practice of batting everything back to the patient, the avoidance of lawyers and the avoidance of other costs—Skipton is keeping the costs down so that its profit is higher. If the company gets involved in such things, its expenditure goes up, so its profit is obviously less. Whether I can get into that, or whether the company can reveal that, is a different matter altogether. The company keeps talking about judicial review, but such a review is normally conducted on an administrative body such as a local authority or a public body. There is a question mark over whether I could judicially review the actions of a private company, if only the private company and not the minister were involved. There is an obstacle involved when the Skipton Fund talks about judicial review.

Dr Turner: That is what I thought.

The Convener: Witnesses from the Skipton Fund are coming later this afternoon. We hope that they will be here by 4.15, although there have been difficulties with their flight. I understand that they have now arrived, so we will be able to put some of those questions directly to the Skipton Fund representatives.

Mr McNeil: I am shocked to hear that consultants are being obstructive and that they are not being helpful. We know that, in other areas, consultants are an essential part of the network to get people who are suffering from certain conditions through the system and referred to self-help groups. I am really shocked and disappointed that that delay has arisen. I do not know whether the committee can do something about that with the minister to clear away some of those problems. It may be useful for us to get some more information about the form. How long does it take for the consultant and the person together to fill out the relevant part of the form?

Dave Bissett: Often they do not have to be together. The consultant has the information.

When I filled out the stage 1 application form, there was one page that the applicant had to fill in and the consultant filled in the rest. For the record, I would like to say that we have had no problems at Ninewells hospital in Dundee. The consultants there have been first class at getting the forms filled in.

Mr McNeil: Can you be more specific about where the problems lie? Which health boards are affected?

Dave Bissett: I believe that there is a problem in Edinburgh.

Mr McNeil: Where else?

Frank Maguire: There is a case in Glasgow.

Mr McNeil: There is one case in Glasgow. How many are there in Edinburgh?

Dave Bissett: I do not have a figure, but I know that there is a problem.

Mr McNeil: It would be useful if we could get some of those figures.

The Convener: Could you do some digging around and get some further information to the committee on that aspect of the issue?

Philip Dolan: Yes. There have certainly been individuals in Edinburgh who have had difficulty with the forms being batted backwards and forwards. We know that, in some instances, consultants took one and a half minutes to complete the stage 1 application form. In other cases, the process has taken months, because the consultants have wanted to go into greater detail. I can talk about individuals but, as you will appreciate, most people who have been involved have wanted to keep away because of the stigma that is attached to their condition.

The Convener: I appreciate that there is a difficulty, but it helps the committee if we can get as much information as possible about what is happening.

I would say the same to Mr Maguire. If you know of specific areas of Scotland or situations in which that specific problem has arisen, could you ferry that information to us? It would be gratefully received.

Frank Maguire: To be clear, I raised the matter with the minister and he took action on a specific case. However, it is a bit silly to have to go to the minister to get a form filled in.

Mr McNeil: The situation that you have described is shocking and not acceptable. We want to have an understanding of the extent of that situation so that we can put it right. Thankfully, we do not need to write to Dundee, because the consultants there may represent best practice, but we need to identify why that is not happening in other areas.

I presume that you have a copy of the submission from the Skipton Fund. Your own submission has been helpful to us in considering the evidence. You say that the two representatives from the Haemophilia Society who are directors were not nominated by the Haemophilia Society to the Skipton Fund. Do you have good links with them? Have they been able to raise and address some of the issues? Or is it the case that they have been of no effect and that you have had no contact with them?

Philip Dolan: I am a trustee of the Haemophilia Society and the matter has been discussed with the trustees.

The concerns about the appointment of the directors, which was done without consultation, have been discussed with the trustees of the Haemophilia Society. For the benefit of the representatives of the Skipton Fund, who have probably now arrived, I repeat what I said earlier: we have an e-mail from the chief executive of the Haemophilia Society—I will make the e-mail available—in which he confirms that the society was not consulted and did not make any appointment. We believe that the Haemophilia Society is having on-going conversation on the issue, but, unfortunately, the chief executive of the society could not be with us today to answer questions. We do not know why the Skipton Fund was set up—whether it was for reasons of speed or for some other reason—but we should have been consulted and had a say.

