PUBLIC PETITIONS COMMITTEE

Tuesday 22 May 2001
(*Morning*)

Session 1

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PUBLIC PETITIONS COMMITTEE
8th Meeting 2001, Session 1

CONVENER

*Mr John McAllion (Dundee East) (Lab)

DEPUTY CONVENER

*Helen Eadie (Dunfermline East) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
Dr Winnie Ewing (Highlands and Islands) (SNP)
*Rhoda Grant (Highlands and Islands) (Lab)
John Farquhar Munro (Ross, Skye and Inverness West) (LD)
*John Scott (Ayr) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Maggie Boyle (North Glasgow University Hospitals NHS Trust)
Mr Eric Drummond
Mr Iain MacSween (Scottish Fishermen's Organisation)
Fiona McLeod (West of Scotland) (SNP)
Paul Martin (Glasgow Springburn) (Lab)
Chris Spry (Greater Glasgow Health Board)

CLERK TO THE COMMITTEE

Steve Farrell

ASSISTANT CLERK

Jane Sutherland

LOCATION

The Hub

Scottish Parliament

Public Petitions Committee

Tuesday 22 May 2001

(*Morning*)

[THE CONVENER *opened the meeting at 10:01*]

The Convener (Mr John McAllion): Welcome to the eighth meeting of the Public Petitions Committee in 2001. We have received apologies from Winnie Ewing and John Farquhar Munro. I ask people with mobile phones or pagers to turn them off, as they interfere with the sound system.

Stobhill General Hospital

The Convener: The first item on the agenda is petition PE354, from Councillor Charles Kennedy, concerning the removal of acute medical and surgical services from Stobhill general hospital. At our previous meeting we considered a response from Greater Glasgow Health Board. Specifically, we discussed the process of consultation that the health board and the local trust are undertaking—how they are involving local representatives and taking on board local concerns.

At that meeting, the local member, Paul Martin, raised a number of concerns about the consultation process. In particular, he said that the North Glasgow University Hospitals NHS Trust is about to embark on a consultation exercise on the future of specific acute services currently provided at Stobhill. He also said that at a recent meeting he was told that the option detailed in the health board's letter to us, which would have seen Glasgow royal infirmary closed and Stobhill rebuilt as the sole hospital for the north and east of Glasgow, was unrealistic and would be discounted.

In response to those concerns, we asked Greater Glasgow Health Board and the trust whether they would send representatives to this meeting to answer questions. I welcome Chris Spry, the chief executive of Greater Glasgow Health Board, and Maggie Boyle, the chief executive of North Glasgow University Hospitals NHS Trust. I thank them for their positive response to our request to attend this morning's meeting.

Before I take questions from members, I remind them that it is not for this committee to intervene in the executive decisions of health boards or to question the suitability of any of the options or proposals that they suggest. Our concern should be to establish that the processes being followed by Greater Glasgow Health Board are appropriate as regards local community involvement and that local concerns are being taken into account.

I invite Chris Spry and Maggie Boyle to make a short statement to the committee.

Chris Spry (Greater Glasgow Health Board): I would like to comment, first, on what we see as the focus of the petition; secondly, on the position of small specialties; and thirdly, on the point that was made at your previous meeting about the possible closure of the GRI. It may help the committee if I say something on those three issues.

When we received the petition, it seemed to us to relate explicitly to the strategic future of Stobhill. During the consultation period so far, the role of acute general medicine and acute general surgery has been at the heart of the debate about Stobhill's long-term future. It seemed to us that the Public Petitions Committee had taken a similar view, because the questions that you put to us focused on the strategic issues—on the consultation process, options, the role of the reference group and the status of the proposals. That is why our reply of 2 May to the committee also focused on those issues. In it we described how our thinking had moved on the substantive issues during the past year. We also said something about the process that we were putting in place to resolve the still unresolved issue of the strategic future of Stobhill general hospital.

In the past few months, we have been worrying away at three principal specialties. The first is elective orthopaedics, which has 17 beds at Stobhill. There are also two beds for ophthalmology and six beds for ear, nose and throat patients. In December, when the health board reviewed the outcome of the consultation to date, it said that it was difficult to see how those small specialties could be sustained in the face of severe pressure on doctors' hours. The board agreed to ask the trust to produce consultation proposals.

Since then the trust has been considering the issue. The board and the trust have been hesitant in dealing with this matter, as we recognise that proposals relating to the immediate future of small specialties would be interpreted as significant for Stobhill's strategic future—although we would argue that they are not. We were heartened by the fact that in January the Stobhill medical staff association recognised the need to consolidate small specialties. In early May, the orthopaedic surgeons confronted us on the issue, saying that it needed to be addressed. However, we have always maintained that none of the small specialties can be moved without specific public consultation.

