HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 23 February 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
5th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Irene Oldfather (Cunninghame South) (Lab)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
*Kay Ullrich (West of Scotland) (SNP)
*Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING MEMBER ALSO ATTENDED:

Paul Martin (Glasgow Springburn) (Lab)

CLERK TEAM LEADER

Jennifer Smart

ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 23 February 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:35*]

Stobhill Hospital (Consideration in Private)

The Convener (Mrs Margaret Smith): I call the committee to order. As everyone who is here this morning knows, item 4 on our agenda is consideration of the Stobhill petition from the Glasgow North Action Group, which we have been dealing with over the past couple of weeks. Item 1 on the agenda is consideration by the committee of whether to take that item in private, as has been the practice with previous petitions such as that concerning Stracathro hospital. We took evidence in public on the Stracathro petition, but discussed our recommendations in private over the course of many meetings. The committee has tried to speed up the process for the Stobhill petition, and to deal with it more publicly.

Dr Simpson, our reporter, has published his interim report, which has given people the opportunity to make contributions and comments and to consider any points that needed clarification or change. We held the discussion on Dr Simpson's interim report in public. We have been urged by the Public Petitions Committee to progress with our work on this petition as quickly as possible, which is what we have done. Today, we are asked to reconsider the petition. Among our papers for today's meeting is Dr Simpson's final report. I hope that the committee can make recommendations and put its final report together on the basis of Dr Simpson's report.

The practice that is evolving within the committee structure in the Parliament, and the way in which this committee functioned over Stracathro and other reports that we have dealt with so far, is to discuss draft reports in private. That allows all members of the committee to state their point of view as clearly as they feel able to. It takes away a tendency that some of us are liable to, which is to play to the press or the public gallery from a personal or party political point of view. It also allows us to get to a position in which we feel that we have all had a chance to input honestly and at length, so that the report that we produce is one that the committee can totally support beyond the Parliament, before the public.

Today, item 1 is a decision to be made on whether what we are doing should be in private or in public. I would like to extend the amount of work that we do in public. I am aware of the fact that Paul Martin and other local members have shown interest in this item. If we take the item totally in private session, they will not be able to contribute today, which is a problem. It is also a problem that the chances are that people will come through from Glasgow to hear what we are talking about today. My recommendation is that we hear Richard Simpson speak to his report, before allowing Paul Martin and any other local members who are present to make a final statement to us on the issue and to respond to what Richard has said.

If we do that, only our discussion of the phraseology of recommendations will be held in private, which compares very well with the way in which we have handled public petitions, such as the Stracathro petition, in the past. I have the impression from the committee that there is a lack of consensus, but that members wish to move this issue forward in public as far as that is possible. I hope that that will allow us to do our business properly and fairly.

Dr Richard Simpson (Ochil) (Lab): As I have already indicated to you, convener, I am happy to proceed in that way. It is important that when we take evidence on complex issues of this sort, we should do so as publicly as possible. I am happy that the initial discussions and conclusions should be in the public domain as quickly as possible. That sends out a message about the openness and transparency that we are trying to achieve throughout Scottish society. To do anything else would be inappropriate. However, it is appropriate that we consider the report's conclusions and discuss what recommendations we may wish to make in private.

Dorothy-Grace Elder (Glasgow) (SNP): Although you have tried to reach a reasonable compromise, convener, I think that because of the unusual circumstances the whole meeting should be held in public.

The Convener: I move,

That the committee consider the report and conclusions in public and move to private session to discuss the recommendations.

Before the meeting, I tried to talk to as many members as possible about this issue, to get a sense of what members felt was the best way forward. From the point of view of pulling together a report that everyone has contributed to and is happy to support, I think that what I have outlined is the best way forward and that we should meet in public up to the point at which we discuss recommendations. We will try to conclude that

discussion as quickly as we can. I hope that we will be able to have our report printed this week.

Are we agreed, or does anyone want to move another course of action?

Dorothy-Grace Elder: I move,

That the committee consider the whole report in public.

The Convener: The first question is on the motion that I have put before the committee. The question is, that my motion be agreed to. Are we agreed?

Dorothy-Grace Elder: No.

The Convener: There will be a division.

FOR

Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Hamilton, Mr Duncan (Highlands and Islands) (SNP)
Henry, Hugh (Paisley South) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Ochil) (Lab)
Smith, Mrs Margaret (Edinburgh West) (LD)
Ullrich, Kay (West of Scotland) (SNP)
Wallace, Ben (North-East Scotland) (Con)

AGAINST

Elder, Dorothy-Grace (Glasgow) (SNP)

The Convener: The result of the division is: For 9, Against 1, Abstentions 0.