Mr McNeil: Is there any reason why you would not have nominated the two people concerned? Do you have objections to them? Do they have any association with the Haemophilia Society?

15:30

Philip Dolan: The Haemophilia Society nominated both of them for the Macfarlane Trust, on which people serve for a period of time. However, the Haemophilia Society might not wish to reappoint those people to the Macfarlane Trust in the future and may have preferred to appoint other persons to the Skipton Fund. The chief executive and chairman of the Macfarlane Trust were initially appointed to set up the Skipton Fund. The chairman of the Macfarlane Trust, who is with us today, is also the chairman of the Skipton Fund. Given the procedures in Scotland to ensure that everything is visible and up front, that relationship is rather close.

Mr McNeil: Given that we will question representatives of the Skipton Fund later on, and that you may not do so at this stage, do any other points jump out of the Skipton Fund submission, including the figures that have been provided, with which you disagree or to which you object?

Frank Maguire: My problem with the Skipton Fund is how it conducts itself. We have discussed the difficulty with forms and how the burden is put on to the patient. It would be of great assistance if the Scottish Legal Aid Board changed its policy of refusing automatically applications from people who want advice regarding the Skipton Fund.

The Convener: Does that happen even at the level of advice and assistance?

Frank Maguire: A person would get something—the initial £80-worth or whatever—but if more work needs to be done, the Scottish Legal Aid Board just says that the Skipton Fund deals with the matter and that is the end of the story. There is a constant struggle with the Scottish Legal Aid Board to get it to authorise increased expenditure to cover more work on accessing medical records and assisting clients. That goes right through the system.

Philip Dolan: To answer Mr McNeil, the concern is why we need the Skipton Fund. Why could the function not have been carried out at arm’s length from, or within, the Department for Work and Pensions? Only a limited time is available. Once all the applicants for the first and second phases have been dealt with, there will be only a trickle of people applying, as their condition worsens from chronic hepatitis into cirrhosis and cancer. The Skipton Fund seems to be an organisation that deals with paper—sending out forms, receiving them, sending out money and coming to decisions based on criteria that are not known to me or other people.

In two years’ time, instead of having a large office in Westminster—the most expensive part of London—a confessional box in a church will be sufficient, because the body will need only a part-time worker. As Mr Maguire pointed out, we do not know how much of the money that the Skipton Fund was set up to pay to patients is being spent on administrative costs and rent. I do not know whether you are planning to consider the appeals system, which is one of our major concerns.

The Convener: You have made that point already. Mr Maguire mentioned specific issues that he wanted to raise. I invite him to take the opportunity to do so now.

Frank Maguire: With regard to compensation, we must consider what is best for people in Scotland. The system is not ideal, but we must be practical about it. It should be possible to access the system both in writing and face to face. There should be face-to-face access to advice. People should be able to go to an office in Scotland to ask someone questions, or another person should be able to do that for them. The face-to-face dimension is completely missing because the fund is based in England. It does not matter whether the system is run by the Skipton Fund or another body.

When people’s claims are rejected, they must be given clear reasons, with appropriate reference to the evidence, for why that has happened. We do not get reasons—we are just given a little one-liner that says “refused”. Why?

The Convener: That is similar to the way in which the Crown Office indicates that it is refusing to proceed.

Frank Maguire: Yes. I am concerned that, if we have an appeals procedure that is London focused, it will be based more on written communication and there will be an attempt to avoid oral representation. Oral representation is essential in any appeals procedure. A face-to-face question and answer session reveals much more than is contained in written documents and allows people to get right to the nub of the problem, without being misdirected in various ways. With face-to-face meetings, people understand why their important application has been turned down.