The small specialties are not strategically significant. Orthopaedics has 17 beds, ophthalmology two and ENT six. Such numbers do not influence strategic choices about the future of Stobhill general hospital. In 1999-2000 there were about 23,800 in-patient cases at Stobhill. Of those, about 18,500—77 per cent—were in general surgery, general medicine and care of the elderly. That gives some indication of the strategic significance of those three specialties. In the same year, orthopaedics had 706 in-patient cases—3 per cent of the hospital's in-patient work load.

Of the four strategic options that have still to be examined as part of the process that we have initiated, two would locate orthopaedics at Glasgow royal infirmary and the other two would retain it at Stobhill. Orthopaedics might move to Glasgow royal infirmary in the short term, to deal with a medical staffing issue, but if one of the two last options for the long-term future of Stobhill were selected, it would move back to Stobhill in several years' time as part of a general realignment of services.

My final point relates to the closure of Glasgow royal infirmary and whether that is a real option. The suggestion was first made to us by members of the public during the consultation period between the summer of last year and December. Because it had come to us from the public, we felt that it should be examined as part of the option appraisal that we were setting up, with exactly the same rigour and transparency as any other option. Our view is that that is what listening to consultation is all about—it is about taking on board what people are suggesting; it is not about applying our own values to those suggestions, but about saying, "That suggestion has been made and it should be considered in the same way as any other."

Closure of the royal infirmary is also the closest realistic approximation to another suggestion that people have made from time to time, which is that a greenfield site should be chosen in north Glasgow for a new hospital—in other words, that Stobhill and the royal infirmary should not be used, but a new hospital should be built on a totally new site. The economics of that suggestion would be a deadweight against it. Shutting the GRI and concentrating on Stobhill would be a cheaper and more efficient option, and that suggestion is still of interest.

Those are the three areas that were raised at the previous meeting on this subject. I hope that that is helpful in setting the scene for the committee.

The Convener: Thanks very much. Paul Martin and Fiona McLeod are here. They are not members of the committee, but they have a keen local interest in the issue.

Paul Martin (Glasgow Springburn) (Lab): Can you clarify that the four acute services that you propose to conduct further consultation on, including urology, are, in fact, acute services?

Maggie Boyle (North Glasgow University Hospitals NHS Trust): Yes, they are. When I spoke to you, Paul, I said that we were considering consulting on a number of specialties. As Chris Spry said, we gave thought to whether we were in a position to do that. We have now narrowed our options to three of those specialties and urology is not one that we are discussing at the moment. ENT, ophthalmology and orthopaedics can be described as acute services, as they are carried out in an acute hospital setting.

Paul Martin: Those services were included on page 13 of the acute services strategy, which was launched in 2000. Regarding the proposed concentration of services at Glasgow royal infirmary, the document asks:

"Are there any persuasive and practicable alternatives to this solution?"

However, you are proceeding to consultation without allowing the acute services review to reach its conclusion, which will be published in September.

Maggie Boyle: Following public meetings and meetings with our clinicians and staff, the medical staff association and the clinicians at Stobhill concluded that the future of Stobhill lies in acute medicine and acute surgery being retained there. However, it was acknowledged that we would be unlikely to be able to sustain the smaller surgical sub-specialties at Stobhill even in the short term. The recommendations of the acute services review will take between five and seven years to implement; we cannot continue to run those services on the Stobhill site for five to seven years and still provide effective patient care and the best service. That is why smaller surgical sub-specialties were taken out of the mainstream debate that we were having about medicine and surgery as the main services to be retained on the Stobhill site.

Paul Martin: Can we clarify the point that on page 13 of "Modernising Glasgow's acute hospital services"—

Maggie Boyle: I am sorry, convener, but I do not know which document the member is referring to.

The Convener: Which document are you quoting?

Paul Martin: I am reading from "Modernising Glasgow's acute hospital services", the document that was published by Greater Glasgow Health Board.

Maggie Boyle: Is it the September document or the December document that was sent to the Executive?

Paul Martin: It is the original document that was launched by Greater Glasgow Health Board.

Maggie Boyle: At the start of the consultation?

Paul Martin: Yes, on 29 December 2000.

Maggie Boyle: I do not have that paper in front of me.

10:15

Paul Martin: I appreciate that. The point that I am making is that it was originally decided that four of those services in the Greater Glasgow Health Board area would be subject to the full acute services review.

