HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 18 September 2002
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE

22nd Meeting 2002, Session 1

CONVENER
*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS
*Bill Butler (Glasgow Anniesland) (Lab)
*Dorothy-Grace Elder (Glasgow) (Ind)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Nicola Sturgeon (Glasgow) (SNP)

COMMITTEE SUBSTITUTES
Brian Adam (North-East Scotland) (SNP)
Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD)
Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:
Helen Eadie (Dunfermline East) (Lab)
Paul Martin (Glasgow Springburn) (Lab)

WITNESSES
George J Brechin (Fife NHS Board)
Malcolm Chisholm (Minister for Health and Community Care)
Karleen Collins
Tim Davison (Greater Glasgow Primary Care NHS Trust)
Tom Divers (Greater Glasgow Primary Care NHS TRust)
Father Stephen Dunn
Simon Harris (Dunfermline Press and West of Fife Advertiser)
Letitia Murphy
Esther Roberton (Fife NHS Board)

CLERK TO THE COMMITTEE
Jennifer Smart

SENIOR ASSISTANT CLERK
Peter McGrath

LOCATION
The Hub

Scottish Parliament

Health and Community Care Committee

Wednesday 18 September 2002

(*Morning*)

[THE CONVENER *opened the meeting at 09:38*]

Items in Private

The Convener (Mrs Margaret Smith): Welcome to this morning's Health and Community Care Committee meeting. I invite the committee to consider item 4 in private. As members know, the Mental Health (Scotland) Bill has been published in the past couple of days. The committee will receive a briefing on the bill from the Scottish Executive bill team, so to cover our blushes and allow us to ask questions that might seem simplistic before we take evidence on what is a technical bill, I suggest that we hold the briefing in private. Is that agreed?

Members *indicated agreement*.

The Convener: Does the committee agree to take in private at our meeting on 25 September a briefing by our adviser on the Mental Health (Scotland) Bill?

Members *indicated agreement*.

Subordinate Legislation

Food and Animal Feedingstuffs (Products of Animal Origin from China) (Emergency Control) (Scotland) Amendment Regulations 2002 (SSI 2002/356)

The Convener: The first piece of subordinate legislation is a negative instrument. No members' comments have been received on the regulations and the Subordinate Legislation Committee has no comments. No motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation on the instrument. Is that agreed?

Members *indicated agreement*.

Food and Animal Feedingstuffs (Products of Animal Origin from China) (Emergency Control) (Scotland) Regulations 2002 (SSI 2002/300)

The Convener: No members' comments have been received and the Subordinate Legislation Committee has no comments. No motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation on the instrument. Is that agreed?

Members *indicated agreement*.

Food for Particular Nutritional Uses (Addition of Substances for Specific Nutritional Purposes) (Scotland) Regulations 2002 (SSI 2002/397)

The Convener: Members should note that the title of the regulations contains the word "addition" and not "addiction", which was on the agenda. Hands up all those who noticed that.

No members' comments have been received and the Subordinate Legislation Committee has no comments. No motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation on the instrument. Is that agreed?

Members *indicated agreement*.

NHS Boards (Consultation)

The Convener: Agenda item 3 concerns NHS boards' consultation processes. Members will recall that the committee agreed to hear evidence about NHS consultation as a result of several petitions on the subject and our previous inquiries into Stobhill and Stracathro, which was the subject of the committee's ninth report since the Parliament's establishment. Members will also recall that the committee initiated a debate on the matter in the chamber.

We have made an open call for evidence and all the submissions that we have received have been circulated. We are considering situations in Fife and in Glasgow. I make committee members, the public and particularly our witnesses aware that the committee's remit and its intention are to consider the wider issues of NHS consultation and engagement among the NHS, patients and the communities that the NHS serves, rather than to consider the specifics. Occasionally, we must extrapolate from the specifics to the general, but the committee's position from day one has been that it will not rerun any decisions that local NHS boards have taken. We have always tried to extrapolate from the specific to the general and make suggestions, which we did when we considered the Stobhill and Stracathro petitions at the beginning.

We are joined by Paul Martin, who has an interest in Stobhill as the constituency MSP. Scott Barrie had hoped to attend, but he is at the Justice 2 Committee's meeting now and cannot join us. He has shown an interest in the item.

Our first set of witnesses includes a member of the press. I think that this is the first time that we have quizzed a member of the press, so that will be interesting. We have with us Simon Harris, who represents the *Dunfermline Press and West of Fife Advertiser*; Letitia Murphy, who is a petitioner; Esther Roberton, who is from Fife NHS Board; and George Brechin, who is the interim chief executive of Fife NHS Board. We are interested in hearing first from Letitia Murphy and Simon Harris. I ask them to make a short statement before we ask questions.

Simon Harris (Dunfermline Press and West of Fife Advertiser): Hello. I am a reporter with the *Dunfermline Press and West of Fife Advertiser* and I am here on behalf of Tom Davison, the editor of the *Dunfermline Press*, who is on holiday.

In his submission, Mr Davison puts the matter into context by referring to Fife Health Board's initial consultation exercise in 1999. The health board consulted on the centralisation of acute services in Kirkcaldy and the transfer of services away from the Queen Margaret hospital. That consultation took place after the health board had stated that its preferred option was to centralise services in Kirkcaldy rather than in Dunfermline. That caused uproar in west Fife, where the decision was felt to be inherently unfair, and resulted in the resignation of the then Fife Health Board chairman, Charlotte Stenhouse. The Minister for Health and Community Care at the time, Susan Deacon, ordered a cooling-off period in Fife.

I believe that the damage that was caused by that episode is irreversible and that the trust that the people of west Fife have in the health board was pretty much destroyed by the consultation exercise. The *Dunfermline Press and West of Fife Advertiser*'s involvement has been primarily in organising a petition against fresh proposals by Fife NHS Board to centralise acute services in Kirkcaldy. We organised a petition against the proposals, which was signed by 36,000 people within a month and ultimately by nearly 39,000 people. We organised the petition because the people of west Fife felt that they had no voice and were not being listened to.

09:45

The "Hands Off Our Hospital" campaign that the *Dunfermline Press and West of Fife Advertiser* launched resulted from a meeting in January, which the health board organised at the Carnegie Hall in Dunfermline. Members of the public who attended that meeting raised two main concerns. First, some people were unable to gain access to the theatre because they did not have tickets. Despite the fact that the theatre was not full, they were turned away. Secondly, people told the *Dunfermline Press and West of Fife Advertiser* that there was a lack of board representation on the panel at the meeting. Although the panel that addressed the public on the proposals featured consultants, doctors, nurses and ambulance service staff and was chaired by an independent person, no health board staff who were responsible for the decision were present. People felt that they were not being listened to, so we organised a petition to let the people of west Fife articulate, in the simplest way, what they thought of the health board's plans.

Ultimately, the health board's decision to go ahead with its preferred option of centralising acute services in Kirkcaldy and taking them away from Dunfermline was approved at a meeting at the end of March, without consideration of a single amendment based on the comments of the thousands of residents of west Fife who thought that they were being consulted. Along with all the other reporters from the newspaper, I distributed petition sheets in west Fife villages. The people to whom I delivered the petitions felt frightened about

what the proposals meant for them and uncertain about the future of hospital services. They also felt powerless to do anything about the situation. They felt that the decision had been made and that there was nothing that they could do. People felt a strong sense of gratitude for the fact that we were giving them a chance at least to have their say. It was quite an unusual situation for a reporter to be in, but people were pleased to speak to me. I was struck by their gratitude for being given a chance to raise their views.

Health is undeniably the most important thing in people's lives. When people wake up in the morning, they ask themselves how they feel. We talk about trying to involve people in the decisions that affect their lives, but there is no doubt that the people of west Fife feel that they have been totally uninvolved in a decision on hospital services that will affect their lives now and in the future. They feel that they have not been listened to.

The Convener: Thanks, Mr Harris. Would Letitia Murphy like to make an opening statement?

Letitia Murphy: I have worked in acute services for 38 years. I am also the chairman of the Fife health service action group.

Soon after the start of the consultation exercise, it became apparent that people felt that it was a sham and nothing less than a charade. It felt more like a dictation than a consultation. During the informal and formal meetings, it was obvious that the outcome was preordained. As Simon Harris said, little seemed to have changed since October 1999. Then, the decision concerned the centralisation of acute services in Kirkcaldy; this time, the traumatology unit was to be relocated as well.

We were informed repeatedly that all sub-specialists needed to be on one site, to ensure that medical staff continued to be registered, but I dispute that. Was it not Scotland that pioneered the clinical networking whereby specialists can gain and maintain the necessary experience at more than one hospital? Especially now, improved technology surely makes that a possibility. We were also told that there was a shortage of consultants. However, according to NHS Scotland's plan for action, 600 new consultants will be on stream by 2004, plus an additional 1,500 nurses.

As has been said, the general feeling of the public of Dunfermline is that, although they have suggested alternatives, they have not been listened to. I am pleased that there will be ambulatory care and diagnostic centres at both hospitals. That is only right—it is progress, and we are delighted with that. However, to the people in the west of Fife it appears that the only people who will be on the move will be those from the west. We are also informed that most cases in Kirkcaldy are day cases. If that is so, why do acute services in west Fife have only 103 beds, whereas acute services in Kirkcaldy will have 722 beds?

We are told that most operations are carried out on older people. That means travel, expense and time. Part of any improvement in the health service should be patient care. During operations and following heart attacks, patients are vulnerable, and a major factor in their recovery is having the support of relatives and friends. The proposal will prevent that. Time and again, I have been told that people will not be able to visit their relatives in hospital because of the distances that will be involved.

We were informed that the health board's decision was based on the need to address the issues of accessibility, deprivation and the needs of people aged 75 or over—the main priority being accessibility. However, the Queen Margaret hospital is more accessible than the Victoria hospital, which is in a built-up area. There are three entrances to the Queen Margaret hospital. There are also two stations in Dunfermline, one of which was rebuilt only a few years ago, so access to the Queen Margaret hospital is better than access to the Victoria hospital.

Finally, it has been reported that, by 2010, the population in the area will increase by only 2,000, but people cannot believe that, as 7,700 new houses are planned to be built there by 2010. Dunfermline is the fastest-growing town in Scotland.

The Convener: Let us move on to questions. If, at the end of our questions, the witnesses feel that there are issues that we have not covered, they will have time to come back to them.

Shona Robison (North-East Scotland) (SNP): Both the witnesses have said why they think that the consultation exercise was severely lacking. Specifically, they mentioned the fact that attendance at the public meetings was by ticket only. Do they have any other concerns about the consultation process that they have not mentioned?

Letitia Murphy: The feeling of the people of Dunfermline is obvious. The chart in my submission shows that 71 per cent of the people who attended the public meetings were from Dunfermline. They were very keen to get something out of those meetings. Only 29 per cent of those who attended came from the east. After every meeting, people said, "What is the point? The decision has been made."

Simon Harris: We must look back to learn how things could be done better in future. The consultation process of 1999 had a big effect on the people of west Fife. The health board said, "This is what is going to happen. Now we will have

a consultation." We cannot take away the damage that that did. At meetings for subsequent consultations, the feeling among the people in west Fife has been "What's the point? The decision has been taken." Although the board made a greater effort to consult in the most recent process, the decision was the same and the people of west Fife feel that they have not been listened to.

Shona Robison: Has that had a bearing on the return of the questionnaires that the health board sent out? Something like 165,000 questionnaires were sent out in the form of a newsletter. Are you aware how many were returned?

Letitia Murphy: Between meetings and the return of questionnaires, the response was 10,000 out of a population in Fife of 350,000. That speaks for itself. The population felt that the questions were loaded. That is what people said.

Janis Hughes (Glasgow Rutherglen) (Lab): One of your main criticisms of Fife NHS Board is that it indicated a preferred option prior to the commencement of the consultation. It could be said that that was done in a spirit of openness and transparency, but it could also be argued that it swayed the process. Was it appropriate for the board to indicate its preferred option to begin with or would you have preferred the consultation to have been conducted without any preference being indicated?

Simon Harris: When the health board got a new chairman and a new chief executive, it acknowledged publicly that mistakes had been made in the first consultation. That is on the record. In the second consultation, the health board went to great pains to ensure that when it decided to make a preferred option known, that was done after a degree of consultation and that people knew that it was doing that in a spirit of openness and so that people knew where it was coming from. However, the ordinary person in the street is deeply mistrustful when a decision is to be made about the future of health services and the board that is making the decision says that it prefers a certain option. Ordinary people want to feel that what they say will make a difference.

Janis Hughes: Are you saying that the lesson to learn is that consultation should take place before the health board forms any ideas of what it would like to do? Are you saying that consultation should happen much earlier than was the case in this instance?

Simon Harris: Yes. That is my view. If consultation were conducted in that manner, even if a decision went against what people wanted to happen, at least they would feel that there was no predetermined decision.

Letitia Murphy: That also came over on 26 March, when the decision was published in "The Fifer". I got phone calls from councillors asking, "Did you see the paper?" and telling me that the decision was in there. When we were driving to Kirkcaldy—it might have been Glenrothes—the decision was on Radio Forth.

The Convener: I will say nothing about whether you should believe everything that you hear on Radio Forth or read in the papers.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Is there not a danger that, if difficult decisions on the planning of health service provision were put to a popular vote, health care services would suffer, because the decisions might be made less objectively? Is there not a danger that efficiency and effectiveness might be lost in the bid to achieve democracy?

Simon Harris: That could be argued. However, as those who serve on health boards are not elected, there is still an issue of accountability to the public when decisions have an impact on their lives. We are talking about hospital services and where the people of Fife will get their hospital care now and in future. The public cannot come to terms with the fact that those who make the decision are not accountable to them at all.

Margaret Jamieson: On the democratic accountability of health boards, such boards include individuals who are professionals and experts in certain fields. Were their views on changing the service delivery clear to the public in your area?

Simon Harris: I will let Letitia Murphy answer.

Letitia Murphy: I did not find that that was the case at all.

Simon Harris: Perhaps the way forward is to have a degree of representation. Health boards need to have expertise, but perhaps there should be more directly elected representatives on health boards, so that people could at least have a say on this or that post. Of the 12 members of the health board that made the decision on 26 March, only three or four lived in west Fife. The rest either stayed outwith Fife or lived in central or east Fife. That was another thing that rankled people in west Fife.

10:00

The Convener: Nicola Sturgeon had a question.

Nicola Sturgeon (Glasgow) (SNP): My question was whether the witnesses have a view on whether there should be direct elections to the health boards, but it has just been answered.

The Convener: Do both witnesses feel that there should be direct elections to health boards?

Letitia Murphy: Yes.

The Convener: I want to ask another question. Had Fife NHS Board's decision gone the other way, so that services were focused in Dunfermline rather than in Kirkcaldy, would not residents of central and east Fife be sitting before the committee today?

Letitia Murphy: Interestingly enough, some of those who signed the petitions were from east Fife. As members will know, west Fife hospital was opened only in June 1993. At the time, it was said to be a state-of-the-art hospital with facilities that were so advanced that it was like something out of "Star Trek". Nobody can understand the decision that was taken in 1999. The hospital had been open for only six years.

The proposed range of acute services—with the exception of obstetrics, gynaecology and paediatrics—and traumatology are being carried out at Queen Margaret hospital. Services could be fitted into phase 1 of Queen Margaret hospital. The hospital is working, and there have never been any adverse comments in the papers from the people of east Fife.