The system that we seek would ensure accessibility to both advice and decisions. Reasons for decisions and access to information would be provided. It would be helpful if that information were held here. There would also be an appeals procedure that was Scotland focused and accessible in Scotland. If the Skipton Fund can provide what we are seeking, that is fine. If it cannot, we must have our own system. If the number of applicants is declining, as has been indicated, such a system would not be very expensive. However, the benefits to people in Scotland would be great.

Dave Bissett: The Skipton Fund submission refers to payments of £20,000 and a further £25,000. No one has ever told us how those figures were calculated. Where did they come from? What do they mean? The Skipton Fund's advisers came up with an equation, based on liver tests, to work out whether someone should receive a second-phase payment. Any liver specialist will tell you that those tests do not necessarily mean that someone does not have cirrhosis or cancer—they are only a guide. Even if a good part of the liver is taken in a biopsy, it cannot provide 100 per cent certainty.

I qualify for the first section of payments, but not for the second. Although some of my readings are high, they do not fit into that category. I have probably had hep C for about 30 years. From the symptoms that I experience, I know that I have some sort of liver damage, but the tests do not show it. The equation that has been developed does not mean much to me. Over the years, even before hep C came into being, we were told that the tests were guides and that there were no guarantees. The fund intended to come up with a non-invasive test, but it was not able to do so. However, if it worked out an equation to determine who should get the second payment, could it not have worked out an equation to calculate what people were losing through ill health and stress?

I have a brother who is seriously ill and cannot work. He had his own business and is probably losing about £50,000 a year in earnings. He qualifies for the second payment, so he gets £45,000. The chap who runs the Skipton Fund probably gets more in his salary than my brother gets in compensation. Where do the figures come from? Did someone just decide that the figures sounded good and that by giving people £20,000 they could get rid of them? That is not satisfactory.

The Convener: We have a few minutes left in this session. I do not want to move off this topic if people want to raise issues. I remind witnesses that we have the written submissions, so it is not necessary to repeat everything that is in them. Committee members have no more questions. Do you have any final comments on the bill?

Frank Maguire: I wish to address an important point on section 24, concerning eligibility. Section 24(2)(b) states that a person will not qualify if their sole or main residence was not Scotland when they applied for a payment or if, in the case of someone who died, their sole or main residence was not Scotland when they died. I cannot see the logic of that. The issue should be that the conduct complained of happened in Scotland. No matter where you live after that, you should be paid if the NHS in Scotland infected you with hepatitis C.

Let us consider the practicalities if we keep that provision. I have cases the length and breadth of Scotland. Take the example of a baby in Shetland who was infected with hepatitis C virus. If as a teenager that person goes to England to get a job, their sole or main residence will be in England. In that instance, they will be disqualified. Why should that be? At the other end of the age spectrum, an elderly person might go to live with or near their children in England, France or elsewhere. By that fact, they will be disqualified. It is illogical that when making an application a person's sole or main residence must be in Scotland. That has no connection to what we are talking about. All that they should be required to prove is that, wherever they live, they were given a product or transfusion in Scotland and that it was administered by the NHS. Section 24(2)(b) should be removed from the bill.

In addition, there is a contradiction between what the Skipton Fund says and what section 24 says about people who receive money by way of another scheme or litigation—cases are proceeding on negligence grounds. Guidance from the Skipton Fund asks:

> "Will any payments I have received from other schemes, or as a result of litigation, be deducted from the payments made to me by the Skipton Fund?"

to which the answer is, "No." However, section 24(3)(b) states that a scheme may

> "provide that the making of a claim, or the receipt of a payment, under the scheme is not to prejudice the right of any person to institute or carry on proceedings … (but may also provide for the taking account of payments under the scheme in such proceedings)".

That seems to say something different from the Skipton Fund. Perhaps section 24(3)(b) should be examined closely and amended.