Maggie Boyle: The acute services review is a vehicle to enable us to consult the public about the provision of services in Glasgow. I do not think that it will ever be a concise enough process for us to be able to delay changes until the review is concluded. Even when the document was launched, there was never a suggestion that we would leave all services in Glasgow untouched and unchanged for seven years, until new facilities were available.

We extended our first round of consultation because people felt that they had not had the opportunity to make all the comments that they wanted to make. At the end of that first round, we believed that there was a general consensus that the smaller sub-specialties could not and should not be sustained at Stobhill. That is the basis on which we thought that we should proceed, while recognising the bigger issue concerning medicine and surgery on which we had reached no general conclusion with either the public or the medical staff association. That bigger issue is still the subject of debate and will be dealt with as part of the option appraisal.

Paul Martin: Nevertheless, the point is very clear:

"Are there any persuasive and practicable alternatives to this solution?"

The public were being asked their views on 29 December. The debate will not have had the opportunity to take its full course until the outline business plan is submitted to the minister in September.

The Convener: Let us be clear about this. Are the public being consulted on the small sub-specialties?

Maggie Boyle: Absolutely. That is why I have difficulty with Paul Martin's comments. A large part of what is proposed must be subject to a wider debate, but there are some patient services on which we believe we can reach agreement, and we are consulting the public on the proposal to move those services earlier. That is the purpose of the exercise.

Fiona McLeod (West of Scotland) (SNP): We are considering the consultation process, which we hear is now fluid, with consultation being undertaken on sub-specialties that were not in the original consultation. Are there any other specialties at Stobhill that you may have to consult on, with the intention of moving the departments to the Glasgow royal infirmary?

Chris Spry: I shall try to unpick that a bit. This is incredibly tortuous; a complex set of choices is faced by hospital services in Glasgow.

Right from the beginning, we differentiated between the strategic significance of medicine and surgery and care of the elderly. Either they will remain and Stobhill will provide those services for its local catchment area, together with ambulatory care services and so on, or alternative or additional facilities will be provided at the royal infirmary to allow a concentration of those specialties. That is a fundamental strategic choice. Services could not be moved to the royal infirmary until we had built another ward block there. That would be a long-range strategic choice and the move would not take place next week or next year. We have been clear about that all along. The issue remains unresolved and is a matter of deep passion in the local community. We have put in place a process to examine those issues in a transparent way that is inclusive of public representation and gets at the essence of the problem.

The smaller specialties such as orthopaedics, ENT, ophthalmology, urology and gynaecology are much less in numbers than medicine and surgery. Increasingly in modern hospital practice, such specialties are based in all district hospitals. For example, there are three large hospitals in north Glasgow—the Western infirmary, Glasgow royal infirmary and Stobhill—and we would expect there to be only one ophthalmology in-patient unit, one urology in-patient unit and one ENT in-patient unit. Not every hospital has smaller specialty units.

We have said consistently that smaller specialties cannot wait for long-term capital investment to resolve their problems. The building of new hospital facilities will take years. The problems facing orthopaedics, ophthalmology and ENT units are here and now. They concern medical staff and the difficulty of providing cover when there is a small number of beds in a particular hospital. We must find a way forward for those specialties. We have said continuously that we want clear, worked-up proposals. How can it be explained to the public that cover is a problem?

To use a radio analogy, it is worth thinking about consultation and a long-wave strategy for medicine, surgery and the number of hospital sites in Glasgow. Short-wave proposals concern small surgical specialties that cannot wait for the big capital investment that is associated with long-wave strategy.

The Convener: Will the consultative process that you have set up to deal with the long-wave strategy be used to deal with the short-wave strategy, too? Will the reference group be involved in the short-term consultation process?

Chris Spry: We do not expect that to happen. We set up the reference group mechanism to deal with long-wave strategic choices. Because of their tenuous medical cover, some smaller surgical specialties are more critical than others. For example, urology and gynaecology at Stobhill do not face the immediate pressure of inadequate medical staff cover that is faced by orthopaedics. We could comfortably sit specialties such as urology and gynaecology in the long-wave consultation process and let that work through. A pattern will emerge and proposals can then be implemented. Short-wave proposals can be implemented quickly because they do not require large capital expenditure.

The particular problems facing orthopaedics mean that we cannot spend another few months trying to resolve them because its difficulty with medical staff cover is here and now.

The Convener: How will the consultation process on orthopaedics be conducted?

Chris Spry: We included some proposals for orthopaedics in the document that we produced in September, which was subject to widespread public consultation. In December, when we reviewed the results of that consultation, the local health council, which has a specific role in such processes, said that it wanted additional information about staffing and cost implications. It did not think that those matters had been covered sufficiently in September. The health council said that if that additional information could be provided, it would be content to take a fast-track approach towards reviewing such issues.