Simon Harris: I tend to agree with the convener that, had the decision gone the other way, people from east Fife probably would be sitting here instead of us and they would be making exactly the same points. However, we need to consider the way forward for consultation on important health issues. Not only in Fife but in other parts of Scotland, we have seen that the general public feel left out of the discussions on huge changes to their health services. The ordinary person is left feeling uninvolved and not listened to. It does not really matter whether people from Dunfermline or Kirkcaldy raise the issue, because the point is that something needs to be done to improve the way in which consultation is carried out.

The Convener: That is why we are taking evidence this morning. Without going into the specifics of the issue, I think that committee members agree with that point.

In his introduction, Simon Harris said that the people whom he talked to felt frightened, concerned and powerless. That is quite strong language—even for a journalist. Many people will not have given a great deal of thought to the matter. To make a good-quality decision, one needs to be provided with or given access to good-quality information. Did people feel frightened, concerned and powerless partly because they did not have the breadth of information about what would happen? Were they simply presented with the end-point of the process—the fact that they could lose their hospital facilities—without being given the totality of the information about why that decision might be taken? Alternatively, were people aware of the information that was available but still felt powerless?

Simon Harris: The context is important. The feeling of powerlessness relates to the fact that people felt that, whatever they said, it would not affect the outcome. That is what people genuinely thought. The convener mentioned that my language was strong, given the fact that many people had not given much thought to the matter—

The Convener: It was not meant as a criticism.

Simon Harris: I would dispute the assertion that many people had not given the matter much thought. A lot of people in west Fife are deeply concerned about the situation. I was genuinely taken aback because I had thought that, when I gave out the petitions, people would say, "Yes, I'll take one," but they would simply put it in the bin, but they did not. People stuck up the petitions straight away. They were genuinely pleased to have them.

Mr John McAllion (Dundee East) (Lab): Simon Harris mentioned the earlier consultation process in 1999, which was botched and led to the chairperson being sacked by the then Minister for Health and Community Care. Is it significant that Fife NHS Board's submission makes no reference to that earlier consultation process but starts the story after the appointment of the new chairperson, as if that was when the whole idea began?

If he thinks that that is significant, can he tell me whether the initial preferred option in 1999 has been delivered by the new consultation process?

Simon Harris: There have been changes. It is not exactly the same preferred option. One change is that there are some in-patient beds at Queen Margaret hospital. You would have to ask the representatives from the health board why their written submission did not start in 1999. From our point of view, the botched consultation was important for the people of west Fife.

Mr McAllion: Mr Davison states in his submission that after the botched meeting in 1999, the meetings that were held in west Fife were led by politicians, trade unions and interested individuals, and that although the health board was sometimes represented, it did not organise the meetings. The health board claims that it held a number of open space events. Are we talking about the same events?

Simon Harris: There were two separate consultations. The meetings to which Mr Davison refers in his submission were held in the period between the 1999 consultation's end and a new regime coming into the health board. Susan

Deacon ordered a cooling-off period. The open space events that are mentioned are part of the new consultation process, on the "Right for Fife" document. That sums up one of the problems—there is confusion. The health board went through a botched consultation process then a new regime came in and started again with a new consultation process. There has been formal consultation and informal consultation. Many people do not know what is going on.

Mr McAllion: Fife NHS Board claims that it has popular support for its final decision. It has been said that there were 5,000 responses to the "Right for Fife" consultation and someone else mentioned the figure of 10,000 at the meeting this morning. Were the responses broken down into those from west Fife and east Fife?

Letitia Murphy: No.

Mr McAllion: So it could be that the popular support for the proposal is in east Fife.

Simon Harris: You would have to ask the health board. Regardless of what the rest of Fife feels about it, at the end of the day the health board has made a decision that at least 38,000 people in west Fife—possibly more—feel very unhappy about.

Dorothy-Grace Elder: I will return briefly to a matter that was mentioned earlier, which is your view on directly elected health boards replacing the current unelected quango system. Can you comment on the advantages of having directly elected members of health boards? Have you worked out how that could be done through a ballot box system or whatever?

Letitia Murphy: Such a system would mean that people would feel that one of them was on the board and that the directly elected member would speak on their behalf. That is important, because the general public do not currently know who the board members are. People would therefore feel immediately that they were, at least, represented.

Dorothy-Grace Elder: Have you worked out how that representation could be achieved at local level? Are you thinking of the ballot box?

Letitia Murphy: Yes.

Dorothy-Grace Elder: Do you feel that an elected person would be more accountable to you?

Letitia Murphy: Yes. Such a person would be more accountable to the general public.

Bill Butler (Glasgow Anniesland) (Lab): I will pick up on the issues that Dorothy-Grace Elder raised. You obviously think that there is a lack of transparency and a lack of trust. There is a feeling that the whole process is unaccountable and that you could not put your views properly because you were not being listened to. Both Simon Harris and Letitia Murphy have suggested that directly elected health boards would be a way forward. Simon said that there should be a balance on boards between medical experts and the general public. What percentage of members should be directly elected and what percentage should be medical experts?

Simon Harris: I do not think that that is for me to determine. I am happy to state that there should be more of a balance than currently exists.

Bill Butler: There is currently no balance.

Simon Harris: Yes.

Bill Butler: Letitia Murphy said that if a board member were directly elected locally, people would feel better about the situation. That person might sometimes go against the popular view, but even if they went for the popular view they might not be able to convince the board. Would you be happy that you could get rid of that person at the next health board elections? Would that make the board more accountable?

Letitia Murphy: I feel that if someone is elected by the people, they are there to represent the people and to express their views—that is why the people put them there in the first place.

Paul Martin (Glasgow Springburn) (Lab): Letitia Murphy referred to loaded questions. That issue has arisen in Glasgow with regard to carefully designed questionnaires. Is there a case for having an independent organisation or company conduct and design the questionnaires so that the consultation exercise would be carried out independently and the health board could not be accused of—

Letitia Murphy: That would be a step in the right direction. Simon Harris mentioned 39,000 signatures, but 67,000 signatures were collected in west Fife and 10,000 postcards were sent to Malcolm Chisholm and Jack McConnell. Some 5,000 people attended a protest march and 60-plus people came to lobby the Parliament. That is the strength of feeling of the people of Dunfermline that the board's decision is wrong.

Mary Scanlon (Highlands and Islands) (Con): That strength of feeling has come over this morning and I congratulate you both on your evidence. You have said that the damage is done and that the board has destroyed trust. You have used words such as "frightened", "powerless", "sham" and "dictator-like" and you have said that people are being manipulated. Given that Simon Harris said that health is the most important thing, how do you overcome all that and get back to having a relationship of trust with Fife NHS Board?

Simon Harris: I am not certain that we can. The people who are in charge at the health board have

taken steps to improve the situation and it is undeniable that the recent consultation has been better than the one in 1999. However, I believe that the situation in 1999 was so bad that the people of west Fife will not trust health boards 100 per cent ever again. Greater accountability and independent questionnaires might be ways forward. I do not know whether I can answer—

Mary Scanlon: Do you think that the damage is irreversible?

Simon Harris: Yes, to an extent, because it is a question of trust. When I mention the health board to people their facial expressions change.

Mary Scanlon: That is very sad.

Bill Butler: Are we moving on to the health board now?

The Convener: No, you are going to ask the witnesses what they would do to improve NHS consultations.

Bill Butler: Well—

The Convener: I will ask the question. We have touched on the issue of representation and accountability. What else would you do to improve the consultation process in the NHS?

Letitia Murphy: The board should listen to alternative proposals. If they are not practical, the board should tell us why not. It seems to us that the alternatives that have been suggested have been ignored.

The Convener: Do you mean the preferred option was stated before the consultation began?

Letitia Murphy: Yes. What is the point of going through the sham of a consultation when, as I said at the start, the process was dictation rather than consultation?

The Convener: I will play devil's advocate and present the flip side of that. Other health boards have put out to consultation much more woolly plans and said, "We are not really sure what we want to do, but here are four or five options". In fact, written submissions to the Health and Community Care Committee have described public meetings at which officials have been unable to provide information for which people asked. The officials are sometimes unable to give such information if the board has begun consultation before options are fully formulated. Therefore, a board might find itself in the catch-22 situation of being damned if it does and damned if it does not. Are there drawbacks in going out to consultation before sufficient information is available to answer people's questions?

Simon Harris: The board should describe, before the consultation process, the stage that it has reached. The biggest problem in west Fife is what happened in 1999. People would be more likely to accept greater transparency.

10:15

The Convener: We are joined by Helen Eadie, who has a constituency interest in Fife.

Helen Eadie (Dunfermline East) (Lab): Yesterday I was at a meeting with the chair of the clinician's committee in Fife and we discussed alternative ways of introducing change. I note that people from my constituency who were at that meeting are in the public gallery. I think that Letitia Murphy and Simon Harris would agree that the health service must continually be modernised and improved. A view was expressed at yesterday's meeting that a way forward would be that instead of a health board proposing a series of options and then consulting on those, opinion and change could be grown by including different kinds of people in different processes at an early stage to get ideas and opinions from the outset. Will you comment on that?

Letitia Murphy: We feel that Queen Margaret hospital was a district general hospital. We are told that it is now a district general hospital, but by no stretch of the imagination can one say that. The hospital deals only with day cases in a diagnostic and out-patient department. When £2.5 million came on stream for stroke units for Fife, we said—using the tactic to which Helen Eadie referred—that we had such a hospital in west Fife. However, we knew what the board's preferred option was. A consultant said at a meeting later that day that the acute stroke unit would be in the same location as acute services. Our hopes were dashed and what he said is now the reality.

We feel that Queen Margaret hospital has lost its status as a district general hospital. That is why we asked for somebody like Professor Darzi, who was brought in to review acute services in County Durham. Queen Margaret hospital will be only a medical centre. To appease us there are now 103 beds, which consist of palliative care, midwifery, convalescent and a few short-stay beds. That situation could be built up gradually. People would accept that in order to restore the hospital's role as a district general hospital.

Simon Harris: To be fair, the board took steps to do what Helen Eadie suggested, but people feel that the board still did not listen to what the people of west Fife said. The consultation is over but people do not feel that they were listened to.

Helen Eadie: Have the clinicians, who are stakeholders, achieved what they set out to do? I think that we all agree that professionals such as Letitia Murphy and others do not think that they have achieved their original vision.

Letitia Murphy: I worked for over 20 years with

the consultant to whom you alluded. As you will know, the situation has changed since he left. The people of Dunfermline cannot understand how a new hospital that has every facility could be downgraded. Queen Margaret hospital has eight theatres, two of which are air-filtered. We could be doing heart transplants, but instead we are sending patients to the new hospital in Clydebank.

The Convener: I have a final question. What do you think about the role that the Executive played in the events in Fife?

Letitia Murphy: I feel that the decision has come from Westminster, because such decisions have been made about Kidderminster and about six hospitals down south—

The Convener: I will stop you there. Decisions about Scottish health are taken in the Scottish Parliament by the Scottish minister and the Scottish Executive. To some extent—when we are successful—they are taken by the Health and Community Care Committee. The only thing that Westminster agrees to is how much money comes in a block grant and, within that, decisions are taken on how much money is spent on health. Health policy in Scotland is very different to health policy in England. I do not have time to list all the differences. I stopped you because you were factually incorrect.

I am seeking your opinion on a situation in which, partly because of a flawed consultation exercise in Fife, the Executive in effect sacked a member of the board. That is quite serious—it does not happen often. I want to find out your feelings about the role that the Executive might have played in the consultation process. Do you feel that, after the events in question, the Executive continued to take an interest or could it have done more?

Letitia Murphy: I think that we received a fair hearing from the Public Petitions Committee and we have again had a fair hearing from the Health and Community Care Committee today. You have played an adequate role.

The Convener: You are referring to the Parliament rather than to the Executive. Are you generally happy with the minister's action in relation to the first consultation?

Letitia Murphy: We had a meeting with him.

The Convener: I thank the witnesses for their evidence on that issue.

We will now hear from our next set of witnesses. I invite Esther Roberton and George Brechin to make a statement, after which we will ask questions.

Esther Roberton (Fife NHS Board): I will be brief. I thank the committee for giving us the opportunity to submit evidence and to come along today. In response to Mr McAllion's point, the challenge of reducing our submission to two pages meant that we could not go much further back than we did.

I took on my present post in April 2000. As a resident of west Fife, I was well aware of public attitudes to what had gone on in 1999, even though I was not directly involved. For more personal reasons, I understood that the problem of trust between the people of west Fife—particularly the people of Dunfermline—and the health board goes back long before 1999 to the days when the old maternity hospital was closed and the new maternity unit in the brand new hospital was not opened.

When I took on the job, I knew that it was not going to be easy. I made the point to those who encouraged me to apply that I could not guarantee any outcome because I did not know nearly enough about the situation. I was well aware that it would be difficult to persuade the public, who had the events of 1999 so firmly in their minds, that we intended to start again with a clean slate. Tony Ranzetta, who was George Brechin's predecessor, and I were committed to doing everything that we could to rebuild public confidence, although we accepted that that might not be achievable.

We embarked on a rigorous process of wide public involvement. We have been told by many who have examined the process from the outside that it has been the most extensive and rigorous process that has ever been conducted in Scotland. I appreciated Simon Harris's comments about our ability to start with a clean slate. When we held our open space events in 2000 and 2001, our aim was to tell the public that we were trying to start afresh and that we had new people round the table. We also wanted to find out what health service issues were important to the public. Another significant factor, which has not been mentioned, is the fact that we were not holding a debate about hospitals; it was a debate about public health and health services for the people of Fife. A broad range of services was involved. Although the hospital element was the most emotive and high-profile part of the services under discussion, it was only a small part of them.

Points have been made about ticketing and board presence at the meetings. The first time round, we were criticised for allowing board members to dominate proceedings. Therefore, it was decided that we would have an independent chair, and that we would include clinical experts and representatives of the ambulance service. We ensured that board members were in the audience, because they were there to listen. There were board members present at every public

meeting. A substantial number of meetings were involved.

On ticketing, there were concerns about the Carnegie Hall's limit of 200, but our experience is that it is not possible to have a debate with 500 people in a hall. By the end of the process, many tickets were still available that had not been used by the people of Dunfermline and west Fife for our last two or three meetings at the Carnegie Hall.

At every stage of our process, we drew our findings together and went back to groups of the public to test the findings before they were presented to the board. As I expected once I had begun to understand the issues, we came up against the fact that people could accept—although not willingly—that we could no longer sustain two full district general hospitals, given Fife's population. The only option that we had, partly because of the level of staff availability, but mainly for clinical reasons and reasons of changes in practice, was to centralise specialist services on one site. We knew perfectly well—I knew this when I took on the job, because I have connections throughout Fife—that we would never get people to agree on which site to choose, and that the board would have to make the decision. We knew that we would be unpopular with the people in the other part of Fife whichever choice was made.

Although it was never submitted to the Parliament's Public Petitions Committee, the people of central and east Fife—when they thought that we might change our minds, having made our decision on a preferred option in September—organised a petition, which in a very short time and without any support from the press at that stage, attracted more than 20,000 signatures. We were well aware that if we were sitting here today having decided that the Queen Margaret hospital was the right place, representatives of the people of Kirkcaldy, central Fife and east Fife would be sitting where Simon Harris and Ms Murphy are sitting today.

There were 13 people round the board table when the decision was made. Of those, six were lay members and the other seven were members who worked for the health service. It could be argued that three of those, being chief executives and including a finance director, were not clinical people. Four of them lived in west Fife, two in Kirkcaldy, one in central Fife and three in north-east Fife. Another three lived outside Fife. Of the lay membership, four were in west Fife, one was in Kirkcaldy and one was in north-east Fife. We have to accept that a number of the people who have to make the decision were locally resident. One of them, my colleague Jim Gallacher, who has 50 years of service in the health service, is a general practitioner from the west Fife villages. As has been stated in Simon Harris's coverage, he agonised over the decision. However, he realised that he had been appointed by the minister to serve the people of all Fife and had to lay aside his local considerations.