Why was the cut-off date of 1 September 1991 picked? I cannot explain that. If it was chosen because it is believed that no infected blood was in the system, I would like to see the evidence. We have never had an inquiry—we will not talk about that today—but because the issue has never been fully explored, how can we be satisfied that 1 September 1991 is the correct date? Where is the incontrovertible evidence? I have indications from clients that they were infected after that date. In any event, why not leave the question of whether you received hepatitis C from infected blood as the matter of proof? Whether you were infected in December 1991 or in 1993, you would still have to prove it. Leave it open and do not prejudge the issue.

I can submit those points in written form.

The Convener: You do not need to now, because you have put them on the record, unless you want to follow up with more detail. We have two minutes left. Do committee members want to ask questions on the last points that were raised?

Shona Robison: That is important evidence. I was aware of the issue around the date of 29 August 2003, but the important points that you make require further explanation, which I hope we will receive.

Helen Eadie (Dunfermline East) (Lab): Is the £15 million that the Executive has set aside adequate?

Frank Maguire: That is very hard to forecast. There are people in the system who do not know that they have hepatitis C. That is another problem, and it is why there is a problem with application. People cannot make an application if they do not know that they have the condition, but they still get disqualified for not making one. Those people in the system who do not know that they have hepatitis C are being discovered as and when they return for treatment, or if they die. The number of people concerned is unknown. We also do not know how many people will die of hepatitis C. Judging from the cases that I have dealt with, deaths have occurred in 2003 and 2004, and there will be some in 2005 and into the future, no doubt. That is difficult to assess.

£15 million may be set aside, but I hope that the Scottish ministers will recognise that there would need to be more if that fund were exhausted. I would not like ministers to keep within that £15 million by trying to keep expenditure down and doing various sorts of cost-cutting exercises. That would only go against the people who are trying to make a claim.

15:45

The Convener: I will allow Mr Dolan to come in very briefly, as we need to move on.

Philip Dolan: Dave Bissett raised the question of the £20,000 payments. The Scottish Parliament set up an expert group under Lord Ross, which recommended a minimum sum of £50,000. We do not understand why that has not been implemented. Perhaps the committee is in a position to review that during its consideration of the bill. The concerns that we have expressed about the appeals system are important, and I know that you will be taking those concerns and our submission into account.

The Convener: I thank the three witnesses for coming along. Witnesses from the Skipton Fund will give evidence later. We now have to move into private session, as previously agreed. We have had to rejig our agenda because of late planes and so on. I will first suspend the meeting for a couple of minutes to allow the room to be cleared.

15:46

Meeting suspended until 15:49 and continued in private thereafter.

16:27

Meeting continued in public.

The Convener: I reconvene the meeting in public and welcome Peter Stevens, the chairman of the Skipton Fund, and Keith Foster, scheme administrator of the Skipton Fund. We have heard evidence from representatives of the Scottish haemophilia forum. Mr Foster did not hear all of that evidence, but he heard a significant portion of it. I suspect that committee members will have questions arising out of that evidence. I ask one or other of the witnesses to make a brief statement about the Skipton Fund in connection with the legislative proposals that we are considering.

Peter Stevens (Skipton Fund Ltd): I apologise for delaying your proceedings, convener. The matter was out of my control.

The Convener: We understand.

Peter Stevens: The Skipton Fund began operations on 5 July last year, having been set up earlier in the year following discussions that have been going on since the announcement of the hepatitis C ex gratia payment scheme at the end of August 2003. Everything that has been done in setting up the scheme and in staffing it has been done in the interests of getting the payments made as quickly and efficiently as possible.

There are four directors of the fund who were all trustees of the Macfarlane Trust, which was invited by the Department of Health, on behalf of the health departments in the four Administrations, to put its resources, expertise and experience at the disposal of the departments to run the scheme. The directors have a job to do in signing off payments and I believe that we have already made well in excess of 80 per cent of the payments that the scheme will ever be required to make. That is all I wish to say at the moment.

16:30

The Convener: I thank you for being commendably brief.

Does Mr Foster want to add anything, or shall we go straight to questions?