We have done that successfully on the south side of Glasgow: we had a fast-track consultation on increasing the number of general medical beds at the Victoria infirmary; concentrating breast surgery from the Southern general and the Victoria into one unit at the Victoria; concentrating vascular surgery at the Southern general when there had been two units; concentrating haemato-oncology, which is leukaemia services, at the Victoria instead of them being split between the Southern and the Victoria; and concentrating gynaecology at the Southern.

We have been through a raft of public consultation on that. There was widespread agreement that the service benefits to patients justified making those moves, even though the long-range strategic choice about the south side, whether the new hospital should be at the Southern general or at Cowglen, is still to be dealt with by the equivalent reference group process south of the river.

Helen Eadie (Dunfermline East) (Lab): I apologise for coming in late, after you had started giving your evidence. I had transport problems coming in from Fife.

The consultation process has concerned me most each time we have had this matter brought before us. We are all aware that there are many ways to carry out consultation. I know that you have set up the reference group, but can you outline more fully the consultation process that has taken place? Have you used citizens juries and focus groups?

Chris Spry: It is fair to say that we have been learning as we have gone along. Everybody's expectations on consultation have moved significantly compared with what they were two years ago and they are still moving. If I were asked, "What would a perfect form of public consultation be?" I am not sure that I would know and I am not sure that anyone really knows.

We have so far used a series of public meetings. We have had smaller meetings with, for example, community councils, meetings with the local health council to discuss the issues, and a wide range of meetings with clinicians and NHS staff. We have also tried hard to produce information on the changes in plain English and in readily accessible small booklets rather than the usual A4 document the size of a telephone directory which the public sector has a habit of producing. We have tried to make the issues more accessible and easier to understand.

We have taken the thinking out on the road. Progress has been made on some important matters. For example, there is now widespread agreement that there should be one hospital south of the river. That is quite a breakthrough as agreement on that did not exist a few years ago. It became clear in December that the controversy is where the hospital should be. We have set up a process to examine that issue in a transparent way so that people can take part in it.

We have not used citizens juries or focus groups. Given the sequence of how one brings these issues into the public domain, the time to have done that would have been about 18 months ago. We might have done that if we had our time again, but we were where we were a year or so ago.

We have learnt that there is a dilemma about what to put into the public domain for debate and discussion. We made specific proposals for some parts of the city when we started the consultation last April, because we had done quite a bit of work on those matters. We had checked out the options and decided that one was better than another.

We had not done so much work on other parts of the proposals: we said, "Here are some questions." We started the Stobhill part of the consultation by asking questions rather than by making proposals. In the case of child and maternal health, we said that someone had suggested that we should consider whether to concentrate children's services on an adult site. We had not done much work on that, but we thought that it would be worth having a debate.

We found that when there were no worked-up proposals we got no comment back, because people did not quite know what they were reacting to, but that when detailed proposals are put out, people react to them, saying, "You've already made up your mind." There is a dilemma there that we have never really got to the bottom of.

10:30

John Scott (Ayr) (Con): What statutory powers will the reference group have? Where will it fit into the chain of command? In such a hothouse atmosphere, with long-wave and short-wave radiation and yet another group, we are in danger of having a greenhouse effect.

Chris Spry: That is true. On the basis of the consultation so far, the Scottish Executive health department has given approval for us to draw up outline business cases—which is a stage in the capital procurement procedure—for the west part of the city, where it is about bringing Gartnavel hospital and the Western infirmary together; the south side of the city, where the service model is clear and it is just a question of where it should be; and the north and east of the city, where we do not have agreement on a service model. In the case of the north and east, whatever the outcome is, one way or another, capital investment will be required. Drawing up those three outline business cases includes going through a process of option appraisal—weighing up the choices and so on.

The responsibility for drawing up the outline business cases lies with the NHS trusts. They will produce them and submit them to the health board, or—if it is after 30 September—to the unified board in greater Glasgow. If the unified board agrees with an outline business case and thinks that it is affordable and so on, it will forward it to the Scottish Executive. The formal statutory responsibility lies with the trusts to produce those business cases and the health board to sign them off. The reference group is there to assist the trusts in working up the option appraisal element of the outline business cases. Because the two principal reference groups—one for the south and one for the north and east—have MSP involvement and so on, it is clear that they are open and transparent. We cannot, as a health service, proceed covertly and without lights—it is all in the full glare of publicity. However, the formal statutory responsibility lies with the trusts and the health board.