The Convener: The second question is, that Dorothy-Grace Elder's amendment to my motion be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Elder, Dorothy-Grace (Glasgow) (SNP)

AGAINST

Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Hamilton, Mr Duncan (Highlands and Islands) (SNP)
Henry, Hugh (Paisley South) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Ochil) (Lab)
Smith, Mrs Margaret (Edinburgh West) (LD)
Ullrich, Kay (West of Scotland) (SNP)
Wallace, Ben (North-East Scotland) (Con)

The Convener: The result of the division is: For 1, Against 9, Abstentions 0.

Amendment disagreed to.

Motion agreed to.

That the committee consider the report and conclusions in public and move to private session to discuss the recommendations.

The Convener: We will consider item 4 on the agenda in the way in which I, as convener, have outlined.

Subordinate Legislation

The Convener: Item 2 deals with two pieces of subordinate legislation: the Food (Animal Products from Belgium) (Emergency Control) (Scotland) Order 2000 (SSI 2000/15) and the Animal Feedingstuffs from Belgium (Control) (Scotland) Regulations 2000 (SSI 2000/16), both of which are negative instruments.

A motion has not been lodged recommending that nothing further be done under the first instrument. After consideration, the Subordinate Legislation Committee determined that the attention of Parliament need not be drawn to it.

09:45

The Rural Affairs Committee considered the instrument at its meeting on 15 February 2000. It was suggested to that committee that, since dioxin scares in Belgium, imports of pigmeat to this country had increased by about 24 per cent. It is clear that the Rural Affairs Committee is concerned about that matter, against the backdrop of the difficulties of which we are all aware in the Scottish pig industry.

Paragraph 5 of the explanatory memorandum that accompanied the instrument states that:

"marketing of pigs and poultry has been prohibited since 15 October, unless from holdings certified as uncontaminated on the basis of testing".

That explanation did not entirely convince the Rural Affairs Committee, because it was not clear whether all holdings certified as uncontaminated at 15 October had remained so, as further outbreaks may have occurred after that date. However, the Rural Affairs Committee agreed that observations on the level of imports of pigmeat from Belgium should be drawn to the attention of the Health and Community Care Committee, but that otherwise the regulations should be simply noted. Those comments relate to both the instruments before us.

Bearing that in mind, I suggest that we should decide that the committee does not wish to make any recommendation in relation to these instruments, but that we ask the Rural Affairs Committee to keep a watching brief on this issue, which it has done to date.

Ben Wallace (North-East Scotland) (Con): I know that this is a rather pedantic point, but the instruments came into force on 17 February. While we do not want to take further action on this occasion, we would not be able to in any event.

The Convener: I will ask the clerk to bring that to the attention of the Procedures Committee.

Ben Wallace: The situation is not unique to this committee.

The Convener: No, it is not. I believe that the Procedures Committee is considering this issue. Certainly, the way in which we deal with Scottish statutory instruments was discussed at the conveners committee, as was the fact that most arrive if not too late, then certainly very late on in the process.

Do members agree to that approach?

Members *indicated agreement.*

Forward Work Plan

The Convener: We now move on to item 3. Members should note the attached report, but I want to bring to their attention some of the issues in it.

The Justice and Home Affairs Committee has indicated that amendments to part 5 of the Adults with Incapacity (Scotland) Bill will be considered on 29 February and 1 March. I understand that more than 50 amendments to part 5 have been lodged and therefore it is likely that consideration of part 5 will stretch over both days. Members of the committee and I will want to attend those meetings on this committee's behalf, to speak to amendments. We have decided to suggest that the Health and Community Care Committee should not meet on 1 March, to allow members to attend the Justice and Home Affairs Committee meeting. I hope that that is agreeable to members.

Ben Wallace: The fact that so many amendments to part 5 have been lodged shows that that legislation is probably being considered by the wrong committee. The hefty controversy over the care of patients is a matter that belongs to this committee. Standing orders do not prohibit the establishment of a full joint committee. We could do that in future.

The Convener: My view, although it is not based on evidence, is that because it was one of the first bills to come through, they wanted to simplify the process by taking it through one committee rather than through a joint committee. Time and hindsight, however, have shown that you are right, Ben, and that it should have been at least a joint committee bill, if not a Health and Community Care Committee bill.

Dr Simpson: While we are discussing processes, I want to raise another point. The original evidence, which to some extent was taken jointly, because we were invited to attend the Justice and Home Affairs Committee, was taken on the basis of the bill as published. Unusually, amendments were then made at stage 1, which does not happen at Westminster. The effect was that a number of community groups that had no objection to the bill as published had objections after evidence had been taken.