Keith Foster (Skipton Fund Ltd): It is probably best to go straight to questions, but I will first explain my role. I came in as administrator at the start of the scheme, so questions on procedures are probably best directed to me, whereas questions on policy can be directed to Peter Stevens.

Shona Robison: My first questions relate to the status of the Skipton Fund. Will you confirm whether it is a private company? Concerns were raised earlier—you might have heard them—about whether, as a private company, you make a profit through the operation of the fund. Will you clarify that and whether the directors are paid or unpaid? Further to that, I ask you to tell me the breakdown of finances for the Skipton Fund—for example, administrative costs, office costs, the payments and the costs of appeal. I do not necessarily expect you to be able to answer that today, but you might be able to provide the information in writing, as it would be useful to have a breakdown of the fund's finances for those elements.

Secondly, I have questions about your written evidence. You say:

> "Activity in Skipton is now running at a low rate."

We heard earlier that there are concerns about the length and complexity of the fund's application forms, which might put potential applicants off applying in the first place and might be one of the reasons for that low rate of activity. What is your view on that? Has that concern been raised with you?

Mr Stevens, you just said that 80 per cent of the payments that the scheme will be required to make have been made. Do you mean by that that you think that 80 per cent of the payments that you will ever make have been made or are you referring to 80 per cent of the payments that have been applied for to date? Will you clarify that point?

The Convener: The witnesses can decide between themselves who should answer which questions.

Peter Stevens: The Skipton Fund is a company limited by guarantee. It is our intention to minimise the profits and to make them as close to zero as possible so that we do not have to concern ourselves with profit distribution or tax. If there is a profit, it will be carried forward from one year to the next to pay for the following year's expenses and, in the long run, I anticipate that the company will be totally non-profit making.

At the moment, there is a slight uncertainty in everything to do with operating costs, because some VAT might be involved in services that the Macfarlane Trust supplies to the Skipton Fund, but HM Customs and Excise is taking a considerable amount of time to analyse the nature of the two operations and whether VAT payments will be required.

The directors give their services for free; there are no directors' fees. We have considered that directors might deserve a fee for the amount of time that they spend not performing directors' functions but coming into the office to process and sign off application forms, but no one has booked one yet.

Shona Robison asked me to amplify my statement that we have made more than 80 per cent of the payments that we will ever make—I emphasise "ever". Roughly 4,400 application forms have been sent out to people who have completed their registration. We are registering people at a rate of about seven a week—one a day—so it will be a long time before the initial estimates of between 6,000 and 8,000 applications are received. Indeed, I do not think that those figures will ever be reached.

When people register, they have no idea whether the application form will be complex. The registration form is very simple and the application form is even simpler for applicants. The bulk of the application form must be filled in by the claimant's clinician, because it is concerned with medical evidence; there is no other complexity in the form. The application process is simple and the form was designed so that it would not put anyone off applying.

That is all the information that I can give in answering the member's questions. Mr Foster will add something.

Keith Foster: I will leave a couple of spare forms with the clerk so that members can see them. The witnesses from the Scottish haemophilia forum made the point that the forms are complex and Shona Robison asked about that. However, the forms are not complicated for claimants, who need only fill in their name, address and national insurance number, sign the form and send it to us in a pre-paid envelope. All the work that needs to be done is then undertaken by the claimant's clinician.

The witnesses also expressed concern that there were difficulties in getting the forms completed. However, such cases tend to be isolated. I administer the scheme for the whole of the UK, so I can say clearly that the number of problems is small in relation to the number of claims that are being processed. Although such cases obviously present a big problem for individual claimants, the problem is not regarded as large globally. The chief medical officer has written to all consultants in a bulletin, to advise them of the existence of the Skipton Fund and to ask them to consider forms in that light.

Members might have encountered constituents who are having difficulties because GPs are being asked to fill in forms. We suggest that a consultant fill in the form whenever that is practical, but that does not always happen. Because of GPs' terms and conditions and their contracts with health authorities, fees might be charged. Also, GPs are not necessarily au fait with the details of the disease.