John Scott: When are the first meetings of those reference groups?

Chris Spry: South Glasgow reference group had its first meeting last month. We have only just completed our discussions with the various political parties for the north and east reference group. We expect the first meeting of that reference group to be in June.

Dorothy-Grace Elder (Glasgow) (SNP): Will the business plan and the means of financing be exposed to the public at public meetings? Will there be open discussion on whether the financing is private finance initiative, public-private partnership or public funding, and will the differences between those be set clearly before the public? We are all aware of the massive weight of the petition—43,000 signatures really says something.

Would you be good enough to tell us what consultation has taken place over the many months about traffic and the availability of cars to some of the residents? A number of the patients we are talking about come from the poorest and most deprived and unhealthy constituencies in Britain, such as Shettleston and Springburn. Have there been any projections on an increase in the availability of car transport for people? At the moment, according to the statistics for Glasgow that I have seen, there has not been a considerable increase in the availability of cars to people in the north-east of the city. Is that a major factor in your general plans? If car ownership is not increasing—indeed, the Parliament is not in favour of it increasing much—the necessity for a more local hospital might be greater than ever, and will continue far into the future.

Chris Spry: The means of procurement will come into the public domain, because the outline business cases will need to show a public sector comparator. We will have to show what the model would look like if it were a PPP procurement and what it would look like if it were a public sector procurement. The reference group will be privy to all of that detail and will have overseen the process by which those numbers are worked up.

Dorothy-Grace Elder: Will the means of procurement be discussed in public meetings

beyond the reference group?

Chris Spry: We need to discuss that with the reference group. The option appraisal process will require the definition of some benefits criteria—whether certain options improve patient care and access and so on and in what way they do so—and the weighting of those benefits. We will have to determine whether access is more important than quality of service or vice versa, for example. As part of the option appraisal, we will also have to measure the options against financial considerations, an economic analysis and a risk assessment.

We expect that there will need to be a workshop, which will come up with a definition of the benefits criteria and how they will be weighted. We are advised that that should be done on a Glasgow-wide basis. In other words, the criteria for hospital redevelopment should be the same across Glasgow. We have discussed that with the south reference group, which has agreed that that should be so. We will need to discuss it with the north and east reference group to find out whether it takes the same view. After we have done that, we will have another workshop, at which we will measure the options against the criteria. Our expectation is that we will agree with the reference group who should be involved in those workshops. We expect that members of the public would be involved, but we need to discuss how to identify those members of the public.

Dorothy-Grace Elder: I must point out that a workshop is not the same thing as a public meeting. In view of the huge amount of public interest in the deals and whether the public are getting best value, could you assure us that you will put the financial arrangements and comparisons before full public meetings that would include representatives of, for example, relevant trade unions?

Maggie Boyle: There is sometimes a perception that we exercise choice on whether to finance privately capital investment in the health service or whether to opt for Treasury funding. There is also a perception that it is more expensive to get private money than Treasury money. As we do not exercise that choice, I do not know that there would be much benefit in putting the issue into the public domain in the way that you suggest. It would be helpful if you could explain what it is that you want us to put in the public domain. Chris Spry has described a process by which we can help people to understand that we determine what investment is required and what it would cost to raise that money from a private source as opposed to a public source. In a sense, we are governed by policy decisions, and the Treasury has determined that it would prefer that public funds were spent on equipment and small capital investments in the health service and that PPP arrangements were used to pay for large capital investments. We cannot influence such policy decisions.

The Convener: We are straying into a debate on the politics of the issue. The Public Petitions Committee is here to ensure that the public are properly involved. The reference groups have MSP representation, and there should not be a problem about the information that they are receiving getting into the public domain. If I know MSPs in Glasgow, they will make sure that it gets into the public domain.

Chris Spry: Can I pick up Dorothy-Grace Elder's point about traffic? We are in the process of appointing traffic and transport consultants, who will do a full analysis of the traffic and transport issues for all the options across Glasgow. That will ensure that thorough professional information is available for all the processes, so that access issues can be taken into account as part of option appraisal.

The Convener: We have an extremely full agenda this morning, and I would like to bring this part to a close. I will offer the two Glasgow members a final chance to ask questions.

Paul Martin: The reference group is important. Earlier, the option of closing Glasgow royal infirmary was discussed. I am asking Mr Spry for a clear yes or no answer. Would he close Glasgow royal infirmary if the reference group recommended that? Can I ask Maggie Boyle whether she would support that proposal? Would she recommend that to the Scottish Executive?