When we consider the processes for this Parliament, we must consider how to take further evidence when such changes occur. This committee did take further evidence, which was helpful, but we must make the meeting of conveners and the people who organise standing orders and processes aware of the need to be careful.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I want to follow that up. We heard evidence from Alzheimer Scotland and Parent Pressure. As far as I could see, everybody was, if not fully, at least half persuaded by what they said. The Justice and Home Affairs Committee refused to hear them on the ground that they heard their evidence before stage 1, which in one way is a consistent position.

I know that the Justice and Home Affairs Committee is a busy committee so I do not want to criticise it, but, as Richard Simpson says, the changes made at stage 1 meant that a whole lot of people had an interest in the bill who had not previously had one. Convener, will you convey the Health and Community Care Committee's conclusions on those evidence sessions to others, which will at least enable us to feed the evidence into the process?

The Convener: Following our evidence session with Alzheimer Scotland, Parent Pressure and the Scottish Law Commission, I pointed out to the convener of the Justice and Home Affairs Committee that we had taken extra evidence. I picked up on the point that Richard Simpson has made that that evidence was important, because the Executive had made substantive changes. None of us is saying that the Executive should not be prepared to change its mind if it is persuaded to go in a different direction following consultation. That may create a set of problems for us, but we do not suggest that the Executive should not listen to what people say.

I asked the convener of the Justice and Home Affairs Committee to draw the attention of members of that committee to the work of the Health and Community Care Committee. When I address the Justice and Home Affairs Committee, I will try to make reference to the difficulties that section 47 has given the committee. I am happy to put that in writing to the clerk and the convener of the Justice and Home Affairs Committee, but some of our concerns have already been passed on verbally.

Let us move on. The committee has been asked to note the intention to hold a briefing on 29 March on the budget process. The Scottish Parliament information centre and the clerks are making moves behind the scenes to provide us with guidelines on what we are and are not expected to do and how we can be assisted, as this is the first time that committees have had the chance to examine budgets.

Is the committee happy to agree, in principle, to recommend to the Parliamentary Bureau the appointment of a short-term adviser to advise us during the budget process? As this is the first year that we have had to deal with the budget process, a short-term adviser would be useful. If I could have the committee's agreement in principle we can pursue that possibility. Although there are guidelines for how committees deal with the budget process, each committee is likely to look at it in a different way. We will be considering a very large and very emotive budget. We need more information on what we can and cannot do.

Mary Scanlon (Highlands and Islands) (Con): Apart from the briefing session, there are five weeks planned for us to discuss the budget proposals. What input are you expecting us to make?

Jennifer Smart (Clerk Team Leader): It should become clear from the informal briefing session on the budget process what witnesses the committee may wish to call. They could be from the Scottish Executive and sections of the health community.

Mary Scanlon: I am new to this, so you will have to excuse me—

The Convener: We all are.

Mary Scanlon: What budget proposals are we discussing? 2000-01?

Malcolm Chisholm: 2001-02.

The Convener: At our briefing on 29 March we can ask questions about how we are meant to proceed. None of us has dealt with the budget process before. It is new to this Parliament that committees have such a role—no parliamentary committee at Westminster has that power, as I understand it.

Mary Scanlon: Can we question the budget priorities?

The Convener: Yes, I think so.

Malcolm Chisholm: I am concerned because unavoidably we have been slow to get our community care inquiry started. After the three evidence sessions on community care between now and 5 April, we lose sight of it for two months so that, at the beginning of June, with a month before the recess, that is all that we will have done. That is not acceptable. We should intersperse the budget meetings in April and May with meetings on community care. We should discuss how to proceed, but I hope that we can produce something by the recess, even if only an interim report. Members of the public and of the committee will feel frustrated if we study the subject for six months and make so little progress.

The Convener: I agree with Malcolm's suggestion. I am as in the dark as other committee members. Once the committee has been briefed on the budget process, we may decide that we want only one meeting about it. I am flagging it up at this point as something on which we could take evidence—we may want to take that evidence over several weeks. Is it acceptable that in April

we cover the budget proposals and community care, plus other business as it arises?

Members *indicated agreement.*

The Convener: One of our problems with the community care inquiry has been that we have not had special advisers in place. The money has been set aside and we have been given the go-ahead to appoint them, so, although I cannot say who they will be or whether they have accepted, I hope that we will have special advisers in place before our first evidence session on 8 March.

Mr Duncan Hamilton (Highlands and Islands) (SNP): What is the process—will you come back to the committee with a range of names that the committee can examine?

10:00

The Convener: That has already been done. We asked people for suggestions about two or three months ago.

Mr Hamilton: Are you saying that there is no more input on the committee side?