His decisions, along with most others, were based on population. We acknowledge that west Fife's population is growing faster, but it will still be smaller than the population of the rest of Fife. The decisions were also based on deprivation. There is no doubt that the vast majority of deprivation, using the Jarman index, is in the Kirkcaldy, Glenrothes and Levenmouth areas. The population growth in west Fife is very much in a younger population. The vast majority of the aging population will live in the centre of Fife, closer to the Victoria hospital.

We realised that there would be difficulties, given that the Queen Margaret hospital is the newer of the two, but significant investment was required at the Victoria hospital anyway. We had committed to two viable local general hospitals. We accept that they do not have all the services of a district general hospital, but they have as many services as can possibly be replicated on both sites.

Having considered the issues, we have committed to working with Fife Council, the Scottish Ambulance Service and others to improve transport, but it is just as difficult for someone from Leven to get to the Queen Margaret hospital as it is for someone from Valleyfield to get to the Victoria hospital. Having to use three buses is not an acceptable arrangement, and we understand that. We will have to do what we can to improve that situation.

We understand wholly why the people of Dunfermline are disappointed by our decision. We knew that if we made a decision that did not centre on Queen Margaret hospital, the people of Dunfermline would be upset and would feel that they were ignored. I can assure you that the board members from central and east Fife made a particular effort to go to Dunfermline, where they learned a great deal and changed their minds about a range of issues. They did not ignore the people there, but in the end, they had to make a decision. It is a decision that we stand by, while understanding that it has upset a number of people in Fife.

The Convener: You said that board members changed their minds about a number of issues. What issues?

Esther Roberton: I can think of a very practical one, to which Ms Murphy referred. By the time the decision was made in March, there were a number of new faces around the table. My two non-executive colleagues, who had been on the board

in 1999, had been wholly opposed to the notion of a midwife-led unit in Dunfermline. We had said clearly that the women of west Fife had made it explicit that they expected us to return some level of service back to west Fife. We eventually won the argument with the clinicians that the proposal was sustainable and deliverable. We accepted that many of the largely young, growing population, including many fairly affluent young women, would be happy to have a midwife-led service closer to home and would be willing to accept the need to travel to Kirkcaldy for any obstetric-led service. That was a specific issue on which people changed their minds, and backed the development.

Nicola Sturgeon: I was going to ask the same question. That is one practical example of what changed during the consultation period. Can you give any more examples?

Esther Roberton: Letitia Murphy has already referred to the fact that we have put in-patient beds back on the site. The original proposal was that there were going to be very few, if any, in-patient beds. There are still some issues surrounding the medical cover that can be provided there, but we have demonstrated that we can provide some. As someone once said to me, the original proposal was to have no beds; in September there were to be 70 beds; and by the spring of this year we had reached 140 beds, if you count day-case beds.

10:30

Nicola Sturgeon: When a consultation process is reviewed, there are always things that could have been done differently. You might be asked about that in a moment.

This morning, we have heard the view expressed that there should be a more fundamental change in the relationship between health boards and the general public. Do you have a view on that? Do you think that you would have a healthier relationship with the public if it could kick you out at an election?

Esther Roberton: I do not really think that I can answer that question. In the end, we are talking about what I am, which is a servant of the minister and responsible for a subsidiary of NHS Scotland. As far as I am concerned, the system that is in place is an NHS Scotland system. I am not sure how to make people more accountable. I can say only that I believe that if I had been the directly elected chair of Fife NHS Board, I would still have had to make a decision.

Nicola Sturgeon: I appreciate that.

Esther Roberton: The decision about whether the boards should be democratically elected is not a decision for me.

Mary Scanlon: It has been said that NHS Fife destroyed trust and frightened people; that it made people feel powerless and manipulated; that it was a sham and dictator-like; and that all that has resulted in irreversible damage. If you were to carry out the "Right for Fife" consultation again, what would you do differently?

Esther Roberton: I believe that some of the words that were used this morning are right, but they go way beyond 1999 in that some of the damage will last much longer and will therefore be more difficult to address.

Many of the public meetings that we held were smaller, particularly in west Fife villages. However, by the time people left those public meetings, they were less angry and aggrieved and more willing to accept, even if they did not like, the arguments that we were making.

What would we do differently? Either Simon Harris or Letitia Murphy made a point about the original document and the loaded questions. I also accept Mr Butler's point. When we have looked at documents that have been produced by other health boards, we have realised that ours could have been better.

We took external advice, but I am not sure that we were well served by that external advice. As soon as the document was produced, we got feedback. To be fair, other people found the document quite helpful.

Other than that, we always had to deliberate on the balance between the time, effort and resource spent on the public consultation exercise and the criticisms that we received from some members of the public who said that we were spending far too much money. I am therefore not sure that there is a great deal more that we could have done in respect of the listening part of the exercise. In retrospect, we are still working on the message and trying to explain it to people.

The fear factor is about the fact that people believed—some still believe—that our plan is to close their hospital. I can say that, as long as I am chair of Fife NHS Board, I have no intention of doing that. We have committed ourselves to two viable hospitals in Fife.

We need to get the message across to people that we are not talking about closure but about delivering the maximum possible service. We also need to get the message across that we are not talking just about hospital services. Across the board, the people of Fife will be able to access the majority of their services closer to home than ever before.

Mary Scanlon: We are concerned with the consultation process itself. Are you admitting that the questions were loaded? Are you admitting that

the petitioners are right about the dictator-like style? Would you say that that has led to the mistrust? In considering what you will do differently, are you trying to get the people of west Fife on board again and trusting their national health service?

Esther Roberton: I do not accept the argument that it was the process that destroyed the trust. The trust was already destroyed and we were trying to rebuild it. I think that we have had some success.

I do not accept the argument that the questions were loaded, but I do accept that the original document could have been better. I expect anybody would say that. We have seen at least one other document that has made us realise how we could improve the document if we were doing it again.

I do not think that people were at all dictatorial. Had we been on platforms lecturing—which I am told that the board was accused of last time round—I could have accepted that criticism. However, this time, board members were out at public meetings during the day, in the evenings and at weekends listening to people.

Mary Scanlon: Are you saying that the decision had not already been made at the start on the option for the reconfiguration of services that you wanted? Did you have an open mind and did you listen to the 68,000 voices of the petitioners?

Esther Roberton: Yes. By the time these decisions were made, there were many new faces round the table who had not been involved in the original decision. I was one of those new faces. Soon after Tony Ranzetta and I were appointed, we had a public debate at a board meeting at which it was agreed that everything with preferred option status that had been on the table was now off the table. We made a public commitment to go back to the drawing board. We understood perfectly well that if the decision that we eventually came to bore any resemblance to the original decision, people would not believe that we had gone back.

Bill Butler: Given the lack of trust in the consultation, as evinced by Ms Murphy and Mr Harris this morning—they said that things had been pre-ordained—what is the purpose of health boards carrying out consultations on service provision? To what extent do you feel that the process has rebuilt trust?

Esther Roberton: In certain parts of Fife, we have rebuilt trust and confidence, but in west Fife, we obviously have a long way still to go.

I did not answer part of Mary Scanlon's question. We have made a commitment that, once we get beyond the outline business case and into the full business case, we will go back to involve the public and will focus strongly on involving the people of west Fife in discussions on the ultimate service provision at Queen Margaret hospital.

The process is long. It has taken us a long time to get to where we are. We will have to keep working at involving people. People such as Ms Murphy give very generously of their time to participate in that process.

Bill Butler: I want to press you on a point that Ms Sturgeon has made. Should part of the rebuilding process be a decision that a percentage of the board should be directly elected? What is your view—not as a servant of the minister but as a citizen?

Esther Roberton: I have mixed views on that. On the one hand, I understand the arguments for local accountability but, on the other, I feel strongly that we could then revert to the postcode approach to the health service, because we would not have a coherent national strategy.

Bill Butler: But those views could be balanced. I am not suggesting that the whole board should be directly elected. If there were a balance, surely there would be a perception in the wider community that things were more transparent and accountable? Directly elected members do lose their seats on health boards and elsewhere.

Esther Roberton: Chairs of health boards lose theirs too.

Bill Butler: Indeed.

Esther Roberton: It will not be my decision, but my biggest concern about elections for health boards would be, first, whether candidates would stand and, secondly, whether the public would turn out to vote. They would turn out when big decisions were being made, but I am not sure that they would turn out during run-of-the-mill times in the health service. We have to acknowledge that, given the position that my lay colleagues and I are in, people would not be queueing up to take the kinds of decisions that we have to take.

Helen Eadie: I would like to ask you pretty much the same question that I asked Letitia Murphy and Simon Harris. How can you encourage ideas on change to grow, as opposed to having preferred options that are fixed from the outset? That goes to the heart of the matter. People feel that opinions have been foisted upon them. With hindsight, do you feel that there might have been a different way of letting opinions grow, in order to get across the agenda on modernisation that I think we would all sign up to?

Esther Roberton: I am sure that there may be alternatives, but I have not come up with any yet. We have looked widely at what others have done and, on this specific issue, I have not seen any alternatives. We are one of the few health boards

that went to the open space meetings to ask people about their priorities. All the way through the process, we involved the public in the setting, and then the weighting, of the key criteria. Access came first, and we have done a whole range of things on that aspect.

Across the health service in Fife, some interesting work has been done. George Brechin may wish to comment on one or two examples—specifically, the services that we provide for people with learning disabilities and mental health problems, where we actively involve patients, users and carers. That is more difficult to do in the acute sector, because that population is much more transient.

George J Brechin (Fife NHS Board): We have worked very closely with the council and have involved users and those who care for people with a learning disability to understand what they want from services and to strike such a balance. As far as mental health is concerned, an area re-design process began about three years ago with open space events that brought together psychiatrists, psychologists, general practitioners, users, carers, community psychiatric nurses and others and focused on maintaining a Fife-wide approach to local services.

It is very difficult to say what we would do differently. My predecessor deliberately started trying to rebuild confidence by asking whether we could examine the spectrum of services that the NHS has to provide. The "Right for Fife" consultation exercise has continued to focus on six principal care groupings, not on the main issues for debate such as general hospital and maternity services.

We have tried to strike a balance. However, in response to a point that Janis Hughes raised, I should point out that in September 2001, when we were nine or 10 months into the process, the board debated long and hard whether the final consultation stage should contain formally declared preferred options. As others have pointed out, there is an argument for not doing so. However, if a board does not do that, it is criticised. Although the board might have decided wrongly, we made a considered decision that it was right to state a preference so that we could involve the public and receive views.

Twice we carried out Fife-wide mail drops, putting the best part of 200,000 leaflets through every door in Fife. The first time we sent out a newsletter, and the second time we sent out leaflets. Each time, we were attempting to explain to the population the whole range of issues we were dealing with. I do not know whether we were successful, but at least we tried to explain the totality of the situation.

Inevitably, we were hoist by the fact that health care does not stand still. During the 18-month consultation process, service changes happened, as indeed they will continue to happen. We cannot freeze the frame, run the 18-month consultation properly and then catch up. Things change.

In primary care, local health care co-operatives have involved users in a very good redesign of local services. That is great, and we want to continue that work. However, the subject is highly emotive.

Margaret Jamieson: Your written submission describes workshops that were designed to score and appraise the different options as a way of reaching the preferred option, which was general hospitals and maternity services. That option agreed with the decision that the board had already taken, albeit in a slightly different way. Why was that option chosen? You have said that different people were on the board. However, Ms Murphy said that the issue of buildings was felt to be paramount. You said yourself that there were changes in clinical practice and that there is a greater need to ensure that we have clinical governance. How were the options scored?

George J Brechin: In the end, the debate came down to two options. The first was that we should try to have a new-build hospital in Fife, which was described as option 4. The second, which was described as option 3, was to bring together specialist in-patient care on one site but to maintain the kind of local access services that exist in Dunfermline and Kirkcaldy. There was a balance between the views of the clinicians, who for a range of reasons quite often prefer to have everything centralised, and the views of the public, who quite rightly want to have everything accessible locally.

The option-scoring exercise came out in favour of option 3—the centralisation of acute specialist in-patient care but the maintenance of a local pattern of service. That was a way of reconciling the views of clinicians and the views of the public. We did not score the choice between Dunfermline and Kirkcaldy, as the exercise was about settling the pattern of care. On 26 March the board debated the issue of geography.

10:45

Margaret Jamieson: Was finance a consideration in the option-scoring exercise?

George J Brechin: The option that the board finally agreed—which makes Kirkcaldy the centre for specialist in-patient care—is marginally more expensive than the option of using Dunfermline. The board took the view, and the accountable officer agreed, that issues of access—particularly the distribution of elderly and deprived populations

in Fife, which favoured Kirkcaldy—outweighed the slight financial penalty associated with the Kirkcaldy option. Finance was a consideration only at that stage in the process.

Margaret Jamieson: So that was the first time that the options was costed.

George J Brechin: We had costed to ensure that our proposals were affordable. Throughout the exercise we talked about six client groups and the financial strategy for supporting those. We used the Arbuthnott formula. We knew that we were consulting on affordable options. However, finance was a consideration only at the end of the decision-making process, when we decided that we were prepared to pay slightly more for the Kirkcaldy option.

Dorothy-Grace Elder: You have already mentioned that you responded to the public by adding midwifery services and day beds to the services offered at Dunfermline. Did you make any other moves in response to public demand?

Esther Roberton: I will have to check the details, but the final decisions about which services will be provided on both sites allow for many more services to be provided on both sites than would have been the case under the 1999 plan.

Dorothy-Grace Elder: Such as?

Esther Roberton: I am talking about a range of specialities, but I would have to check the details.

George J Brechin: We are committed to continuing and expanding the magnetic resonance imaging services that are available in Dunfermline. We want to go beyond plain film X-rays and to take a much broader approach to imaging and testing. That supports one-stop care and retains people locally.

Dorothy-Grace Elder: An accusation has been made concerning the Carnegie Hall meeting that took place during the more recent consultation, which started in January. We have been told that

"Just 200 people were allowed into the 600-seat theatre"

and that some of those places

"were taken up by hospital officials."

It is alleged that the panel included

"consultants, doctors, nurses, an ambulance official and an independent chairman"

but no one who

"was actually a member of Fife NHS board."

How do you explain that?

Esther Roberton: Very clearly. The message that we received from the first consultation—before 1999—was that the public were unhappy about having members of the board on the platform. They wanted to hear from the people who delivered the service, rather than from the board. As we had committed ourselves to being in listening mode before we made our decision, we made a conscious choice to ask for two independent chairs. We received very positive feedback from the public about those chairs' handling of meetings. Members will recall that some of the original Dunfermline meetings were very heated. We wanted chairs who could stay detached from that atmosphere. Board members were in the audience at every meeting to listen to what was said.

Dorothy-Grace Elder: How many people were involved in making the decision to proceed in that way? It is fine to have consultants and service deliverers on the platform, but at the end of the day it is the board that decides. Why was there not even one board representative on the platform?

Esther Roberton: The message that we received from the public was that they had heard enough from us and wanted to hear from the people who provide the service. They wanted us to listen.

Dorothy-Grace Elder: Are you certain that you heard the message with clarity? People may say that platform panels should be dominated by service providers, but did they say that they did not want one member of the board on the platform?