Chris Spry: The reference group has the job of overseeing the option appraisal process. If the option appraisal process came up with an analysis that showed that closing the infirmary was the best option, that is what the health board would have to consider at that time. I do not want to prejudge the outcome of the option appraisal. It is a very technical process. People might have all sorts of hunches and expectations, but the important thing is that we must honour the process, given that we have put it in place. If the process produces an answer that people find surprising, but the answer is well worked out, we must take it seriously.

Paul Martin: My question was very clear. Would you recommend that to Greater Glasgow Health Board?

The Convener: Mr Spry has said that if that is the recommendation, he would have to go with it.

Paul Martin: Would it have the chief executive's recommendation? That is what I am asking about.

Chris Spry: I would not make a recommendation that was divorced from the outcome of the option appraisal.

The Convener: We are interested in the process. We cannot jump to the argument about the conclusions that come out of that process. That is a matter for local decision—it is not for the Public Petitions Committee.

Fiona McLeod: Mr Spry said that he would honour the process. Could you explain to us more fully the membership of the reference group? So far, you have mentioned only MSPs. Can you tell us who the other members of the reference group are and how you have sought those members? Will the new reference group have a stronger voice than that of the current group on the siting of a secure care centre?

Chris Spry: We have discussed the membership of the reference group with each of the main political parties. First, in March, we had a meeting with the Glasgow city Labour MSPs group. We shared with them our concern about constructing the reference group. When we considered the number of local authorities and community councils that had an interest, it was clear that we might end up with a cast of thousands. That is not a dynamic that can do business. The suggestion that came out of that discussion was that we should work closely with MSPs. The group of Labour MSPs came up with four suggestions on their MSPs who should be involved. Those MSPs are Paul Martin, Frank McAveety, Pauline McNeill and—

John Scott: Sandra White.

Chris Spry: She is an SNP member. I was listing the Labour members. Patricia Ferguson is the fourth Labour MSP.

We then had a conversation with the SNP's health spokesperson, Nicola Sturgeon. As a result of that, Sandra White was nominated to the group. We have had discussions with the Liberal Democrats and the Conservatives. The agreement that we have reached with Robert Brown and Annabel Goldie respectively is that we will set up watching brief arrangements for them—that is because of their particular commitments. We have also been in touch with the Scottish Socialist Party about how we can involve it in the process.

10:45

That is the MSP component, but there is also a local health council component—the chair of the local health council will be involved. There will also be representatives of the Stobhill medical staff association, the Glasgow royal infirmary medical staff association and the staff partnership forums at Stobhill and the GRI. There will be GP involvement, and we will write to the local authorities asking how they want to be involved in the subsequent work, such as the option appraisal workshops.

Fiona McLeod: But at the moment you do not have specific names that you can put against the groups other than MSPs' names. That must cause problems in setting a date for the first meeting.

Chris Spry: The names for the other groups, which are mostly internal to the clinicians and so on, can be produced pretty quickly by the trusts. What took time was the completion of the discussions with the political parties.

The Convener: Thank you for taking the trouble to come and give evidence to the committee. You have been very helpful this morning—answering all the questions openly and honestly.

Before we move on to the rest of the agenda, we must discuss whether we believe that the evidence that we heard from the trust and the health board reassures us that sufficient weight will be given to local opinion in the process. It appears to me that there will be local involvement and that local points of view will be taken on board. The trust and the health board seem to be listening.

Helen Eadie: I agree.

Dorothy-Grace Elder: The approach of the health board and the officials has improved enormously—they have responded to the public outcry. At the beginning, Glasgow was given Hobson's choice, but now the board and the trust seem to be prepared to explore other avenues. However, overall, we are stymied by the fact that we are not working from a blank sheet of paper. The plan for the monster-sized hospital down in Govan is overshadowing the thinking of the health board.

Maggie Boyle: We are where we are.

The Convener: I am sorry, but we are now discussing how we should deal with the petition.

In my view, a local mechanism has been set up, which involves MSPs, local representatives from the health council and staff interests from both hospitals; the option appraisal process will go through their views. The petition should go to the reference group to be taken into consideration as part of the option appraisal.

John Scott: I agree with that. We could keep the petition live and stay in touch with what is going on. We could monitor the situation and if it transpires that people still feel that the option appraisal is not working out as it should, perhaps we could revisit the matter. In the meantime, there is an improvement on the previous situation, which is what the petition called for. Let us see whether that works.

The Convener: That seems to be the view of the committee. Do the two MSPs who are not members of the committee—Paul Martin and

Fiona McLeod—want to comment?