The Convener: There was input in the sense that members of the committee suggested people whom they would be happy with. I do not want to go into a sort of competitive tendering process, but on this occasion we have had difficulty. I have told the conveners committee—and through it the bureau—that, when we are looking for special advisers, we do not necessarily have a big pool to choose from. People who are experts in their field tend not to sit around, twiddling their thumbs and waiting for us to ask them to get involved in something for several months. When you have a shorter—

Dr Simpson: Sorry to interrupt, but I am worried that we have a massive programme this morning.

The Convener: I am trying to explain that there has been a fairly long-winded process. It has been pointed out to the bureau that it should streamline the tendering process, because of the difficulties that committees face in attracting and paying for special advisers. The bureau has accepted that and is starting to streamline the process. Until now, we have been working with the old process, which has been cumbersome. I am happy to discuss this with Mr Hamilton in private, after the meeting.

If everybody else is happy with that change in April, I move to the substantive part of our—

Mr Hamilton: I wish to make two points. First, on the forward work plan, although I am mindful of what Richard Simpson has said, there are still matters outstanding relating to cross-cutting issues in committees. A report on that is due from the conveners committee; it would be useful to know where that will fit into the work plan.

Secondly, would it be useful at some stage to put down a date for interim reports on each of the sub-groups? Otherwise, that will simply slip off the agenda again.

The Convener: I think that we have agreed to all those points. Matters are in hand and we will know more the next time that we consider this issue.

Mr Hamilton: My point is that until we have a definite date for the reports, the matter will tend to spiral.

The Convener: I will ensure that that matter comes before us at the next meeting, when we may be less pushed for time.

Stobhill Hospital

The Convener: I thank the Glasgow North Action Group for putting this petition before Parliament. That has been worth while, not only in raising local issues relating to Stobhill hospital, but because it has unearthed a number of other issues—relating to consultation, accountability and the planning of health services—that members of the committee mentioned at the interim report stage.

I direct members' attention to the papers before them. Among others, there are papers from the Glasgow North Action Group; Greater Glasgow Health Council, on the private-public issue; and the Rev Alan Ford.

I suggest that we ask Richard Simpson to speak to his report. Although he has given us an interim report, he had further work to do—he can bring us up to date on that. I will then ask Paul Martin to make any further comments on the issue.

Dr Simpson: Once again, I thank the committee for asking me to undertake this task, which proved to be extremely complex and would have been impossible without the co-operation that I have had from all parties. I wish to stress that—whatever conclusions and recommendations we make, we want to encourage open examination of complex situations such as this. If we discourage that, we will have problems.

The situation is undoubtedly complex—it involved one health board, two trusts and their staff, two significant new developments and at least two local authorities. It was that very complexity that, in part, has led to the situation in which the local community and the health board find themselves.

The events took place against a background of significant structural change within the health service in the period from 1997 until the present. There were also local and Scottish Parliament elections and a transfer of responsibility for health services to the Scottish Parliament. It is important to recognise that the issue was complex and the background was difficult.

The development has had a number of phases. The development of the medium secure unit programme began in 1992, when the Reed report indicated that such units were the way forward. The health service in Scotland subsequently adopted that recommendation, which was a priority in the national health service planning guidelines in 1994-95. At that point, the Greater Glasgow Health Board—appropriately, and fulfilling its responsibilities—prepared a draft strategy, which gave the options for dealing with mentally ill offenders. The board circulated that strategy widely. I included information on that consultation in the appendix to the interim report—that appendix is not attached to the main report today, but the appendices are the same as in the interim report—to demonstrate the breadth of the consultation.

The board undertook that consultation between August and December. It prepared the final strategy document—which included the proposal to develop the medium secure unit—in December. It was unanimously accepted throughout the west of Scotland that the strategy was good.

I believe that, until that point, the consultation was exemplary. It was wider than many health boards would have undertaken. The board went to considerable lengths to ensure that everybody was aware that a controversial and difficult-to-place unit was going to be located in the west of Scotland. Nobody can say that that information was not in the public domain.

At that point, warnings were already coming from those who had been consulted—both from staff and from the Greater Glasgow Health Council—that the implementation of the strategy would be difficult and controversial. The background is that there is currently no requirement in the guidelines for health boards to consult; there is no structure for that consultation or for informing and engaging communities and staff, except for the human resources strategy, which was published after the initial mentally ill offenders strategy was published. The legal situation is that there is no guidance on newly built units. Anything that the health board has done is more than is required. However—as Chris Spry recently said to the Public Petitions Committee—good practice is that there should be wide consultation.

When the full strategy was published, staff groups and the Greater Glasgow Health Council warned that the implementation would be controversial. At that point, there were no public, published plans about the consultation process. People were moving into the process, but the process was not visible.