Esther Roberton: I cannot answer that question explicitly.

The Convener: I think that we have exhausted that line of questioning. I am conscious that our time is limited. There is time for a quick question from John McAllion, and then I want to come back to the petitioners.

Mr McAllion: You mentioned the advice from clinicians that all specialist services should be concentrated on one site. Did the population distribution in Fife and the cost of having two such sites not make it inevitable that all specialist services would have to be concentrated on one site? Does that not make a nonsense of your claim that you started with a clean sheet, because a two-site solution was never on the cards, given the clinical advice that you received?

Esther Roberton: I do not think that that is the case. Some of the arguments were about the clinical services, but the board—and particularly lay members of the board—wanted to be persuaded and convinced that it was not possible to run two fully staffed district general hospitals.

Mr McAllion: On the ground of cost?

Esther Roberton: Not just on the ground of cost.

Mr McAllion: You could not have two specialist hospitals in Fife, given the size of the population. There was not a clean slate when the consultation started; there was an assumption that there would be one site and one site only.

Esther Roberton: There was an assumption that we would have to move to some centralisation. There was a question about degree. There was then a question as to whether it was one of the two existing sites or a new site.

Mr McAllion: The two district general hospitals were never on the agenda?

Esther Roberton: They were on the original assessment of the options. At the September meeting last year, it was agreed that the two district general hospitals were not sustainable, for clinical reasons rather than cost reasons.

Mr McAllion: So consultation is about managing the population to accept the clinical advice that you get from consultants.

Esther Roberton: No. I do not agree with that at all.

Mr McAllion: That is how it appears.

Esther Roberton: In the end, we listen to the clinicians and to the public. We must accept that we deliver as much as we can deliver in the way that we can. Members of the board, and particularly the lay members, were keen and determined to ensure that we centralised only that which clinical argument said that we had to.

Mr McAllion: Would the board accept the views of members of the public if they absolutely contradicted the views of the clinicians?

Esther Roberton: We have put extra things on the non-specialist site, and we have accepted clinicians' advice only where—

Mr McAllion: No. The clinicians got their single site with all the specialist services.

The Convener: John, please let Esther Roberton answer.

Esther Roberton: Most of the clinicians wanted a separate specialist site—

Mr McAllion: So they were always going to—

The Convener: John, stop heckling her and let her answer the question.

Mr McAllion: If she will give me the answer that I want.

Esther Roberton: I am trying my best. I will not tell a flippant story on the record, but I may tell it later. Many members of the public have a strong view that the services are clinically driven. I assure you that I came to this job determined that the service would be driven not by the providers for the providers, but by the needs of the patient. However, I have to accept that royal colleges and others hold sway over what we are allowed to do and what it is safe to do. Although access was a top priority, the public were concerned about public safety too and many members of the public left public meetings willing to accept the clinical arguments. I am talking not just about doctors but about all the people who work in the service, including nurses, allied health professionals and others. They said that, if they are to deliver the best service in those areas, they must be co-located on one site. I accepted that argument, as did my board members. I do not believe that I delivered what the doctors wanted to suit the doctors, if that is what you are worried about.

Paul Martin: As a result of the changes, does the acute services review document set out in contractual terms how the patient experience will be improved? For example, will waiting times be reduced by a specified length of time?

George J Brechin: It was not an acute services review. It was a review of six main strategy areas. In all the documents, including the document that went through every door in Fife around the turn of 2001-02, we have tried to explain the benefits to patients. The most recent document, which is now virtually in its final draft form, and which Mrs Eadie has a copy of, examines specific issues surrounding general hospital and maternity services. It sets out how those services would change as a consequence of the outline business case. We are committed not only to setting out high principles about what the service will look like, but to translating that into terms that mean something to the users.

Paul Martin: Could you give an example?

George J Brechin: We have tried to explain in that document what changes somebody suffering from a heart attack in west Fife would experience as a result of the business case. We also give an example of somebody accessing the breast service in west Fife.

Esther Roberton: The one thing that we have not mentioned, and which relates to Mr McAllion's question, is the argument that finally persuaded me. I was not convinced that centralisation of any services was really necessary. I now am.

One of the points that we have made strongly is that part of the reason for doing what we are doing is to ensure that we can continue to deliver many of the services in Fife. If we did not take some of the steps that we are taking, the services would be lost north and south. Likewise, we are putting ourselves into a position in which we are able to bring back to Fife services that we have been unable to provide. Our big ambition is to deliver more for the people of Fife in Fife, so that they do

not have to travel.

The Convener: Thank you for your evidence. We have other witnesses to hear from but, briefly, I wish to return to the petitioners. Do any points arise from the health board's comments that you wish to pick up on?

Letitia Murphy: First, the meeting in 1999 that caused all the controversy, at which 1,000 people turned up, was cancelled—it did not take place. Secondly, I was unaware of the lack of trust between east and west before 1999. Thirdly, many tickets were supposed to have been left for the meeting at Carnegie Hall, but 180 people attended the first meeting and 200 people attended the second meeting. Lots of people went to the hall and could not get tickets. Lastly, the work that is required to upgrade Victoria hospital—new build with 560-odd beds and a new theatre complex—is more than just a little more expensive than the cost of developing Queen Margaret hospital. We were told initially that it would cost £14 million with £1.4 million in revenue costs.

Simon Harris: I wish to return to the suggestion that the establishment of the midwife-led unit was an example of the board listening and making a change. When that unit was raised at the meeting at the end of September, when the preferred option was to centralise services in Kirkcaldy, the medical director of Fife Acute Hospitals NHS Trust approached me and said that the people of west Fife were being duped. Mr Brechin's predecessor, Tony Ranzetta, made great play of the fact that he was bringing back maternity services to Dunfermline—as Esther Roberton said, the loss of those services had been unpopular. The medical director felt that people were being duped because the unit was merely a midwife-led unit. As the name suggests, it consists of a midwife in a unit, and is unsuitable for a great number of births, never mind traumatic births. That is not my opinion; it is the opinion of the medical director of the trust.

The Convener: I challenge your use of the word "merely" in relation to midwives.

Simon Harris: I did not mean to be disrespectful to midwives, but my point is that the unit is not suitable for dealing with a number of births simultaneously. On that premise, the medical director of the trust felt that people were being duped when they were told, "You might lose these services, but this is what you're going to get."

The Convener: We have to hope that the women of Fife have a higher opinion of midwives than some people have, given the comments that we have just heard.

I thank everyone who has given evidence this morning, both for your oral evidence and for your written evidence. We will take a two or three-minute break while we change over the witnesses for the next set of evidence.

10:57

Meeting suspended.

11:03

On resuming—

The Convener: Our next witnesses are Father Stephen Dunn, Karleen Collins, Tom Divers and Tim Davison. Good morning. We will use the same format that we used in the previous evidence session. We will hear from and ask questions of both petitioners, ask questions of the health board representatives and then give the petitioners a chance to come back on any of the issues that have been raised. Colleagues should be aware that we are a bit tight for time this morning. I invite Father Dunn and Miss Collins to make a short statement. I stress the word "short", because we want to spend as much time as possible asking questions.

Father Stephen Dunn: As you will have seen from the paper that I submitted, I felt that there were many flaws in the consultation process on the secure care unit on the part of Greater Glasgow Health Board and the two primary care trusts.

The problems started in the autumn of 1998, when Stobhill was rejected for the siting of a secure unit because it was felt that there would be insufficient space for the ambulatory care and diagnostics unit and the secure unit. At that point, clinical advisers who sat on the committee that was being consulted on the process understood that the consultation process was closed, but that turned out not to be the case. Greater Glasgow Health Board, the Greater Glasgow Primary Care NHS Trust and the North Glasgow University Hospitals NHS Trust decided to act without clinical consultation in the spring of 1999.

In 1999, Scottish Office guidelines for health, social work and related services for mentally disordered offenders were issued. They stated:

> "The overall objective is to promote the provision of a sufficient and effectively co-ordinated range of services … to meet the individual needs of mentally disordered offenders and the public interest."

However, if the clinical advisers were not consulted, how could the arrangement be effectively co-ordinated?

In early 1999, there was a dramatic change in the structure of the trusts. The change involved a replacement of management staff and an amalgamation of hospitals from individual trusts to a greater trust, which became North Glasgow University Hospitals NHS Trust. From then on,

there was a reduction in hospital services, a policy that was pursued in a rather underhand manner, as there was no consultation with clinicians, consultants or area medical committees. I will back up that claim with evidence from area medical committees that was given in December 2000 and January 2002.

An initial paper or document was sent out by Maggie Boyle, the chief executive of the North Glasgow University Hospitals NHS Trust on 15 July—the beginning of summer and of the Glasgow fair fortnight—seeking comments on the paper, which was more than 100 pages long, by early August—

The Convener: Do you intend to read out your entire statement? We have already read it.

Father Dunn: I have other things to say, but I wanted to highlight some points first.

The Convener: Could you pull two or three points out at this stage? We are a bit tight for time and would like to ask you questions.

Father Dunn: I would like to quote from a paper dated 29 January 2002, in which Greater Glasgow NHS Board details its plans following its review of various aspects of health care provision. It says that a full and consultative process was carried out in relation to the ACAD unit and the secure unit. The Stobhill site is divided into three zones, one for general adult mental health services, one for acute services and one for secure care. Page 38 of the paper says:

"There are no conflicts between these 3 zones, which can accommodate all planned development in each category."

That is a complete and utter lie. The clinicians and the area medical committee clearly stated that it was not possible to move the ACAD unit from its original site without a reduction in the services that were to be granted. The paper also says that there was full public consultation until 2002, which is also incorrect. After 1998 and all through 1999, there was no full consultation process. People were denied access to information. When I tried, in December 1999, to access information, I was told that only 140 papers had been printed. I could get hold of only one, although I had wanted five so that other members of my group could read them. What is being said and what is true is like night and day.

The paper says that there was

"Engagement with key local interests."

However, the only reason why we had interest was that we formed a committee and made our case strongly against what was being done in an underhand manner. The consultative committee that assessed the secure unit after the site had been rejected had no members who were Stobhill staff and no local community representatives, so how was that

"Engagement with key local interests"?

I am sorry, but that is rubbish and incorrect.

Detailed information is said to have been "widely circulated" in 1999, but people could not get hold of it. I was able to obtain only one copy of the paper that was issued, when I had asked for five. The accompanying document to the paper says:

"If you have comments, wish to discuss … the paper, or require additional copies, please contact"

the health board. What has been said and what has been done are like night and day.

The decision-making paper was circulated at the beginning of December 1999 and responses had to be made by early January 2000—over the millennium. That was again asking people to do stupid things. On such a controversial issue that required a paper of more than 100 pages, people had to go into it in depth and be given a chance to discuss it. Issuing a paper in early to mid-December and asking people to go over it during Christmas and the millennium and make responses by 7 January is unrealistic.

The Convener: I will stop you there. We must move on to questions. If, by the end, we have not covered any matters that you want to cover, we will return to you. We will now hear from Miss Collins.

Karleen Collins: My main concern about the Stobhill situation is the conflicting information that we were given at every stage. Initially, local stakeholders were not to be consulted, except when the planning application was submitted. By forming the committee, we managed to force a consultation process, albeit a retrospective consultation. We instigated and primarily organised the many public meetings and requested the attendance of the primary care trust, the health board and Maggie Boyle, who was the chief executive of the North Glasgow University Hospitals NHS Trust, although I am not sure whether she existed, because I do not recall meeting her, except once.

Our main problem is that Stobhill is a major employer in our area, so we are stakeholders not only as local community members who use the services. We all have a family member who is employed there, so we take an active interest. The NHS board is taking a stealth approach to chipping away at our services. The only new services of which I am aware at Stobhill in the past few years have been primarily psychiatric. I am more likely to give birth than to require mental health services at this stage in my life.

The consultation process refers to leaflet drops and neighbourhood notifications, which would

happen at the planning stage. I live five minutes from Stobhill's entrance and I have never received such documents.

We forced the primary care trust and Greater Glasgow Health Board into what they called a rerun of the original option appraisal, which was insulting in the extreme. It was a public relations exercise so that we could see the decision that had been taken behind closed doors being made in front of our eyes.

Stobhill is a preferred option for the primary care trust and the NHS board because it is a district general hospital, but I fail to see how, in the light of the acute services review and centralisation of services elsewhere, they can hope to maintain Stobhill as a district hospital. That was one of their primary reasons for siting the secure unit at the hospital.

The Convener: Can I stop you there and move on to questions? We will sweep up at the end.

Karleen Collins: I would just like to say lastly that, throughout the fiasco, our local MSP has tried, on our behalf, to lodge a member's bill that would allow people to object to a local sheriff if NHS boards do not consult or consultation is inefficient. I urge strongly that that be considered and developed.

The Convener: We intend to ask the minister about that in due course.

11:15

Margaret Jamieson: Father Dunn, in your written submission you refer to North Glasgow University Hospitals NHS Trust rigorously pursuing a policy of reducing hospital services in "an underhand manner". Can you elaborate on how the trust pursued that policy?

Father Dunn: The trust pursued it by having no consultation with the clinicians. People say that there are clinicians on the boards and trusts, but they are often people who sing to the right tune—that is why they are there. If one consults the area medical committees, one often finds a different view. That different view is set out clearly in a two-page summary from the area medical committee in December 2000 and again in the paper from January 2002. There is a serious grievance about the consultation process. The clinicians were not on the committees. Why is the trust not listening to those who have got their finger on the pulse, who have the best input and who can bring the most direct experience to bear?

At a public meeting in January this year, we were told that services would not be moved from Stobhill hospital and two years ago we were told that the ACAD unit would not interfere. Now we have been told that three wards must be knocked down. The weather does not change as often as the Greater Glasgow NHS Board and the North Glasgow University Hospitals NHS Trust have changed primary care. That has been underhand because they have not consulted local area groups or the area medical committees. They have not listened to people.

Margaret Jamieson: Would you accept that the delivery of health services has changed significantly throughout Scotland because of service development? I will give an example that affects my constituents. Previously, my constituents had to travel to Glasgow to receive renal dialysis and a significant number of them were accommodated at Stobhill. The local health board took the decision to provide dialysis at Crosshouse hospital in Kilmarnock. That meant that the number of patients crossing the border into greater Glasgow was reduced, so it was incumbent on Greater Glasgow Health Board to consider the provision in Stobhill. Do you consider that to be underhand?

Father Dunn: No. I fully accept what you have just said. However, my experience as a chaplain going round the wards daily shows me that there is still a great deal of demand. I continue to meet people in Stobhill hospital who come from the north-east, from Kilsyth, Falkirk and Denny, requiring treatment. I go to Stobhill intensive care and see that there are no beds available. The beds in other wards are all full, yet there are attempts to reduce the number of beds. That is why I call the policy underhand. The facts and the truth are not being given or considered fully.

Margaret Jamieson: My point is that although your interest is Stobhill and the people who see Stobhill as their local hospital, the hospital was also serving the people of Ayrshire and Arran, Argyll and Clyde, Lanarkshire, Forth valley and the greater Glasgow area. There was obviously consultation with those health boards before renal services were removed.

Father Dunn: Well, I have never come across it.

Janis Hughes: Miss Collins, you say in your evidence that you considered the conclusion of the rerun consultation process to be a foregone conclusion. Why do you think that?

Karleen Collins: I will use an analogy that Father Dunn has used in the past. If you have watched a horse race and have seen which horse has won the race, why would you rerun the race all over again? The same people—the same representatives of the same groups—sat down to score the same sites in the same way two years later. By their nature, humans are not going to sit in a room full of their peers and take a different decision in exactly the same circumstances in which the original decision was taken, albeit earlier.