Paul Martin: I have already made the point that I believe that we have contaminated the process by reducing the four services and deciding to go to consultation on them. It is unfortunate that we have done that. Once again, I make the point that the trust should consider awaiting the outcome of the acute services review before going to consultation on those four services. It is unfortunate that we have contaminated the process in that respect.

I want to make a point in response to the comment that during the public consultation process there was some suggestion within my constituency and perhaps within the constituency of Fiona McLeod, that Glasgow royal infirmary should be closed. On no occasion did I hear anyone suggest that. Perhaps Fiona McLeod can give further information.

When we proceed to the completion of the acute services review in September, we will not have had a full and open consultation process. The petition does not ask the committee to take a view, but asks it to consider whether the public consultation process was carried out properly. I appreciate that the outcome of the review is not a matter for the committee.

Helen Eadie: If Paul Martin were in the position to make a recommendation, what would he recommend to the committee? We have been talking about the consultation process. I know that he is awaiting the outcome of the acute services review. Is he suggesting that further consultation be deferred? I am not clear about what he means.

Paul Martin: It is not for me to make a recommendation, but it is for the Health and Community Care Committee to decide whether the process was contaminated. To proceed to consultation on the four services was unfortunate and should not have happened. That was meant to be the view of the medical staff association.

Helen Eadie: If the committee said that the process was contaminated, what would we do then? What would Greater Glasgow Health Board do? As a local MSP, what would Paul Martin do?

Paul Martin: With respect, the issue is to ensure that the acute services review is carried out properly. Initially, I signed up to the consultation process, but I will not support it now because four services have proceeded to consultation.

The Convener: Each member has a right to take his or her position on matters, but the committee must concern itself with whether a local process has been set up to consult the people of Glasgow and local representatives. In my view, that has happened. The issues that Paul Martin raised about the separate consultation for the specialties can be dealt with locally by the reference group, and I am sure that it will deal with them. As a Parliament, however, we cannot become involved in decisions about the shape of strategic services in Glasgow. That is a matter to be decided by local representatives. Our job is to assure ourselves that the process is involving local opinion, and I believe that it is.

Dorothy-Grace Elder: Can we pass on the matter to the Health and Community Care Committee?

The Convener: No. We have already consulted the Health and Community Care Committee. It is reluctant to have the petition referred to it, because it would for ever be involved in all acute services reviews throughout Scotland. Each time people did not like something that was happening locally, they would drag the Scottish Parliament into such matters. Parliament cannot intervene. All it can do is satisfy itself whether a local democratic procedure is being followed and local people consulted. Unless evidence can be brought to my attention that that is not happening in Glasgow, we cannot do anything other than to pass the petition to the local mechanism for resolution.

Rhoda Grant (Highlands and Islands) (Lab): Many petitions that we receive are about public consultation and how that process has broken down. I accept that we cannot pass on the petition, but can we not write to the committee and ask it to examine ways in which communities can be consulted? It might be able to issue guidelines on consultation for public bodies. People often say that they have not been consulted properly. If either this committee or another committee took on such work, that would reduce the number of petitions that we receive.

The Convener: That is something which we can do as a committee in general, but not specifically in relation to this petition.

Dorothy-Grace Elder: I do not know about "in general", because this is the biggest matter of its kind in Scotland. It could be a flagship for the future and influence the way in which consultation is handled elsewhere. No one believes that orthopaedics can be moved from Stobhill to Glasgow royal infirmary for seven years and return. The public are still concerned that it is the usual plan of death by a thousand cuts.

The Convener: As we heard this morning, a local reference group made up of political and local representatives will consider the whole process and pass comment on it. It can influence matters. I do not agree that the group will not consider the petition properly. Indeed, it should consider it, as part of the process of looking at the appraisals for the north-east of Glasgow. I am sure that it will influence the outcome. The petition will

be sent to the group for consideration and action.

Fiona McLeod: I will be very brief. You say that you are satisfied on the evidence that you heard that the public consultation has been adequate.

The Convener: It will be adequate, once the reference group is set up.

Fiona McLeod: You said that you would need evidence to prove the contrary. Apart from inviting you to public meetings, it is difficult for Paul Martin and me to make you see that although on paper the consultation process looks adequate, in practice, it is not. It is not satisfying the needs of the public so that they feel that their views have been taken on board.

I have concerns about the reference group. We have not heard exactly who will join it or how it will perform its task.

John Scott: We have said that we will have a reference group of fairly strong-minded MSPs. We must have confidence in the local MSPs and give them their chance. We also said that we would be happy for them to return to us if they felt that the consultation process of which they had become an open and public part was inadequate. Give the proposal a chance.