As there is a history of controversy over the locating of units for people with learning disability and mental illness, there is no doubt that the health board and the primary care trust—at that time the community mental health trust—knew that they would face considerable controversy. They were faced with a decision about when to inform, engage and consult staff and the public. Those are three different issues, which have been wrapped up in the generic term "consultation". Later, we will see that the public felt that they were being informed rather than consulted. The many members of the public who have written to me or spoken to me have repeatedly made that point.

A decision had to be made on how to involve staff, and how to engage community leaders and opinion formers. At that stage, the health board began the implementation process. That process is pretty standard. All health boards would do the same, except that in this case the primary care trust carried out an internal option appraisal. I did not mention that in my interim report, because I was not aware of it. The interim report, which was published on 28 April 1998, indicated that the Stobhill greenfield site was the preferred option.

The first comment on inadequate consultation came at this point, from Stobhill NHS Trust. The past chairman, and one of the non-executive members, wrote to me independently, indicating that they were unhappy about the level of consultation on a decision that was being made by another trust to site the medium secure unit on the acute trust's ground. Clearly, they were informed, and there were discussions at officer level, but the board members felt that the consultation had not been adequate. With those comments, the first fracture line began to appear.

There were no less than three option appraisals, two of which I referred to in my interim report. The first was internal and the second and third were externally facilitated. The option appraisals were full and entirely appropriate, and were referred to as such by Greater Glasgow Health Council, which was not the only organisation to state in correspondence to me that the appraisals were conducted appropriately. At the appraisals, mornings were spent looking at the factors that might influence the siting of the MSU, and afternoons were spent looking at how the sites stacked up.

However, there were problems, because the staff from the four acute hospital sites that were listed as possible sites for the unit were not involved in the second or third consultations. One would not normally expect to consult outside the trust that was going to build and run the unit, so it was the second consultation that was a problem. Although health council officials were involved in the process, and saw it as full and appropriate within the terms of the option appraisal, they did not view it as a substitute for subsequent consultation with council members and other elected officials.

At this point, I can find no evidence of discussion with either the joint planning groups forum or the human resources partnership—both of which were in place—about the process of informing, engaging or consulting. There were indications in the minutes that decisions were being reported to those groups, but there seem to have been no discussions.

By September 1998, at the end of the first externally facilitated option appraisal, there were a number of problems, but already the process was fractious and difficult. Quite appropriately, the board was beginning to inform interested bodies, according to the 1975 changes-in-use circular. It endeavoured to engage MPs, and was about to consult community councils in Possil, Lenzie and Bishopbriggs. However, there were problems with the consultation. First, the MP Michael Martin indicated that he was not prepared to be briefed because he had been advised that the briefing had to be private and confidential.

All along the line there has been a conflict between the desire to manage and control information and to keep it out of the public domain, and the desire to brief people and engage them. Michael Martin offered to hold a public meeting in order to discuss the matter. He offered to chair the meeting so that it could be conducted, as he said in his letter to me, in a calm and reasoned manner.

So by this time, although a consultation or informing process has begun, there is growing hostility among the community groups. There is also the beginning of opposition among the staff at the Stobhill acute sector—we are in a difficult situation.

At this point, the process is suspended, and for a perfectly good reason: the plans that were drawn up for the ambulatory care and diagnostic unit, which have been developing in parallel in the background, demonstrate that the greenfield site is occupied, mainly by a car park.

The board decided—quite rightly—that it had to suspend consideration of the greenfield site. Unfortunately, that was interpreted in two ways. The board maintained that the ACAD process had to be considered because there were problems with revenue expenditure, which I have made clear in my report. There is therefore a process of redesigning the ACAD in the background. In the foreground is the decision to suspend, which meant that the community felt that consideration of Stobhill as a site was off the agenda. In the communication strategy document update of 21 June 1999, that is described as "victory for the people". It is evident that everybody was aware that Stobhill was supposedly not being considered as a site.

10:15

There is a division, because the Stobhill site is still the preferred option of the Greater Glasgow Health Board and the primary care trust. They publicly acknowledge, however, that things cannot proceed because of the ACAD.

Unfortunately, at that point, and for whatever reason, that very good decision, which should have reassured the community about the primacy

of the ACAD, was in fact not effectively promoted, or the community did not take that on board. Everybody should have been very happy, not just about the MSU being off the agenda, but about the fact of the ACAD getting primacy. That is still not felt to be the case; it is still felt that the ACAD does not have primacy. I will return to that point.

The initial process was fractious before it was suspended. It involved growing hostility among the community. I cannot find any evidence of any published plans or public documents that show how the community would be engaged, informed or consulted when the issue came up again—which was not until the communication strategy documents of June 1999.