Shona Robison: Are you saying that you do not expect the £15 million that the Scottish Executive set aside to be claimed? You seem to be indicating that fewer applications than you expected have been made to date. How much of the £15 million has been claimed so far? What figure is represented by the 80 per cent of payments that you say that you have made?

Peter Stevens: Currently, Scottish stage 1 and 2 payments total roughly £8 million. If we were going to reach the figure of £15 million, which would be consistent with the entire scheme having around 8,000 applications, I would have expected that by now we would have heard from more than 6,000 people. However, we have heard from 4,500 people. I do not see where the other 3,500 applicants are. The scheme has been running for several months and has received quite a lot of publicity through the chief medical officer's circulars. We receive requests for new registrations at a rate of seven per week, as I said, and the figure has been falling gradually for about three or four months. I do not know where the other 3,500 applications would come from.

Shona Robison: Unless eligibility for payments is widened.

Kate Maclean (Dundee West) (Lab): I was not clear about Peter Stevens's response to Shona Robison's question about the fund's running costs. You said that the VAT issue is being sorted out, but notwithstanding that, what percentage of your budget goes on ex gratia payments and what percentage do you budget for running costs? You must have an idea of the approximate percentages. It would be interesting to know what they are, because there seems to be concern about the matter.

Peter Stevens: So far, we have paid out about £65 million in ex gratia payments. The fund's running costs to date are less than a quarter of 1 per cent of the total figure.

Helen Eadie: Convener, should I ask all my questions now?

The Convener: Yes.

Helen Eadie: Why was not the Haemophilia Society invited to nominate individuals to the Skipton Fund's board? Why was there no correspondence with lawyers? I am raising issues that Frank Maguire mentioned.

Peter Stevens: I am sorry, but I did not catch your second question.

Helen Eadie: Why did the Skipton Fund decline to enter into correspondence with lawyers such as Frank Maguire who took on cases?

Is the Skipton Fund regarded as a public body under freedom of information legislation? Would it respond to requests for information in the same way as a public body would do?

Finally, in answer to Shona Robison's questions you said that information had been provided to consultants in a bulletin. We all receive bulletins and newsletters and it is not possible to read everything. Would it be better to provide such guidance to doctors in a direct letter? I do not think that a bulletin is an appropriate form of communication.

Peter Stevens: As I said, the composition of the board was designed simply to get things started and to get the job done quickly. As directors, we regard our appointments as being interim, and at some stage I am sure that we will be asked to stand down and perhaps a more representative board will be set up. We have no problem with that. It might be worth pointing out that the principal function of directors is to approve the making of payments. There are four directors, three of whom are Macfarlane Trust trustees who are resident in London, so we can get to the office quickly without having to spend time and money before we can perform our function. In other words, the directorship is a working job rather than a question of status.

In general we have not replied to lawyers' letters because we passed them back to the officials in the health departments of the four Administrations, who asked that they, rather than the fund, should enter into correspondence on legal matters. I stress that we act only as agents; we are not an independent body that has discretion over matters.

I understand that we are subject to the freedom of information legislation and would have to respond appropriately to requests, although I am sure that we would take guidance from officials in doing so.

I take Helen Eadie's point about the communication of information. Again, information about the scheme and the Skipton Fund is in the hands of officials from the four Administrations, rather than in our hands. We do not have access to the process of sending circulars to doctors or consultants; that is a matter for the health departments of the four Administrations.

Mr McNeil: Is the 80 per cent achievement rate a UK figure? What is the figure in Scotland?

Keith Foster: That is an overall figure. I would have to calculate the Scottish figure. I will give some statistics that I prepared before I came here. Your paperwork talks about 581—

Mr McNeil: I have seen that somewhere.

Keith Foster: I am talking about the Smoking, Health and Social Care (Scotland) Bill and the related documentation, which says that Scotland has 581 hepatitis C sufferers. I do not know where you took that figure from, but at our last count, we had received 461 applications.