Janis Hughes: How could the consultation process have been improved?

Karleen Collins: To be honest, I did not see the point of it. It seemed to be a public relations exercise in which the primary care trust and Greater Glasgow Health Board showed us how they reached a decision that had already been taken. I will touch on something that Father Dunn said earlier about hearing of the proposals for the secure unit in the local press and via a system of Chinese whispers. That is not the way in which local people should be consulted on brand-new proposals for brand-new services in their local community.

Janis Hughes: We discussed with previous witnesses whether, if a board has a preferred option, it should make that clear from the outset of the consultation. Do you believe that it should or should consultation exercises be undertaken at an earlier stage before the preferred options have been worked up?

Karleen Collins: It is not possible to consult anyone on any matter if a preferred option is on the table from the outset. People at the local level have to be involved from the outset of the decision-making process for new-build local hospital projects or services that have not been offered before at the local hospital.

Janis Hughes: Do you not accept that there is merit in seeing the finer details of a preferred option?

Karleen Collins: No. If people are to be involved in a process from the outset, the final detail will come in due course when a decision on the preferred option is reached. People do not have to have all the detail at the outset to try to work towards making an informed decision.

Mary Scanlon: Father Dunn, it is a pleasure to see a man of the cloth so passionately representing his own community. I am tempted to ask whether you have ever had a member of Greater Glasgow NHS Board in the confession box and, if so, whether you took pleasure from serving them a penance. I congratulate you on the passion with which you made your points. Will you explain briefly your objections to the consultation process that was undertaken to determine the most appropriate site for the medium-secure unit?

Father Dunn: Certainly. The principal objections relate to the fact that a consultation process, in which the area medical committee and consultants at Stobhill were involved, had taken place in the autumn of 1997. I am referring to what was called at the time the Stobhill NHS Trust. It was thought that the trust would interfere with the ACAD development and the decision was made not to take it forward. Greater Glasgow Health Board, the primary care trust and the North Glasgow University Hospitals NHS Trust, as it had then become, made a decision to go forward in their own manner.

At the same time, land was being sold off for financial gain. I have to disagree with something that was said earlier about health not being governed by London. What happens in health is very much governed by the finance that comes to Scotland from down south. We saw the selling of sites at Leverndale and we also hear of plans to sell off Gartnavel. People in the poorer areas have to pay a price for the implications of health board plans.

Mary Scanlon: My question was about your part, or your community's part, in the consultation process for the medium-secure unit. I represent the Highlands and Islands, so I am not as familiar with sites in Glasgow as other members around the table are. I want to get to the bottom of whether the consultation process was totally wrong or whether your main objections are about the unit being a medium-secure unit.

Father Dunn: The consultation process was completely wrong. People were not involved. When they were involved and the conclusion that suited Greater Glasgow Health Board was not reached, the board started a new procedure that would meet its ends. That is my objection. Like Karleen Collins, we became aware of what was going ahead through the press.

Mary Scanlon: The petitioners said that the health board in Fife changed things as it went along. You mentioned 1997. Has Greater Glasgow NHS Board learned anything from its earlier attempts to site the medium-secure unit? Has it responded to the issues that you and others have raised on behalf of the community? Has there been a change of heart?

Father Dunn: In my view, no. The area medical committee stated in January:

"There is a general lack of confidence in the present Trust Board's ability to manage the major problems and changes which lie ahead for the North Glasgow Trust".

That conclusion is obviously also influenced by Greater Glasgow NHS Board's input. That is what is felt by the doctors and those who have their finger on the pulse.

Mr McAllion: We are talking about a medium-secure unit for mentally disordered offenders who leave the state hospital at Carstairs. If the health boards were required to consult every community about locating such a unit in their midst, how many communities do you think would say it was okay for them to go ahead?

Karleen Collins: Probably not many.

Mr McAllion: If any.

Karleen Collins: If we take the view of the primary care trust and Greater Glasgow NHS Board, we are all ingrained nimbys who do not want anything in our backyard. My problem is not with the fact that the proposal is for a medium-secure unit; it is with the fact that our district general hospital has had no money invested in it for many years, other than in geriatric and psychiatric services. The services that I use are not there. I have to go to the Royal infirmary if my children or I want to use hospital services, as we cannot use Stobhill.

My mother, who works at Stobhill, has also heard rumours that the casualty unit there is going to be closed during night hours. What is the point of having a district general hospital if all the services are centralised at the Royal infirmary? All that will be left on the Stobhill site is a centre for excellence in geriatric and psychiatric services, a halfway house for prisoners with mental disorders and—if we are lucky—an ACAD unit.

However, over the past few years, while we have been fighting to prevent the medium-secure unit from being sited at Stobhill, the ACAD unit has stalled. We are fighting to stop the medium-secure unit being sited at Stobhill because it compromises the ACAD unit, the development of acute services and any hope of developing and keeping the hospital.

Mr McAllion: No community would admit to objecting to such a unit because it happened to be for mentally disordered offenders. People would always find some other rationale for saying that they did not want it.

Karleen Collins: Probably.

Mr McAllion: More than 30 patients are being kept in the state hospital at Carstairs because we do not have sufficient medium-secure units. The NHS must provide those units in local communities.

Karleen Collins: I agree. The NHS had to provide such a unit four years ago, yet it has spent a lot of time and money in treating the local Stobhill community as nimbys and in trying to swat us away like irritating mosquitoes, even though our arguments are valid. The unit cannot be sited there until Stobhill district hospital is reviewed overall, through the acute services review and proper consultation in the area—never mind the shambolic consultation on the medium-secure unit. The health board is not prepared to discuss the real issues; it is prepared only to say, "We are going to have a problem wherever we try to site this, so we will just browbeat you into having it here because we have spent a lot of money." That is the attitude that we have hit at every turn, Mr McAllion.

Mr McAllion: There is a danger that in any community people will say that. The authorities have to build such places.

Karleen Collins: Yes, but I resent being called a nimby.

Mr McAllion: I am not calling anyone a nimby. However, all communities are reluctant to have secure units located within them. Most communities will find reasons for saying why they should not be there.

Karleen Collins: I do not have to find reasons. The reasons that exist are valid.

Father Dunn: We were told:

"It is important for staff to know that the Secure Care Centre proposals do not compromise our plans for an ACAD."

That statement has been shown to be clearly false. The plans have been compromised three times in the past three years. We are being forced to knock down wards at Stobhill.

The Convener: Father Dunn, will you indicate what document you are citing?

11:30

Father Dunn: I was quoting a statement by Maggie Boyle from July 1999 concerning Greater Glasgow Health Board's proposal for a secure unit at Stobhill. The document was circulated to staff at Stobhill hospital.

Margaret Jamieson: Ms Collins, in your submission you use the word "manipulate" to refer to the timing of what you call retrospective consultation on the planning application. What tactics were used to manipulate the consultation?

Karleen Collins: As Stephen Dunn said, the original discussions about the greenfield site at Stobhill took place at the end of 1998. The Stobhill NHS Trust said that there were proposals for the site that had to be considered. I do not know whether the trust acted as it did under community pressure or for its own reasons.

In summer 1999, I heard through the press that the same proposal had been tabled with the then North Glasgow University Hospitals NHS Trust. The ACAD plan, a broad outline of which I had seen, had been changed completely. The ACAD unit had been moved off the site and shoehorned into a car park. From subsequent meetings I could see that the primary care trust and Greater Glasgow Health Board were determined to manipulate the process at every turn. I always felt that the trust and the board were stage-managing how much and the manner in which information was provided.

We were told things only on a need-to-know basis. If we asked for a statement to be put in writing, for documentation or for an issue to be

followed up, that rarely happened. Often panel members replied to direct questions that were put to them at public meetings by saying that they did not know the answer and would get back to people—which they never did.

Nicola Sturgeon: In discussions of this sort, it is always difficult to separate people's views about the consultation process from their views about the outcome of that process. No consultation process, however exhaustive, will satisfy everybody. It is human nature that people who are disappointed by an outcome will criticise the process. I ask you to be as objective as possible about the issue and to separate yourselves from the decision.

Had the consultation process on the secure unit—I understand that there is overlap between that and the acute services review—been adequate, and had the many deficiencies that you have rightly highlighted not been present, do you believe genuinely that a different decision would have been reached?

Karleen Collins: Given the proposals for an ACAD unit, the acute services review and everything else that is happening at Stobhill, and the reasons that the board gave for wanting to site the secure unit there, I honestly believe that the unit could have been accommodated on any number of sites. I believe that in attempting to site the unit at Stobhill, the board and the trust were choosing the path of least resistance. They thought that the people of Springburn were not very intelligent because they live in the most deprived area in Scotland and that it would be possible to sneak in the proposal by the back door. They thought that by the time people found out about the unit, they would have started to build it.

Dorothy-Grace Elder: Does Miss Collins feel that the NHS board and trust made adequate efforts to explain why they did not go along with her preferred option?

Karleen Collins: I never had a preferred option. My only concern was that Stobhill hospital, as a district general hospital, should provide services that the local community needs.

Dorothy-Grace Elder: On that point, have the board and trust ever come back to you or other campaigners and given you an explanation?

Karleen Collins: I have never heard of a consultation process in which a health board has changed the initial decision after having consulted local stakeholders.

Dorothy-Grace Elder: Both of you are well known in Glasgow as long-term and active campaigners. I want you to give us a flavour of the effort that campaigning takes. For how many years have you been involved in the campaign and how much of your busy lives has it consumed?

Karleen Collins: I first became involved in campaigning on Stobhill hospital when maternity services were removed, which I believe was about seven or eight years ago. We feel that, since then, the health board has taken a stealth approach and has tried at every stage to remove services.

Dorothy-Grace Elder: That is seven or eight years of regular involvement. For how long has Father Dunn been campaigning?

Father Dunn: I have been at Stobhill hospital for almost seven years. It is about five or six years since things started being done in an underhand manner. I did not think that that was correct and I wanted to get involved.

Dorothy-Grace Elder: Trying to find things out has made more work for you.

Father Dunn: Yes. I have tried to get hold of all the papers—there are hundreds of pages—highlight untruths in them, point them out to people, bring them to the committee's attention, organise petitions, attend meetings of local action groups and let the public know the truth that has been denied them.

Dorothy-Grace Elder: Miss Collins said that initially there was to be no consultation, but your efforts and the efforts of many others forced consultation. Did it make any difference?

Karleen Collins: It is unfortunate that it made no difference whatsoever.

Dorothy-Grace Elder: Do you think that everything was preordained?

Karleen Collins: Absolutely.

Dorothy-Grace Elder: Are you saying that the whole process was a retrospective fake?

Karleen Collins: Completely. It was a public relations exercise, because we had embarrassed the board and the trust publicly. I would go as far as to say that for some individuals it was a personal crusade to force everyone into accepting their point of view in order to vindicate the decision that was made at the outset.

The Convener: Bill Butler and Paul Martin may ask very quick questions before we move on.

Bill Butler: Miss Collins—

Paul Martin: On a point of order, convener. I am not a member of this committee but I enjoy the same rights as any member of the committee. This is the second occasion on which I have been asked to ask a quick question at the end of the other questions, which is unfair.

The Convener: You do not enjoy the same rights as members of the committee.

Paul Martin: I understand that the standing orders allow me to ask questions in the same way as any committee member.

The Convener: Excuse me. You have not caught my eye in this whole evidence-taking session. On two occasions I have looked at you specifically to catch your eye and the last time that I did that you shook your head as if to say that you did not want to ask a question.

Paul Martin: I caught the eye of the clerk, who advised you that I wanted to speak.

The Convener: I do not have anything written down about that.

Paul Martin: I am sorry, but I did.

The Convener: I am not going to get into a discussion with you. I have said that Bill Butler can ask his question and then you can ask your question, quickly.

Paul Martin: I am making it clear that I have the same opportunity to ask questions as do members of the committee.

The Convener: You have not caught my eye once in this whole evidence-taking session. Every member of the committee intimated in advance of the public part of the meeting that they wanted to ask a question. You did not do that—

Paul Martin: On the same point of order, convener—

The Convener: You did not catch my eye, right. I have said that Bill Butler can ask his question and then you can ask your question.

Paul Martin: I apologise if I have not caught your eye—

The Convener: You did not, so how am I supposed to know? I am not a lip-reader.

Paul Martin: I advised the clerk and indicated that I wanted to speak.

The Convener: Time is being taken away from questions.

Paul Martin: I make it clear that I shall take the matter further.

Bill Butler: I am glad that I caught your eye, convener.

I want to follow on from the point that Dorothy-Grace Elder made. The witnesses think that the consultation exercise was, as Miss Collins said, a PR exercise and was pointless. What do they think should be the point of a real, objective consultation process? If the health board and the trusts had to go through the exercise again, what should they try to achieve?

Karleen Collins: From the outset, and before a decision is reached about the provisional siting of a new service at any hospital site, local stakeholders should be approached and invited to take an active part in the decision-making process. Eight or 10 options will be identified for a new service. At that stage, community stakeholders from each site should be invited to sit round the table and agree the option appraisal process—how the sites will be scored on all the different criteria, what the new service will be, what services the board hopes to provide and whom those services will be aimed at.

Bill Butler: If the process that you have outlined had been followed, and the outcome had been the same, would you have accepted the result?

Karleen Collins: If I felt that the unit did not compromise the ACAD and Stobhill as a district general hospital, I would not have a problem with such an outcome.

Paul Martin: Two processes were involved in the rerun that took place, which I know Father Dunn was involved in. The first took place at Stobhill headquarters and involved a reconstruction of the option appraisal event. The purpose was to decide whether Stobhill should have been selected as the appropriate site in the first instance. I ask both Father Dunn and Karleen Collins to confirm that Professor Alexander took up his post as independent facilitator on condition that the trust would be willing to walk away from the Stobhill site if that independent option appraisal proved that Stobhill should not have been selected. I also ask them to confirm that, after that four-day event, the Belvedere site scored the highest and Stobhill came fourth. Finally, I ask them to confirm that, following that unsuccessful outcome for the trust, there was a further event in December during which local views were carefully orchestrated in order to ensure that the Stobhill site was selected.

Karleen Collins: Without a doubt, Belvedere scored as the preferred option during the rerun of the original option appraisal process. Professor Alexander certainly stated that a condition of acceptance of the post of facilitator for the event was that Glasgow North University Hospitals NHS Trust, Greater Glasgow Health Board and the primary care trust all had to stipulate at the outset that they would walk away if we proved beyond doubt that Stobhill was not the preferred option and that it was not a suitable site. They agreed to that condition, but, as Paul Martin said, after Belvedere scored higher than Stobhill—incidentally, the same scoring system was used in the original option appraisal process—the authorities stage-managed a meeting in December at which it was agreed that the unit would go to the Stobhill greenfield site that had originally been chosen.

Father Dunn: I confirm everything that Miss Collins said. I remember that Professor Alexander said that he would take the information back to the health board. However, although I recall that he got quite irate and hot under the collar about the situation, he said that he could not force the health board to change its decision. He emphasised that point to us. If my memory serves me correctly, I think that the health board said that it would review the process if it produced an outcome different to the one that had already been reached, and that walking away from Stobhill would have to be one of the options.

I would like to answer an earlier question that I did not have a chance to answer. Dorothy-Grace Elder made a point about facilities and the process when she was talking to Miss Collins. From memory, I believe that, in 1998, the outline business case for the secure unit stated that it was hoped to have the application for planning permission in by June and dealt with within six months, and the secure unit up and running within 63 weeks. I read the outline business case last night but, unfortunately, I do not have my copy with me this morning.