Between September 1998 and July 1999, there was no attempt to engage the Stobhill acute sector staff, for example. There is an impression that the three boards were quite happy to let the acute sector staff at Stobhill, the community at large and the elected members of East Dunbartonshire Council to believe that the process was off the agenda. That is, I have to say, only an impression—it is quite subjective.

In February 1999, we come to the second option appraisal. Stobhill is not just back on the agenda but, from 24 named sites, six involve Stobhill. It is not just back, but very much back on the agenda for consideration. The community and its leaders and the staff at Stobhill were still under the impression that Stobhill was not on the agenda. The senior managers and the estates departments knew it was, so there were communications at various levels, but there was no contact between the forensic psychiatry staff and the acute services doctors, so there was a fracture line there. There was apparently no communication with the nursing staff in the Stobhill unit, who had considerable concerns. There was no engagement with or involvement of the community.

The second option appraisal involved East Dunbartonshire Council, Glasgow City Council and West Dunbartonshire Council officials. None of the acute site hospital managers were formally involved, but it was a perfectly reasonable process of deciding what sites should be agreed. What emerged was that the Stobhill greenfield site again became the first preference option. Some council officials were of the view that, because Stobhill could not be considered—because the only public decision around was that Stobhill was off the agenda—the chosen site would be Leverndale. Alternatively, it might be Belvidere. In other words, the second and third options were more likely to be progressed.

Discussions were therefore not opened up among the elected members in the various councils. There was a misinterpretation, leading to further problems.

A site was recommended in February. The two boards—the health board and the primary care trust—decided to make decisions on 24 June and the management strategy group, which is made up of senior managers from the three trusts, was in charge of the management of information. There is a clear indication that, between February and July, there was an attempt not to allow information to flow into the public domain.

The communication strategy document, which I saw only after the interim report, talks about the process being one of information, not consultation. It talks about listening, but the overwhelming point that must be made is that the management strategy group did not want the information to enter the public domain because it knew that there would be a lot of hostility in the community. However, by doing that, the community leaders were disengaged from the process. The management strategy group did not want them involved because they feared an organised and hostile campaign in the community. In fact, that came to pass; it was not prevented by the group's strategic approach.

If the community leaders or the council officials had been engaged in the process and allowed to play a role in the siting of the secure unit, there would have been a chance that the situation might not have ended up as bad as it did after July.

Despite the fact that the strategy committee had said that plenty of notice should be given of meetings, a letter inviting MSPs to attend a meeting on 26 July was sent out on 15 July. I am not a Glaswegian, but I understand that there is some sort of a fair or a holiday around that time. Because of the climate of mistrust, the community assumed that the management strategy group had deliberately tried to hide the meeting in the Glasgow fair fortnight and nothing will convince the community otherwise.

The meeting that was to be held on 26 July was a briefing meeting. The communication strategy group said that it wanted to inform everyone of the plans the day before the announcement was made that the full business plan would be proceeded with.

The staff group in Stobhill hospital did not know that the announcement was to be made. It was informed on the day of the announcement. Community leaders did not know that the announcement would be made. They were informed the day before the board meeting. The public did not know that the announcement was to be made. It was informed by letter the day after the meeting.

Unfortunately, the story broke shortly before the board meeting. Where have we heard that happening before? With Stracathro? All hell broke

loose. The public feared for its safety and there was a degree of nimbyism. It must be said that it might be impossible to address the public's fears. Some feared that the secure unit would create a problem for the ACAD, on which the future of the community's hospital depends. The fears of three groups of people came together: rational, reasoning people who feared for the long-term future of the hospital, people who feared for their safety and people who displayed simply nimbyism. Those fears came together in July, shortly after the health improvement meeting at which the news was broken.

At the end of July, Greater Glasgow Health Board and the primary care trust had completely lost the initiative. There was no possibility of pro-actively publishing a sheet to say, "We are going to announce this. We are not telling you what the decision is, but we will engage the leaders and will make an announcement on 27 July, and will then conduct the following process of consultation." If that had been published at that point, it would not have been possible for the Glasgow North Action Group to say—as it and the community councils have said to me consistently—"Those meetings wouldn't have taken place unless we had organised them."

The board has said to me, "Nonsense. We demonstrated after the first option appraisal that we arranged to go out and consult the community"—which it did. It has said, "We would have organised those meetings if the Glasgow North Action Group had not, but there was no point in both of us doing it." The situation is now one of total hostility and mistrust, and the acute staff are backing the community. That is very important. When medical and nursing staff come out on the side of the community, against their own board, that is a recipe for dynamite—the situation is totally explosive.