16:45

The Convener: That is not our figure; it is the Scottish Executive's. Any discrepancy is between the Executive and you.

Keith Foster: I was just making a comparison. The documentation talks about 580 people and 460 payments have been made.

Mr McNeil: There have been 460 claims.

Keith Foster: Yes. We have gone through those who knew about the scheme fairly quickly. The fund's concern, which Mr Stevens just touched on and Frank Maguire talked about, is about reaching people who were affected many years ago and do not necessarily know about the scheme, although it is hep C awareness year. The Skipton Fund has asked the Department of Health how it will promote the scheme to the wider public. We would like the devolved Assemblies to think about that, too.

It is vital not to miss people. The Haemophilia Society and the haemophilia world are close and have good contacts, but one of my big worries as an administrator is that people who were affected many years ago and are probably becoming elderly may not know about the scheme, so we need people to be advised of it by their GPs and others.

Mr McNeil: That information about the figures was useful. Will you provide us with figures for Scotland and the achievement rate here?

Keith Foster: Yes. That is no problem.

Mr McNeil: You said that the other figures were unrealistic, because you have received 460 claims. In your experience, are cases under-reported? What figures would you expect?

Keith Foster: As I said, we have processed claims from people who are aware of the scheme. We must try to quantify who else out there should benefit from the scheme. We are beginning to see many claimants who are different from those who claimed at the start. Many now are elderly and have heard of the scheme only through word of mouth. Their infection dates are much earlier than the peak times of the 1970s and 80s. That is why those people's claims are appearing more slowly.

Mr McNeil: Have you no feel for the additional number?

Keith Foster: Mr Stevens said that when the fund started, the top figure that was talked about was 8,000 for the UK. That is probably too high. If we can have not so much a relaunch but the right emphasis in the medical world, the global figure might reach about 6,000 to 6,500.

Mr McNeil: That leads me to another line of questioning that I might as well run with. Have you allocated some of your budget to targeting those people and raising awareness? How will you fund that process?

Keith Foster: Unfortunately, our hands are tied. We have no budget for marketing, if that is the right word. We must approach the Department of Health for what we need. We are involved in the hepatitis C awareness programme, which is widely available through the internet. Only a week or so ago, we talked to the department about raising our profile again in the press, so that people more widely are aware of what we are doing.

Mr McNeil: I have a question about clinicians and medical evidence that I was going to skip but will not. How long does an average Scottish claim take?

Keith Foster: The question, "How long is a piece of string?" comes to mind. The whole process can take seven to 14 days, or it can take many months if the clinician spins it out. With regard to what was said earlier, it is true that applications come back much more quickly from certain pockets. Much depends on an individual's viewpoint on filling in the forms. As was highlighted earlier, there have been cases in which the Parliament had to step in to say to consultants, "This is part of your doctor-patient relationship. The forms need to be completed."

Mr McNeil: The earlier evidence about certain areas can be substantiated. Can you provide us with some of your information?

Keith Foster: No, I would not wish to do that.

Mr McNeil: Why not?

Keith Foster: That would isolate people who do not need to be isolated, because the problem has been solved.

Mr McNeil: So there are no current problems. The issue has been resolved.

Keith Foster: As far as I am aware, we have no outstanding applications from Scotland that are causing us problems.

Peter Stevens: We use the same form for people with haemophilia and people without haemophilia. Consultants who have to complete the application form on behalf of somebody with haemophilia—who will be somebody about whom they are well informed; they will know him or her quite well—say that it takes two or three minutes. However, it will take some time to complete the form for somebody without haemophilia who is rarely seen, whose hepatitis C is not active and who was infected through some form of hospital process perhaps 30 years ago. The issue is not the form itself, but digging out the paperwork and finding the records that will demonstrate the source, date and route of infection. The form itself is simple.