The health authorities tried to ride roughshod over people. That was their objective then and it seems to have been their eternal objective, except that they have met stiff opposition, which has held them back.

11:45

The Convener: People have managed to do that, even if the intention was to ride roughshod.

I thank the witnesses for their written and oral evidence.

We now move on to hear evidence from Greater Glasgow NHS Board. The witnesses may make a short statement and then we will move on to questions.

Tom Divers (Greater Glasgow Primary Care NHS Trust): I would like to make a very brief statement. As a quid pro quo, if there are any points that have not been addressed at the end of the questions, perhaps we could make a short statement then as well.

The Convener: Yes.

Tom Divers: I want to highlight three points that we made in our written submission. First, we continue to develop our approach to involvement and consultation to learn how to do them better. In paragraph 2.2 of our submission, we have set out the arrangements that we put in place to deal with the most recent public consultation exercise.

To pick up on Paul Martin's earlier point, I advise members that, right at the top of page 2 of our submission, they will see that part of the approach that we adopted in that exercise was to undertake a quantitative and qualitative survey of patients and public. That survey was carried out by external consultants and their researchers. Yesterday, they were able to feed directly into the NHS board the outcomes, or what they had found in the survey.

My second point is about the importance of the debate on involvement and consultation, which has been amply demonstrated by this morning's discussion. We have to grapple with formulating a clear view on issues such as whether there should be options or preferred options.

In the 1990s, the health board was slated for not declaring its hand and showing what the preferred option was. Indeed, in the mid-1990s we had to rerun a formal consultation exercise because the local health council protested that we had not disclosed the full detail of all the work that had been done, including what the preferred option was.

Linked to that, paragraph 3 of our submission makes a point about consultation being an end point in a process. This morning, we are grappling with which other steps and processes should form part of on-going involvement in service change, prior to the final launch of more formal consultation processes.

The third and final point of my introduction picks up a point made by Nicola Sturgeon and John McAllion and relates to the first point in paragraph 4.2 of our submission. At times, there will unquestionably be difficult and sensitive issues on which we will not be able to harness a consensus.

At present, for good or ill, NHS boards are changing the construction of their memberships. In Glasgow's case, the board is materially different from how it was in October last year. It falls to NHS boards to take decisions on the basis of all the advice that they gather.

Nicola Sturgeon: I agree with your final point. No consultation process, no matter how exhaustive, is going to satisfy everybody. Health boards have to make difficult decisions. We can agree on that.

That said, I believe that the public is entitled to consider that the proof of the consultation process is in the eating. One criticism that has been made repeatedly in Glasgow, as in other areas, is that no matter how exhaustive consultation processes may look on the surface, they have absolutely no impact on the decisions that are taken at the end of the day. How do you respond to that criticism, which has been made in particular of the acute services review?

Can you give illustrations of how the

consultation process on the acute services review has changed the end-product? What views from the public have found their way into the final proposals?

Tom Divers: In the discussion about the decision that was taken on 29 January this year as part of the Glasgow acute services review, we have perhaps lost sight of how fundamentally different the proposals issued for consultation in April 2000 were from the previous strategic proposals, which the health board had considered earlier in the 1990s.

For my sins, I was director of planning on Greater Glasgow Health Board at that time. In the public consultation exercise on which we embarked earlier in the 1990s, the proposition that was up for debate was that acute services should be delivered from three sites, not five. The proposal issued for consultation in 2000 was that acute services should be provided from five sites. Major new investment would secure the future of Stobhill and the Victoria infirmary, but in-patient facilities would be concentrated on three sites. That proposal was itself a significant reaction to the expression of public unhappiness about the previous strategy.

The strategy for 2000 to 2002 had to deal with three material issues. The first was whether Glasgow was in a position to continue providing adult in-patient services on five sites, or whether that would be unsustainable in the long term. The second concerned south Glasgow, where there had for a long time been broad agreement that a single in-patient centre represented the way forward, but there was an issue over whether such a centre should be situated at the Southern general or on a new site at Cowglen. The third issue concerned the provision of accident and emergency services. Those were the three central issues on which the health board ultimately took its decisions.

Nicola Sturgeon: I agree with that analysis, but my question was how the views of the public had an impact. The second of those issues was the site of a single hospital on the south side. Some people's views changed because they perceived the consultation process as flawed, because Cowglen was given as an option but was not really an option. I think that consensus could be built in the south side of Glasgow on the need for a single site, but there is absolutely no support for the site that the health board has chosen. How can you convince me or the Glasgow public that the consultation process was adequate when the outcome flies in the face of literally everything that the health board was told?

Tom Divers: I do not accept that the outcome flies in the face of everything that the health board was told—

Nicola Sturgeon: It flies in the face of almost everything.

Tom Divers: I accept that there was strong support for Cowglen, but it was not exclusive.

As an NHS board, we had to sit down and consider the implications—including the financial and manpower implications—of a decision to use the site at Cowglen rather than the Southern general hospital. As part of the discussion, we put in front of the board the external design teams that had worked up the costed profiles for redeveloping the Southern general and Cowglen sites respectively.

In the final analysis, the additional capital cost of £136 million that a rebuild at Cowglen would have involved and the additional running costs of £10 million a year—which, as Tim Davison pointed out to the board during that discussion, equated to the cost of between 300 and 350 direct care staff—were too big an opportunity cost to bridge for what, we concluded, were the relatively marginal benefits of location at Cowglen.

Nicola Sturgeon: However, the vast majority of the population of half of Glasgow is left feeling that it is about to be given a single-site hospital in an inappropriately inaccessible site. Where does that fit into the equation? I heard what you said about the factors that led you towards the Southern general, but what about the other factors, which appear to have been completely and utterly ignored?

The Convener: The discussion is straying into the acute services review—although, in their written submission, the witnesses did give examples of how they were improving acute services. I have allowed a little leeway, but I want us to concentrate on the consultation exercises. Nicola Sturgeon's point is that many people do not feel that they have been listened to. Rather than focusing on the details of the decision, can we focus on the consultation?

Tom Divers: Thus far, we have failed to get a clear message across to the populations in the south-east and north-east of the city that they will have a substantial reprovision of modern health care in their areas. We have to engage more broadly with community interests.

As we said in January, we need to work with transport providers and others to ensure that progress is made on the necessary infrastructure links between different parts of the city—those are not there at present. We are committed to those implementation issues, and we will make progress on them.

Paul Martin: I want to ask Tim Davison about two issues relating to consultation. Karleen Collins referred to the consultation process in 1999. The

local community was advised, through the local newspapers, that the proposal on the secure unit was on the table. That was in July 1999. At a meeting that bore no relation to the issue of the secure unit, a colleague of mine was advised informally by an official, Catriona Renfrew, that the secure unit would be placed at Stobhill hospital.

Karleen Collins has talked about the fact that no consultation took place other than through the planning process. That was confirmed in the question-and-answer document. To the question of why there had been no consultation, the answer was that consultation would be carried out through the local council planning process. Do you find it unacceptable that that route was taken? Do you now accept that that process led to the difficulties that you have faced? John McAllion said that people require a service, which you are not in a position to provide because of the decision not to consult that was taken in 1999.

Trust in consultation is very important. People want to trust the people who are carrying out the consultation, but it is difficult for them to do so—and I hope that you will agree with this—when they see documents that say that other sites have been discounted for public and political reasons. One of those sites was at Gartnavel. In a 1998 document, that site was discounted for public and political reasons. How can the local community trust a consultation exercise in which other sites have been discounted for public and political reasons, but, as Karleen Collins said, the site at Stobhill—in a working class community where the land value is significantly lower than at Gartnavel—is considered?

Tim Davison (Greater Glasgow Primary Care NHS Trust): We have made a lot of mistakes along the way. We were probably destined to, because it was such a desperately unpopular service development; we felt that we would be mugged wherever we went. However, we have learned a lot. The process that led to the January 2002 decision was probably the one that we should have started with four years ago. We said to the people of Glasgow, "Glasgow needs this unit. It is important for public safety. It is for a socially excluded, vulnerable and stigmatised minority group who will suffer from the tyranny of the majority wherever we propose to put the unit. The unit needs to go somewhere. We want to engage with local communities and decide where on the map of Glasgow the pin is going to fall." Ultimately, that is what we did, although the process was criticised. We should have done four years ago what we have ended up doing now. We have learned from that.

There has been talk of Scottish Parliament guidance on consultation. I have spent 12 years in Glasgow trying to develop community care for vulnerable, stigmatised groups. It would be helpful to people such as me for that guidance to acknowledge that if the general population understands consultation to mean that unless we agree with them, we are not listening to them, we will be pushing water up a hill with a rake. The Scottish Executive needs to help us out when it is trying to develop services.

12:00

A lot of mistakes were made. The problem was that we had spent 10 years developing dozens of community-based mental health and learning disabilities facilities in Glasgow as we replaced the old institutions. All over Glasgow, in every locality in the city, we were developing, for example, community mental health team bases, community learning disability team bases and supported accommodation projects. The process that evolved in the absence of guidance from the then Scottish Office was to find a location that we felt was right and then speak to local people about it. When we were faced with the issue of where to put a secure unit, we thought, "Goodness gracious—no one will want it." We were paranoid about the process of deciding the site becoming public because we knew that every locality in Glasgow would be up in arms before we had even got off first base.

The option appraisal process that was criticised for being behind closed doors and secret involved a minority of primary care trust representatives. It was constituted involving the local health council, user groups from the Glasgow Association for Mental Health, social work, local authority representatives, the police and clinicians. We came up with the view way back at that stage—it feels like 20 years ago, although it is probably about four or five years ago—that Ruchill and Stobhill were likely to be the favoured options.

I approached the Westminster MPs in advance of the issue becoming public and asked them to come and talk to us because their site was likely to emerge as a favoured option. One of those MPs came to see me and said unequivocally that she would fight to the last man or woman standing to oppose the site in her constituency being chosen. The other Westminster MP declined to meet me and wanted to ensure that he was completely distanced from any proposal to site the secure care centre in his constituency.

We have learnt lessons. We should have done four years ago what we ended up doing. Having said that, I think that wherever we put the secure unit, we would have had the equivalent of Karleen Collins and Father Dunn saying that it was a disgrace, that the population unanimously did not want it and that we did not listen to them. The community councils around Lennox Castle, Belvedere and Stobhill said the same.

We are in a desperate catch-22 situation. The unit is desperately needed. The Mental Welfare Commission has harangued us for years about the deficit of care and abuse of human rights that result from the lack of such a facility in Glasgow. Edinburgh has had one up and running successfully for the past couple of years. The Scottish Parliament must help us to develop services for vulnerable people and not leave us in the position in which we find ourselves, in which whatever we suggest will be criticised.

Paul Martin: A question has not been answered. It was on the public and political reasons why the Gartnavel site was discounted prior to the 1999 decision. It is an important question.

The Convener: Mr Davison mentioned that he had tried to engage with the two MPs.

Paul Martin: That is not the same issue.

Tim Davison: I will try to respond. I do not ascribe to the statement to which Paul Martin refers. Although it was made in an internal document, it was someone's view. It comes from the fact that the plan to rebuild Gartnavel royal hospital involves selling a big bit of the land at Gartnavel and turning that capital receipt into a new hospital. Gartnavel is a Victorian hospital. It is vital that we replace it. The land at Gartnavel is likely to generate between £20 million and £30 million.

There was a view that, if we were going to build a secure care unit, we should not build it on a bit of land that the NHS could use to generate £20 million or £30 million to build modern hospital facilities; we should use a bit of land that would cost a lot less. I understand why people might misinterpret that as saying that middle-class areas will never get difficult services, but I have mentioned that we have spent 10 years developing community care, and we have community mental health team bases, learning disability bases and supported accommodation projects in every part of Glasgow. The decision is not at all driven by a desire to keep a secure care unit away from the affluent middle classes. The Morningside unit is in probably one of the most affluent middle-class areas in Scotland.

The Convener: I was saying to my deputy convener that the argument that was mentioned does not stack up in relation to the Edinburgh unit, which post-dates your consideration of the issue. From my little knowledge of the matter, the Edinburgh unit went ahead without a great deal of opposition from the local area, which is one of the most middle class and affluent areas in the city.

Dorothy-Grace Elder: Mental welfare services began more than 100 years ago in the Morningside area, when it was more countrified. The unit is there almost by accident.

On the point that Paul Martin made, do you accept that this is a real concern in Glasgow? You referred to the pin falling. With regard to anything difficult or unpleasant, the pin never seems to fall on the west end or Bearsden. From what you are saying, that is related to land values. The Gartnavel site, in a very plush part of north-west Glasgow, could be sold for £20 million to £30 million. That figured in your decision did it not? As Paul Martin stated, that figured in your decision to place the unit in a working-class area.

Tim Davison: That was one of the considerations, but it was not the overriding one. The overriding consideration is that we need to build the unit. With every year's delay in building the unit to provide the vital service, the urgency for its delivery becomes greater. The land that I am talking about at Gartnavel, which could generate between £20 million and £30 million, will not be available for disposal for four or five years. The land at Stobhill is available now. Although there was a financial consideration, the bigger consideration was that there is NHS land that is available for development now.

Dorothy-Grace Elder: The petitioners' main criticisms are that the consultation process was flawed and underhand. A 100-page document was released for people to see during a holiday period and there were a very limited number of copies. How do you answer those criticisms of your handling of the consultation process?

Tim Davison: I think that I said that in the past four years there has been a litany of attempts to do something and we felt defeated before we started. We would do things differently.

I genuinely believe that if you approach a community with a preferred option, the community is likely to regard it as a fait accompli, unless people manage to persuade you to change. When it comes to writing the guidance for NHS consultation, that issue will have to be considered. The guidance should probably also suggest, to help us, that locating services for people who have committed serious sexual offences, and serious crimes such as murder, in an area is likely to arouse opposition. We have to deal with that. Any consultation that a local community perceives as taking services away from their area is likely to arouse opposition. We must also deal with that.

I think that the consultation process was flawed because we came up with a preferred option and tried to sell it. I agree with Karleen Collins's comment that a number of people felt that the board was on a mission to do something. The process became adversarial. There is no doubt about that.

Dorothy-Grace Elder: Do you think that in the

future you should present the public and key stakeholders with a number of choices?

Tim Davison: Yes. At the end of the process, we did what we should have done earlier. We said that we had a preferred design for the unit, which we thought maximised security, and we said how much space it needed. We went through every NHS site in Glasgow and considered which of them could accommodate the unit. We involved communities in trying to help us to assess which of the sites best met the need for the service. We reached the conclusion that, of course, the best site was—surprise, surprise—Stobhill. You might say that that feeds the cynicism or scepticism in the Stobhill area that the whole process was rooted in pre-ordained decisions.

From a professional perspective—although I understand that it is important to have more than just a professional perspective—we were clear that because we had modernised acute psychiatry services in Glasgow, we were going to have our acute in-patient psychiatry services in general hospitals. There were a number of reasons for that, not least the desire to move away from stigmatised, outmoded, standalone psychiatric hospitals. Such development has been happening all over the United Kingdom.

Next we had to decide where to put a secure unit. A secure unit is also an acute psychiatric in-patient facility. It was clear to us and to our clinical staff that there were huge benefits in locating the secure unit alongside one of our three acute in-patient units. Stobhill, of course, is one of those three units. I can understand why people are sceptical, but there were genuine reasons for the conclusion.