The board's ability pro-actively to manage this process, far from being improved by the communication strategy group, was weakened by it. Now the Glasgow North Action Group is beginning a campaign of public meetings. I use that word advisedly: these were not consultation meetings; they were held in an atmosphere that has been described to me by several respondents as very difficult. At some of the meetings, the same people turned up to ask the same questions. We have got involved in the sort of process that no one was ever going to be able to manage very well.

The draft papers were sent out on 5 December. There has been a suggestion that some people were unable to get hold of those papers, but by that time the whole process was in trouble anyway. Then the decision was made on 18 January to proceed with a board meeting after the Public Petitions Committee had asked the board to suspend it. The point that I made in that committee—and I shall reiterate it—is that the board should have said, "We have got all these people here, and all these papers in front of us. Let us have a discussion about this to inform the Health and Community Care Committee and the Public Petitions Committee, but let us suspend any decision until after the petition process is completed."

In my view, Greater Glasgow Health Board has acted no better or worse than most health boards in the way it has consulted, informed and engaged. There are no guidelines in Scotland for that process.

A cultural change is beginning to happen, which is reflected in the openness of board meetings. For example, Greater Glasgow Health Council attends all the board meetings and has speaking rights on all the boards. The public can attend, and MSPs are beginning to attend. In the south of the city there is collaboration with the board on the acute review strategy, which I hear is going very well.

However, there must be a more rapid change of culture, not just in terms of openness and the provision of information; there must be transparency and planned programmes of consultation. That applies not only to the controversial MSU; there are problems inside the ACAD, which are not being consulted on. I was going to produce a full appendix on the situation of the Marie Curie unit in the ACAD. The staff felt that they had been consulted reasonably on the MSU but not on the ACAD, and feel excluded from that process.

I am sorry that the report's conclusions are fairly lengthy, but it is important that we get them right; therefore, we need to discuss them. There was a failure to publish a programme of information, engagement and consultation. Making that process public, and saying how it was to be done, would have helped a lot. As it was, the process gradually emerged. Any attempts by the board to inform the communities—and it made significant attempts—were damaged by that failure.

There was a failure to engage community leaders at a variety of stages, which disconnected them from any possibility of supporting the MSU. The leaders were put in a position where they had no alternative but to go with the community and the staff groups inside Stobhill.

All the boards have extremely difficult decisions to make. I am glad that I and this committee do not have to make the decision about where the unit should be placed. It is important to restate that.

In the past, the boards have been mainly accountable upwards, to the management

executive and to the minister, but not to their staff and to the community. The process is changing, but it will be difficult to retrieve this situation, as the process is bogged down in mistrust—who said what to whom and when. The peripheral issues that have been raised, although not totally relevant, reinforce that mistrust. Both sides interpret every twist and turn negatively. It is a real problem when hospital staff and the community are in outright opposition to the board.

10:30

In November 1999, in the middle of the stramash, there was finally consultation between forensic psychiatrists and the medical staff association. The medical staff association's position, which had been one of outright opposition to an MSU on the Stobhill site, changed. It accepted that it was appropriate to have an MSU on the Stobhill site, but not that it should be on the greenfield site, as that might curtail the ACAD development.

Will there be any improvement? Resolution will come only once the plans for the ACAD reach the stage of full business outline and planning consent, so that the community can see that the long-term future of its hospital is validated.

The board consulted well on strategy and involved partners in full and appropriate consultation on the option appraisal, but thereafter it failed to publish a clear plan for informing, engaging and consulting the community and acute staff. The board lost the control that it sought. Having lost the initiative in July 1999, the board has been unable to regain management of the process. The staff and community remain suspicious and hostile.

It may be invidious to single out any one group, but I want to record—not just because Danny Crawford is here; I did not know he was coming—the fact that I have been particularly impressed by Greater Glasgow Health Council, which has conducted itself to the highest possible standards.

When the initial draft strategy came out, the health council advised the board that implementation would be a problem. The council has taken measured decisions, which on the whole have been supportive of the board. The health council has also been involved in discussions, has attended board and trust meetings and has kept the public informed, through its bulletins, which are widely distributed. However, it has also consistently warned the board, in letters and in minuted representations, about the likely problems that would be faced and has repeatedly drawn the board's attention to what the council regards as failures to consult.

I believe that health councils have a crucial role in the accountability process, which is under-recognised and underused. Had the board listened to the warnings of Greater Glasgow Health Council, some of the problems that have occurred might have been prevented. However, it was inevitable that there would be controversy and that some members of the community would oppose the MSU, whichever community it was placed in.

I am sorry to have taken so long.