Mr McNeil: But there is a problem with people in some areas not prioritising the completion of the form. Is the fee a problem? It was suggested that because consultants are not given an appropriate fee, or if there is a dispute, the form is at the bottom of their list. A clinician can obstruct the whole process, which can prevent people who need the money from quickly receiving payouts. Where are those people?

Keith Foster: We know of a few, but they are not all in Scotland. There have been some in Scotland—

Mr McNeil: But not now.

Keith Foster: Not that I am aware of. There have been problems, but as far as I am aware they have been resolved. I do not know whether you have information that I do not have.

Mr McNeil: We may be able to give it to you.

Keith Foster: We always have a number of forms that are out being filled in and of course I do not know where all those forms are, but our overall impression is that there is no huge problem. There have been isolated pockets, not only in Scotland, where consultants have said, “I’ve got too many to do,” which is a problem. There may be a problem with GPs completing forms if they are not happy to do so. That may be another area about which we are not entirely aware.

The Convener: You heard the end of Mr Maguire’s evidence. Can I confirm from what you are saying that the decision on the 1991 cut-off was not taken by you?

Keith Foster: Correct.

The Convener: Can I also confirm that the decision to confine a person’s right to make a claim to their residency in Scotland at the time of filling in the form was not taken by you?

Keith Foster: Correct.

The Convener: Mr Maguire also raised questions in respect of the appeal procedure. Was it set up by—

Keith Foster: The appeals process is still being set up by the Department of Health.

The Convener: Right. So it is outwith your bailiwick.

Keith Foster: We will administer it once it is in place.

The Convener: But you do not make decisions about it.

Keith Foster: No.

The Convener: I am trying to address the points that were raised. I am beginning to get a clear understanding of your role. Effectively, all policy decisions are made elsewhere. You simply administer them.

Keith Foster: We do what we are told.

Mike Rumbles: When do you envisage the appeals process being in operation?

Keith Foster: We would like it to be in operation as soon as possible but, unfortunately, we are in the hands of other people.

Mike Rumbles: Have you been given any indication?

Keith Foster: No.

Peter Stevens: I understand that there was a meeting yesterday between officials from the Scottish Executive Health Department and the Department of Health at which reference was made to the appeals process. I am told that the meeting was useful, but I have not yet received a report on it—I will get that tomorrow.

The Convener: Helen Eadie has a question. Is it one that these witnesses can answer?

Helen Eadie: My question is on a point that was raised by Frank Maguire. I do not know whether these witnesses can answer it. Can the Skipton Trust be judicially reviewed?

Peter Stevens: Presumably.

The Convener: But that has not happened.

Shona Robison: I have a point of information. In a letter to me dated 21 December, Andy Kerr, the Minister for Health and Community Care, stated that the employment of the appeals panel would be done through the public appointments process and would take a few months to complete. We may want to tie him down on that.

I have a more direct question on an issue that I pursued earlier, although I do not know whether the witnesses will be able to answer it. As a manager and an administrator of the system, they are indicating that there may be money left in the system after everybody is paid. I am interested in that on behalf of those who are excluded from the scheme because their relatives did not die before 29 August 2003. As things stand, will there be enough money left in the system to widen the eligibility criteria to include those people?

Peter Stevens: If my view is right that we are heading towards—as Keith Foster said—6,000 to 6,500 eligible claimants rather than 8,000, the fact that the departments have put aside money based on 8,000 claimants would suggest that there will be unspent funds at some time. However, I do not know when it might be decided that progression from stage 1 to stage 2 has gone as expected and will not require a greater proportion of the budget than was originally estimated. That will be up to the health departments.

The Convener: There are no further questions. The session has been helpful, although there have been many questions that you cannot answer. The fact that you are not in a position to answer them is in itself helpful to us. I am sorry that you had such a hard time getting here today.

Peter Stevens: It has been a pleasure.

The Convener: It must seem like an awful long journey for such a short time. Nevertheless, your attendance has been valuable and I thank you very much.

I ask for the room to be cleared as we move back into private session.

16:58

Meeting continued in private until 17:10.

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