Margaret Jamieson: You described a process that involved looking at the model and the size and examining all the available facilities within Glasgow to see where the secure unit would fit. You referred to the stigma that is associated with mental disorder. Perhaps you should have tackled that first, instead of starting a discussion about buildings. To a certain extent, similar situations could arise daily. We saw such situations at Lennox Castle and Woodilee. That is perhaps what Tom Divers and I are referring to.

When services are removed, the reasons for that must be discussed. Throughout the process, I have not heard anyone mention the consultation on why we need to move forward. Nothing has been said about what consultation took place with the users of current mental health services or about the consultation that is taking place with those who are cared for inappropriately in Carstairs. Their views should be brought into the equation. Did such consultation take place?

Tim Davison: The process was quite interesting. In Glasgow, we began by consulting on a strategy for mentally disordered offenders. The strategy said that we would put in place a raft of measures, not least of which were many measures that did not involve the secure unit. Those measures involved better liaison with the police, court liaison services, community forensic teams and day services. Those things are largely invisible. In general, the population seems to concentrate on hospitals and, to some extent, what we do in the community is forgotten about, even though that is the front door of the service.

I will concentrate on the in-patient unit. The response to the consultation indicated unanimous support for the strategy that included a secure unit. A number of respondents said that we would have an extremely difficult time deciding where to put it. Even at that stage, people were agreeing with the principles of having a safer, better service—it was like motherhood and apple pie, to that extent—as long as it was nowhere near them. We got the sense that the unit was needed.

Much of the strategic development process involved users and carers. The whole of our modernising mental health strategy, which involved replacing Gartloch, Woodilee and Lennox Castle, had huge user and carer involvement. As a health service manager, I hope that I always have a glass-half-full—rather than a glass-half-empty—mentality. Even that degree of optimism was challenged by the thought of persuading a local community that a secure unit was the best thing since sliced bread.

Janis Hughes: We have heard from a number of people about the deep distrust of health boards' ability to consult meaningfully with people. Tom Divers admitted that the trust had failed to get the message across. That is of particular concern to the committee.

I will use the example of Glasgow acute services, because I am familiar with the situation there. We used the model of public meetings in communities. Fife NHS Board told us that, in its opinion, a public meeting involving 500 people does not constitute debate. What is the answer to that? We also considered an option-appraisal situation, which fell by the wayside because it was not regarded as an appropriate, fair or useful way of doing things. What can we do? How can we improve the situation? It is obvious that the model that has been used so far is not a good model. Perhaps we are simply not applying the model properly. What can we do to make consultation meaningful to the public so that they feel that their views are being considered?

12:15

Tom Divers: I accept that our approaches

failed. There were 44 public meetings in Glasgow, but the speakers on the panel sometimes outnumbered those who had come along to hear about the issues and participate in the debate. We must find fundamentally different ways of continually engaging with communities and community interests. The current difficulty is that flash-points arise in acute services strategies that become huge set-piece issues. We must find a means of developing a continuing dialogue with communities about necessary service change.

Working more broadly on community planning structures can help, because statutory agencies and others need to engage communities in a raft of issues. We must find new mechanisms for involving communities in future arrangements. We must avoid planning issues becoming big set-piece events that involve prolonged consultation periods of three to six months or even two years. We must have continuing dialogue about service changes because we know that there are drivers for change.

We must build people's confidence that we are making changes not because we are awkward, have cloth ears or want to upset people, but because we genuinely believe that our arrangements will be sustainable and will deliver the best quality of care for the years ahead. We have not reached that situation with the acute care services. However, we have done so in other areas, to which George Brechin and Tim Davison referred, which perhaps have more readily identifiable groups that are interested in the issues of mental health and learning disability.

We must have a different form and level of engagement with communities as part of our developing work. We need all the advice and help that we can get on the best mechanisms for interesting communities and making them believe that their voice will count.

The Convener: We are way over time, which is probably my fault. Shona Robison will ask the final question, after which the petitioners will make a final comment.

Shona Robison: Were the recommendations of the Health and Community Care Committee's report on visits to medium-secure units in England and wider consultation on the ACAD proposals acted on?

Tim Davison: We were keen to organise visits and offered two, but the community representatives with whom we were working did not want to go on the visits. My recollection is that they thought that we would stage-manage the visits and introduce them to workers in MSUs who would have a vested interest in supporting a proposed MSU. Therefore, there were no organised visits.

We organised a video, however, which was hugely criticised as propaganda and a waste of public money. However, we produced a video on three MSUs in Birmingham, Newcastle and Edinburgh respectively. The video showed patients and staff being interviewed and showed how the MSUs were closely located to local shops, houses and populations. Our reasoning was that if people did not want to visit the units, we would bring the units to them and show them that communities do not abandon an area because an MSU is located there. The video was a compromise, but we thought that it was helpful.

The current processes in Lanarkshire NHS Board and Argyll and Clyde NHS Board to find a site for the MSU have been heavily influenced by our video. A video has been commissioned to demonstrate to people, without having a visit, what an MSU does, how it works and that those who are treated there are not demons.

The Convener: Okay. The petitioners will comment briefly on what they heard from the health board witnesses.

Karleen Collins: First, I disagree completely with Tim Davison's statement about why no one wanted to take up the offer to visit an MSU in England. That was not, as he said, because we felt that the visit would be stage-managed, but because the siting of an MSU in Glasgow is not the crux of our opposition. That is not our problem.

Tim Davison has failed at every stage to accept that, although there are nimbies in the area who do not want the secure unit just because they do not want such people on their doorstep, the main focus of our opposition throughout the whole forced consultation period was on Stobhill general hospital as a site. Our opposition has focused on what is being done and why we should have to go away into town to the Royal, where there is no parking, for all the services that we want to access. Orthopaedics and renal services have been moved. All that we have seen coming into our hospital are psychiatric services and units moved from Woodilee and from Parkhouse. All we have now are general medical and surgical wards for geriatric and psychiatric patients. We are not all over 50 in the north of Glasgow. We need to use other services, and we do not want Stobhill general hospital to be a centre of excellence for psychiatry.

Father Dunn: I am astounded by what I have heard, and it could not be further from the truth. Some of us went to look at the site at Leverndale, which was being sold off to builders because the sale would bring in money and not for any other reason. There had been a psychiatric hospital at Leverndale for a long time, and it would have been far easier to go into a site that was already established and to develop things there. With

regard to acceptance and consultation, the public were told clearly by the staff in December 2000:

"It is unfortunate that the north Glasgow trust management, in particular, has not taken its own clinicians into its confidence in the planning of services".

The staff went on to recommend that:

"No service be transferred until new facilities are … in place … facilities must be at least as good as those which exist at present."

We got the same promise from Mr Divers in January this year, and yet we are now told that gynaecology is to be moved and there is no service at the Royal. We also hear from the clinicians, as it says in the January document, that there is a general lack of confidence.

The Convener: What document are you referring to?

Father Dunn: I am reading from a report of the public meeting that was held in the Mitchell library on 29 January 2002, when undertakings were given to the public. It lists 11 areas of concern for medical staff associations, the first of which is

"general lack of confidence in the present Trust Board's ability to manage the major problems and changes which lie ahead for the North Glasgow Trust".

The fifth point is:

"There is a perceived lack of feed back and failure to respond adequately to clinical concerns."

That was said in December 2000 and in January this year, but nothing has been done about it. The trust continues charging on, but does not listen.

Karleen Collins: Could I just say one more thing.

The Convener: No. I really must—

Karleen Collins: I just want to congratulate Tim Davison on his appointment as chief executive of the North Glasgow University Hospitals NHS Trust. His dedication to the medium-secure unit and moving to the site himself is commendable.

The Convener: I thank all witnesses for their written and oral evidence.

We shall now hear evidence from the Minister for Health and Community Care. I thank the minister for attending and for waiting patiently and listening to what has been going on. Do you wish to make a statement, or shall we go straight to questions?

The Minister for Health and Community Care (Malcolm Chisholm): As we are running late, I think that we can proceed straight to questions.

The Convener: Okay. Are you generally satisfied with the consultation processes that were conducted by boards and trusts on service reconfiguration? Does the Executive believe that the consultation processes that led to the Dunfermline and Stobhill decisions were satisfactory?

Malcolm Chisholm: Our general view is that the old guidance was very much in need of renewal, so we agreed totally with the recommendation from the Health and Community Care Committee more than two years ago.

It is instructive to compare the wording of the old guidance with that of the new guidance. We had moved on and wanted to create a different culture in the health service. There will perhaps be time later to go into some of the details of the new guidance. With reference to your question, that basically means that we are looking for improvement. Our whole approach to the health service is to create a culture of improvement. I am not going to sit here and say that the consultation process was perfect. Indeed, Tim Davison admitted that just a few moments ago. The Health and Community Care Committee itself contributed to the learning of some of the lessons. It would be uncontroversial to say that there were serious problems in the early stages in Glasgow. The situation got better, but, as I said, I will not say that it was perfect.

I have read some of the written evidence that the committee received on Fife. It praises highly the recent consultation there over the past year and more. Because that was more recent, some of the new suggestions and insights of the recent guidance have been taken on board in Fife. Perhaps the most interesting thing in that guidance is the suggestion that proposals should be developed in partnership with local communities and staff. Such an attempt was made in Fife, where discussions were held with people in the community before any options were developed, never mind a favoured option. Apparently, the options were then formed on the basis of those discussions. Later, a favoured option was picked. Some of the new approaches were taken on board in Fife during the recent consultation.

The Convener: Would you come down on one side or the other in the debate on whether a preferred option should be put forward or whether it is better to proceed with a longer-term approach of developing options together with communities?

Malcolm Chisholm: The new guidance makes it clear that there may be a preferred option; equally, it is absolutely clear that there should not just be end-stage consultation. The guidance says that people should work in partnership to develop proposals, but options and a preferred option may emerge at a later stage. That is when the formal process of consultation should take place.

The words "consultation" and "involvement"

have been used in the new guidance. We are examining the responses and taking on board some of the concerns before we issue final guidance. More clarification may be required around the concepts of involvement and consultation, but the point is that we have to involve people broadly before any final process of consultation on a preferred option.

The Convener: I wish to mention something briefly; I do not particularly want a long answer on this. This point was made by some of the people from whom we have taken written evidence, rather than oral evidence. We seek guidance from the Executive on how it handles consultation on what might seem to be smaller-scale changes, for example changes to the out-of-hours GP provision in Fife. That was not handled as well as other matters.

I think that the minister has referred to the same document that I have in mind, in which it was stated that Fife had learned some of the lessons at the higher level on the hospital side of things, whereas things were not quite so good at the community level. We would seek guidance to cover that whole range, from local community services to the larger-scale services. That point was put to us by the Scottish Association of Health Councils. What is important in a small community may appear to outsiders as a fairly minor issue.

Malcolm Chisholm: I am sorry that I was not able to attend for most of the evidence about Fife, so I do not know what was said about that by the representatives of Fife NHS Board, but it highlights the issue around the word "substantial". Comments about that were fed back to us from the consultation on the draft guidance, which mentioned substantial issues and substantial service changes, over which consultation is required.

It was suggested in the written evidence that the committee received on Fife that the change to the out-of-hours service should have been regarded as substantial. I understand that the view of Fife NHS Board—although I did not hear board members' evidence—is that, from the point of view of a member of the public, there would not in fact be a difference in the service as experienced. The change was not, therefore, substantial in their view. I accept, however, that there may need to be more clarification around what exactly substantial means. It is a difficult matter. The ultimate test has to centre on how the service is experienced by members of the public in the area concerned. We perhaps need to do a bit more to clarify matters.

12:30

Paul Martin: Earlier, we mentioned the fact that it is important that the public trust and have confidence in the consultation exercises that the boards conduct. We touched on the political and public reasons behind the discounting of the Gartnavel site, which are set out in a NHS board paper that is available for public scrutiny. Do you think that it is unacceptable that a site would be discounted for such reasons?

When he was in Westminster, Sam Galbraith, the previous minister with responsibility for health, advised that changes in health care should be clinically led. Do you take the view that, if clinicians make their point of view known, the board should follow that view rather than taking into consideration the local view, or do you think that a joint approach between the clinicians and the local community should be taken?

Malcolm Chisholm: On your first question, only Glasgow can explain the reasons for not choosing Gartnavel, although I heard Tim Davison give more than one explanation for that and, to be fair, I do not think that what he said was consistent with what you just said. You are referring to a board paper that I am not familiar with, but Tim Davison's words, which are on the record, do not match with what you are suggesting.

On your second point, I think that it is important that we get some clarity around that issue. We must have a clear view about who should make certain decisions. Politicians have to know what their role is, boards have to know what their role is, clinicians have to know what their role is and the public have to know what their role is. As I keep saying in debates, we support a collaborative approach between politicians and managers on one hand and the public and clinicians on the other. Certainly, I would never say that decisions on service issues are only for clinicians to make. Equally, it is important that we recognise the important role of clinicians in the health service. They must not only deliver services but lead change. We have to have a model of change in the health service that allows front-line staff to lead a lot of the new developments.

Obviously, the views of clinicians are important with regard to service reorganisation. We have to listen to their views in relation to the quality of care that can be delivered through any particular reorganisation. However, the public have a view as well and I would never say that we should listen only to the clinicians' view. The same applies when it comes to redesigning services in a narrower sense. It is useful to distinguish between reorganisation, when services might be moved from one hospital to another, and redesigning services, which involves changing the way in which a service is delivered. The establishment of one-stop clinics is a well-known example of redesign, and managed clinical networks are another. It is important that such changes in the

design of service delivery are led by the clinicians but also that the public are involved.

As I said last week in the debate on the acute services review in Glasgow, the decision about the three in-patient sites was supported not only by the area medical committee but by Greater Glasgow Health Council. On some of the most controversial decisions, the clinicians have not been the only parties to have taken certain views.

Shona Robison: Is there not an argument that the guidance or guidelines that are issued to health boards should specifically rule out decision making on the basis of political factors?

Malcolm Chisholm: I am not sure what you allude to. Will you give me an example?

Shona Robison: The example is what has appeared in the documents from the health board. Major concern has been expressed about that appearing in black and white and what that means. Is not there an argument for your department to issue guidance to health boards saying that it is inappropriate to put such statements in consultation documents or even internal documents and that decisions should be made for the right reasons and not for political reasons?

Malcolm Chisholm: Obviously, I agree that health decisions should not be made for political reasons. All that I am saying is that Tim Davison did not say that in his evidence. I have not seen the document to which you refer, so it would be foolish of me to say anything detailed about it. I do not know when it was dated or what it said, but that is not what Tim Davison said about decision making on Gartnavel and Stobhill.

The Convener: I suggest that Paul Martin should make a copy of that available to the minister.

Paul Martin: I am more than happy to do that.

Mr McAllion: Everyone agrees that the priority is a clinically safe and modern national health service. Clinicians appear to say that, to achieve that, we must concentrate all specialist services in single sites at big hospitals. Is the purpose of a consultation process to persuade the public of the necessity of changing to such an NHS, or is it to listen to what the public think about such an NHS? For example, could a local community have the right to veto proposals that were made because of clinical advice?

Malcolm Chisholm: You go to the nub of the matter when you refer to a local community.

Mr McAllion: Fife is an example.

Malcolm Chisholm: It is good that you have given that example. As I have not made a decision on Fife, I will not give a view on it. I will speak generally, but Fife highlights the issues more than anywhere else, although some of the issues are relevant to Glasgow, too.

As I said in relation to Glasgow, the first decision involves establishing the model of care. Agreement is needed on whether, in the interests of better quality care, some services must be put together on one site, so that one site expands its services and another site changes its services in the opposite direction—although the decision has been made to propose significant services for Victoria infirmary and Stobhill. If that model is agreed to, the issue relates to sites.