The Convener: The fact that it took so long shows the dedication with which Richard has approached his task. I thank you again Richard, publicly, for the amount of work that you have put into the report on our behalf. I thank also all the people who have spoken to Richard within such a short time frame. The report is fair, balanced and comprehensive.

I open the floor now to Paul Martin, the local member and the only non-committee member here, to give us his final thoughts on the issue and to pick up on any points arising from what Richard has just said.

Paul Martin (Glasgow Springburn) (Lab): I also thank Richard Simpson and the committee for their commitment to this petition. It is important that we are not seen as a toothless Parliament with toothless committees. We want to prove that we are the people's Parliament—today's recommendations will prove that point.

While Richard's report is accurate, I wish to draw the committee's attention to paragraph 6.2.12 on page 14 of the report, which refers to Michael Martin MP and on which I have some inside information. I would like to add that, in 1998, Michael Martin indicated his willingness to arrange and to chair public meetings. He was advised that the health board had asked for attendance at those meetings to be limited to between 20 and 30 people, because it felt that the meetings could get out of hand. It is important to note that point, because it shows both the kind of the consultation exercise that the health board was willing to enter into at that point and why concerns were raised about consultation.

Richard has gone into great detail in his report. While I understand your concern about your difficult schedule for today's meeting, convener, I want to touch on the consultation issue and to make it clear that the communication strategy was always an information process. We have repeated our concerns locally that informing the public of a decision that has already been taken is simply not good enough. Genuine consultation is about consulting members of the public and seeking their views on local matters.

Locally, we support the need for a medium secure unit in the Greater Glasgow Health Board area—I stress that once again for the record.

However, we have great difficulties with this particular proposal.

The fact that the action group arranged the public meetings is another important issue. We talk about the board's willingness to enter the consultation process. It has been well documented and is on the record—I have a letter from Greater Glasgow Health Board—that the health board felt that it was not relevant for the North Glasgow University Hospitals NHS Trust to attend the public meetings. As a result of representations made by my constituents and by me, it became the case that Maggie Boyd, the trust's chief executive, would attend the public meetings.

I submit that we are talking about people's willingness to attend meetings, to exchange views and to listen to views, but here we have the health board saying that it was not relevant for the local trust to attend public meetings—until the local community and I, the local MSP, raised our concern about that. That gives an indication of the health board's so-called consultation exercise package, which has quite clearly been an information process. The board's approach was: "This is what we are proposing and, okay, we will listen to your views, but we have already taken our decision."

The issue of the medical staff association is also important. Past guidance from ministers has been that changes in health care should be clinically led. That poses a further question because, as Richard said, the medical staff association was not consulted on this issue and was advised of the proposal on the day it was announced. How can clinical staff lead health care changes if they are not consulted?

Option appraisal is an important process and should be fully inclusive. In his report, Richard mentions a number of organisations and people who were omitted from that process, such as the medical staff association, the local trust and local community leaders. I do not see any reason why local people cannot be involved in option appraisals, and I do not take the view that the matter is too technical for them to understand.

The Convener: We are very aware of the fact that we are running out of time. Paul, do you have any final comments?

Paul Martin: I have a number of other points. I was not aware that there was going to be a time restriction for this item.

The Convener: The next part of our meeting was meant to begin at 10:30.

Paul Martin: I feel that I still have to raise some really important points.

The Convener: Please do so as quickly as possible.

Paul Martin: I am not known for going on at great length, and I would like to raise these points.

During the option appraisal process, other sites were being marketed while they were being considered. Were those sites being appraised effectively if they were also being marketed? Did market forces take over? Was it decided that although Stobhill hospital was not exactly prime land for sale, there were other sites on the market that would receive much larger capital receipts? I do not have any inside information on that issue, but it is a question that I want to raise.

Convener, I appreciate that you are pushing me for time, but I would like to make this point. If you are asking me what I want the Health and Community Care Committee to do for the community, it is to correct the injustice that has been done. In Richard Simpson's report, I have counted at least a dozen examples of mismanagement by Greater Glasgow Health Board. Given the high number of errors and the examples of serious mismanagement of this issue, we should return to the option appraisal process and openly and transparently appraise the sites that were under consideration. That process should be managed professionally and properly.

I appreciate that I am being pushed for time. I hope that you will be able to use the issues raised in Richard Simpson's report to make your final recommendations.

The Convener: We have heard from you and Richard Simpson at previous committee meetings and have the information that you supplied last week at the Public Petitions Committee.

I thank members of the public who have come this morning, and particularly thank the people who have attended our other meetings on this issue. We will now move into private session to discuss the recommendations in Richard Simpson's report.

10:42

Meeting continued in private until 11:39.

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