I understand that, although there was much agreement about the model of care in Fife—I cannot quantify that—two areas of Fife fundamentally disagreed about where the larger hospital should be. I suppose that the answer in principle is that a view must be taken about what is best for Fife as a whole, just as, in Glasgow, a view must be taken on what is right for greater Glasgow as a whole. One part of an NHS board area might be overwhelmingly against a proposal while the majority of that area was for it—I am speaking generally rather than specifically. That highlights some of the dilemmas with the idea of a local veto.

Mr McAllion: I would like to be clear about that. Once the model of care has been agreed at the highest level in the NHS, there is no argument about that and all that is decided is how that should be implemented locally.

Malcolm Chisholm: No, because obviously the model of care is consulted on. That was done during the early consultation in Fife. I do not doubt that a failure of some consultations in the past has been not dealing with the basic issues in that early involvement with local people, so that some issues that you, as health experts, know about have not been raised. You know at least the different arguments on why grouping specialists together might be better for subspecialisation and more consultant-delivered care, for example. Equally, you know some of the secondary but important matters, such as the working time directive and junior doctors' hours, which are good positive developments, but which have knock-on effects for the organisation.

Mr McAllion: Would it not be better to be honest about the consultation's purpose? If you undertake a consultation process, people will think that they are being asked what they think and that when they tell you what they think you will accept that, but that is not the consultation's purpose. Often, a consultation is undertaken to persuade people of what you have made up your mind to do.

Malcolm Chisholm: That is the traditional view of consultation and it is explicit in the 1975 guidance, which is what applied in Scotland until

this year. The tenor of the 1975 guidance was that boards knew best, boards decided and boards consulted, but it did not even mention the public. Health boards were to consult health councils as proxies for the public, and they were to consult a few other people.

The new guidance takes a different approach. It does not state that boards will consult having made up their minds. It states that people must be involved in discussions at an early stage. Obviously, clinicians have views, and relevant factors, such as the working time directive, have to be taken into account. In addition, as Cowglen illustrated, money is not irrelevant. All those issues must be put on the table in engaging with the public.

I am optimistic about public involvement. I am not saying that all people will come to the same point of view, but if they are involved properly we can get round a lot of problems. John McAllion's area provides a good example. I was in Tayside on Monday. John will remember that three years ago, this committee did the same kind of exercise on Stracathro hospital that it has done on Stobhill hospital, and produced a devastating critique of Tayside Health Board. In Tayside, the people in Angus have been involved in talking about an ambulatory care and diagnostic centre—a type of unit that has caused a lot of controversy at Stobhill and the Victoria. Now that local people have been involved in planning that unit—for example, they were involved in discussions on what will be in it—there is a lot of enthusiasm for it. It is worth examining what has happened in Tayside, because it shows how the situation has been turned round through proper public involvement.

Mary Scanlon: When you were a lowly member of the committee, you signed up, as deputy convener, to Dr Richard Simpson's excellent report on Stobhill. Before I ask you how that issue has moved forward, I wish to raise a submission that we received from the Helmsdale and district general practitioner action group. It has no representatives here this morning, so I wish to raise its point that, in the consultation process,

"References were made repeatedly … to Dr. Harold Shipman, implying that Helmsdale might get such a doctor."

The chairman of Highland Primary Care NHS Trust said:

"If you don't like the service, don't use it."

When someone is in the middle of Helmsdale, Kildonan or Loth, all they have is access to a general practitioner, unlike in Glasgow, where people have access to many hospitals.

Is that a proper way to involve people? Does that resonate with the Fife petitioners' feelings of being frightened and powerless? Have all communities moved forward in the way that you say Tayside has in the three years that members have been here? Have you considered Richard Simpson's report in moving forward?

The Convener: That was about 12 questions.

Mary Scanlon: No, it was three.

Malcolm Chisholm: Of course I reread Richard Simpson's report. Indeed, I wound up the debate on that report in the Scottish Parliament two and a half years ago. It is obvious that not everyone has made the necessary progress. It would be surprising if they had responded completely to our guidance, because the guidance came out only a few months ago. We have a long way to go. There has been more activity in the broad area of public involvement and patient focus, as we call it, this year than there has ever been in the history of the NHS. We are trying to do no less than change the whole culture of the health service, and we will not do that in a few weeks or months. However, progress has been made.

Helmsdale is an interesting example, because it reminds us that there are external constraints to service change. I have mentioned some already, but Helmsdale illustrates the issue of the availability of staff who are willing to work there. Similar recruitment difficulties have arisen elsewhere in the past few months. Such difficulties change the nature of what is possible. The fundamental point in Helmsdale is that the board failed to recruit anyone.

Mary Scanlon: Are you monitoring the consultation processes of health boards and trusts throughout Scotland, to ensure that they do not threaten communities such as Helmsdale with a Shipman and do not say to people,

"If you don't like the service, don't use it"?

The Convener: Before the minister answers that question, Margaret Jamieson would like to ask a mini-supplementary.

12:45

Margaret Jamieson: The minister will not be surprised by my question, as it refers to my old hobby-horse of the tick boxes of the performance assessment framework. Will the framework include a box to deal with the issues that Mary Scanlon has raised, or will you drill down lower? The current performance assessment framework refers to the NHS system, which is fine and good. However, the attitudes of the people about whom Mary is speaking can be somewhat at odds with the direction in which everyone else is moving.

Malcolm Chisholm: We are developing indicators for public involvement as part of the performance assessment framework. However, I hope that those will not be of the inadequate tick-box variety to which Margaret Jamieson refers.

The performance assessment framework must engage with the issue of consultation, because the framework is the overarching means for assessing and monitoring what is happening in the health service. In principle, I agree with Mary Scanlon. If something is happening that should not happen, we want to pick that up. It is more difficult to pursue specific comments—those may be picked up in the way that the member has just suggested, through quotation.

The Parliament and the Executive are very good at consulting on new policies. Some people would say that we consult too much, as consultation makes the process take longer. However, we carried out a pre-consultation exercise on new structures for public involvement, which did a great deal of the groundwork for the proposals that we will present in a formal consultation paper on the issue. I hope that the paper will be published next month. In particular, it will discuss the role of health councils. We propose to retain local health councils but also to establish a Scottish health council, which would be independent of the Executive.

The details of what is being proposed can be changed after we hear people's views, but the idea is that the Scottish health council should oversee consultation to ensure that it is carried out properly. We propose that that council should have a variety of other roles—in monitoring, supporting public involvement developments, helping individuals to secure feedback and so on. It would be a good idea if the Scottish health council had a role in the performance assessment of each NHS board, so that it could give an external view on how public involvement was being conducted.

The Convener: It is not surprising that exactly the same point was made by the Scottish Association of Health Councils in its submission to us. That is an example of consultation in action.

Helen Eadie: The area that I represent falls between Dunfermline and Kirkcaldy—it does not include either town. The minister will be aware that there are five constituencies in Fife. He may be surprised to learn that the health board in Fife failed to arrange any meetings in Dunfermline East constituency as part of its formal consultation process. A meeting was arranged only after I made representations to the board.

The clinicians and public in the area feel that their views are not being taken on board. Clinicians and health service professionals are telling me that the board has instructed them to keep quiet. That conflicts with what the minister said about the opinions of front-line service staff mattering. How do we prevent the gagging of health board staff?

I will offer the minister some advice about the health service in Fife—if I may be so bold. In Fife it is accepted that acute services need to be centralised. However, Fife NHS Board does not accept that medical services should be split from the main hospital that you propose in Kirkcaldy.

The clinicians and public in Fife have suggested that medical services should be in one area and that surgical operations should be carried out by the acute service in the other area. The proposal has not even been considered. However, I have tried to grow opinion in that area. As you pointed out, we should take a less conventional approach to consultation by working with people at the grass roots and asking them what is acceptable. That does not seem to be happening in Fife.

The Convener: Some clinicians have occasionally been critical of developments. In fact, many comments appear to have been clinician led. Father Dunn mentioned some examples of clinicians who have said something very different.

Malcolm Chisholm: As Helen Eadie knows, I have not proposed anything for Fife, and I am still waiting to receive details of proposals for Queen Margaret hospital. I will then consider the whole range of views that she has mentioned this morning. As a result, it would not be right to reply in too much detail to her question. I suppose that the points that she has raised in relation to Fife can still be taken into account. However, I am able to say that, in general, the process on which Fife has embarked has positive features, and that impression has been confirmed by written evidence that the committee has received. Obviously, her other points can also be investigated.

It is right to suggest that clinicians have differing views, and it would be wrong to gag them. I am certainly aware that GPs in Dunfermline have spoken out and that clinicians have expressed differing views about what is happening in Glasgow.

Janis Hughes: The draft interim guidance on consultation, which was published in May, specifically mentions the mechanism for consulting local people, staff and other interested bodies. I am particularly interested in the word "engaging", which you have already used. "Informing" is one thing, but the term "engaging" indicates more of a two-way process involving dialogue that might lead to some result. The crux of the matter is that, although there was consultation, nothing apparently changed as a result. How will the engagement process work? Do you have any thoughts—apart from those in the draft interim guidance—about how we move things on?

Malcolm Chisholm: You have raised a critical difference. When I used the word "permeability" in

winding up the debate two years ago, most people looked at me blankly and thought that I had taken leave of my senses. However, I was trying to suggest that NHS boards should be open to ideas and suggestions instead of acting as a big barrier that refuses to let things pass. Belatedly, I have been able to explain what I meant.

We have tried to take that concept into account in the new guidance. The old guidance is explicit that people should simply be informed of decisions. However, it is very important that we engage and listen to what people are saying. As a result, we are talking about a more formative process.

Although it is not terribly visible at the moment, we are carrying out a lot of work with boards to ensure that they learn how to engage. We are certainly not working from the assumption that they already know how to do so. Why should they? The old guidance never asked them to engage with people. This stuff is all fairly new.

All the designated directors of public involvement across Scotland met representatives of the department in the last week of August, and a lot of training and engagement—I am sorry to use that word again—is being undertaken with them. Furthermore, a toolkit of methodologies was published last year. Through training, we are seeking to attune the service to the new way of doing things. We should not expect that to show up in a sudden culture change, although that is what we have to aim for.

Perhaps I come across as being over-optimistic. Part of me believes that if we conduct an exercise properly, we will achieve greater consensus than has been achieved in the past. I suppose that that will not happen sometimes and that no matter how much we talk about the problems, sometimes people will disagree.

The issue of the secure care unit may be the most dramatic example of that. Various people have agreed that, at this stage, there is no area of Glasgow in which local people will say that they want the unit. The experience in Edinburgh has been totally different, for whatever reason. When we are confronted with such a situation, we have to say that there can be no veto over a service that is required. Logic dictates that, if a service is necessary but no one wants it to be located in their area, we have to go against majority opinion. The secure care unit illustrates that difficulty starkly, but similar situations might arise in connection with other service changes.

Dorothy-Grace Elder: Could you clarify whether the fact that a consultation was flawed should be grounds for appealing a substantive decision made by an NHS body on service reconfiguration? Does the Minister for Health and Community Care have a role in arbitrating on any such complaints?

Malcolm Chisholm: At present, one of the issues that a minister would have to consider would certainly be the consultation procedure. It may be appropriate to give that role to the new, independent Scottish health council. We will want to consider that as part of our consultation. It is right that someone takes a view, because if a consultation procedure is totally flawed, the conclusions that are arrived at will not hold much credibility.

Dorothy-Grace Elder: Are you saying that a hospital plan could be wiped out later, if the consultation process was found to be seriously flawed?

Malcolm Chisholm: The new guidance says that a body would have to go back and do the consultation better. I am not necessarily saying that the plan would be wiped out—I am saying that one would have to consider whether the consultation had been adequate. To an extent, that is what happened in Glasgow. The report of the Health and Community Care Committee was one of the factors that led to a new round of consultation on Stobhill. That plan was not wiped out, but the health board had to do the consultation again—but better—although people have expressed different views about the second consultation this morning.

Dorothy-Grace Elder: My last question is a brief one. Have you been concerned or disturbed to hear some of this morning's evidence from members of the public who have worked hard on hospital campaigns—over seven or eight years in some cases—and who have come out the other end without feeling that their views have been taken into consideration? You referred to the situation in the 1970s, when the public was not consulted at all. From the evidence that you heard today, is the result any different, given that the consultation was held to be a sham?

Malcolm Chisholm: I have already indicated that I think that decisions about secure care units throw up particular difficulties. We all recognise that that is the case and that we would have a problem if we were to listen to opinion from every local area, because there would be nowhere for such units. Obviously, there are wider issues around the Stobhill situation, which we discussed last week. We have to listen carefully to people in Stobhill but, equally, we must listen to people across the greater Glasgow area when we make those decisions.

Dorothy-Grace Elder: Are you concerned that people feel quite wounded by the experience and that they feel excluded?

The Convener: You have put it on record that

people feel excluded, Dorothy-Grace. I want to try to finish the meeting by 1 o'clock, when, as you know, we will have a briefing on the Mental Health (Scotland) Bill.

Dorothy-Grace Elder: Fair enough.

The Convener: Bill Butler will ask the final question, on behalf of his friend Paul Martin.

Bill Butler: Thank you, convener, but I will ask this question on behalf of the committee. Is the Executive minded to support the proposed bill on health boards' requirement to consult, which was lodged by Paul Martin on 7 January 2002? Does the Executive think that it is a helpful bill?

Malcolm Chisholm: NHS boards should certainly be required to consult—indeed, according to our guidance, they should do a lot more than simply consult. The more controversial aspect of Paul Martin's bill is the right of appeal to a sheriff. We query whether a sheriff is the most appropriate person to whom an appeal should be directed. I have already indicated that it might be more appropriate for a body such as a Scottish health council to deal with appeals, given that it will be independent and will have expertise. Of course, I do not want to cast aspersions about sheriffs, but—if I may put it this way—it is clear that health consultation is not their area of expertise. The idea of having a body to which people can appeal is a good one, but appealing to sheriffs is probably not the right approach.

Bill Butler: Is your answer no?

Malcolm Chisholm: I have already indicated that the Scottish health council would fulfil that role better than a sheriff could.

The Convener: Do you accept the need for an appeal procedure somewhere in the system?

Malcolm Chisholm *indicated agreement*.

The Convener: Thank you. I ask the minister not to leave yet—I am thanking him only for his evidence on consultation in the NHS at this stage.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 11) (Scotland) Order 2002 (SSI 2002/388)

The Convener: Before I let the minister leave, I move on to item 4, which is the emergency affirmative instrument on amnesic shellfish poisoning.

Malcolm Chisholm: I have a feeling of déjà vu.

Today's debate concerns the emergency order to ban the catching of king scallops in waters off the west coast of Rum. The order prohibits the harvesting of king scallops and has been triggered by the finding of levels of amnesic shellfish poison above the action levels set by Europe. The order is a consumer safety measure—scallops that contain high levels of the toxin can cause illness in humans, ranging from dizziness and headaches to extremes such as paralysis, coma and death if a large amount of toxin is ingested.

I move,

That the Health and Community Care Committee, in consideration of The Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 11) (Scotland) Order 2002, recommends that the order be approved.

The Convener: The Subordinate Legislation Committee has nothing to report and we have received no comments from members. Are we all agreed to the motion?

Members *indicated agreement*.

The Convener: That concludes the public part of the meeting. We now move into private session for a briefing on the Mental Health (Scotland) Bill.

13:01

Meeting continued in private until 13:59.

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