The Convener: I thank the witnesses again for attending. It is my view that we should pass the petition to the local reference group that Greater Glasgow Health Board will establish and ask that group to take the petition into consideration as part of its appraisal of the four options that are available for north-east Glasgow. Is that agreed?

Members *indicated agreement*.

New Petitions

The Convener: The first new petition is PE365 from Mr Iain MacSween on behalf of the Scottish Fishermen's Organisation. The petition calls on the Parliament to review fixed quota allocations. Mr MacSween has three minutes to address the committee. At two and a half minutes, I will indicate that you have 30 seconds to go. Thereafter, I will open the meeting to questions.

Mr Iain MacSween (Scottish Fishermen's Organisation): Thank you. I hope that my petition will not be as contentious as the committee's first item of business was.

It is unnecessary to outline the difficulties that have faced the Scottish fishing industry recently. In an attempt to confront some of those difficulties, the Executive decided to implement a decommissioning scheme, to reduce the size of the Scottish fishing fleet. At present, each fishing vessel in the fleet has attached to its licence a number of units, called fixed quota allocation units. They are the quantities of fish that the vessel caught from 1994 to 1996.

Fixed quota allocations were introduced in January 1999 and are used to calculate the quotas that are allocated to the group to which the vessel belongs for quota management purposes. When fixed quota allocations were introduced, the minister responsible said that no trade in such units would take place and that individual transferable quotas, which would confer property rights on fishing vessel owners, would not be introduced.

Despite that, discussions on implementation of the decommissioning scheme seem to be moving towards a different policy approach. The Ministry of Agriculture, Fisheries and Food's view that fixed quota allocations attached to decommissioned vessels can be sold by the fishing vessel owner is likely to prevail. That will mean that fishing vessel owners who accept taxpayers' money to decommission their vessels can sell their quota units, presumably to the highest bidder. Property rights would be introduced into the Scottish fishing industry, which would allow quota and access to quota to be sold.

Fishing vessel owners from other European Union member states could then participate in that trade. That would end the protection that Scottish fishing grounds have enjoyed in the past 20 years, during which successive British Governments have attempted to restrict access to Scottish fishing grounds. That would be to no avail if foreigners could simply purchase such access by acquiring fixed quota allocations.

It is ironic that, as the review of the common fisheries policy—on which the European

Committee produced an excellent report—seems to be moving towards a more regional dimension, a policy could be introduced that would undermine that, by allowing other member states to buy access to British fishing grounds. That would mean that future generations of young fishermen would be precluded from the fishing industry, as they would not be able to purchase access to the grounds round the Scottish coast. Not only would the jobs of Scottish fishermen vanish, but the jobs in the processing sector would contract as foreign-owned vessels landed their catches abroad.

The ability of the Scottish Parliament, to which responsibility for fisheries was devolved, to exercise control over a vital industry would be lost. The industry needs decommissioning, but not a move to a situation in which Scottish quotas and access to Scottish grounds are put up for sale to the highest bidder. Fish stocks are a national resource, and should continue to be treated as such. It is the Parliament's responsibility to ensure that future generations of Scottish fishermen will continue to have access to the grounds round the coast, and the stocks therein.

11:00

Rhoda Grant: What do you want to happen to the quota to overcome the problem that you foresee?

Mr MacSween: The way in which the problem can be overcome is straightforward. At present, it is likely that the Executive will seek bids from fishing vessel owners who wish to decommission their vessels. In a sense, there are three components attached to the licence: the vessel, the licence, and the quota units. We believe that the quota units should be left within the total pool that is available to all fishermen in the United Kingdom, but there are a number of possibilities. One that we find attractive is that a special pool could be created whereby young fishermen could be given access to quota units to help them to gain access to the industry, because without young men coming into the industry, the long-term future does not look healthy.

Rhoda Grant: Would the system in Shetland, where the community owns the quota, work elsewhere? If communities owned the decommissioned quotas from their harbours, they would be able to lease them back to new entrants or existing boats.

Mr MacSween: The Shetland model sets an interesting example, but Shetland enjoys the considerable benefit that the community was able to fund such purchases with its oil fund. We have approached not only local authorities, but Highlands and Islands Enterprise with a view to replicating community ownership in other parts of Scotland, although to date, no financial assistance has been forthcoming. Without that funding, it is difficult to see how community ownership could be activated.

Rhoda Grant: But if quotas were included with the boat and the licence as part of the decommissioning package, one would imagine that they would revert to the Scottish Executive, and it would be for it to do—

Mr MacSween: That is right. There is an interesting model in Northern Ireland, where the quota units from decommissioned vessels will be left in the port from which the vessel is decommissioned. The system of central quota management is, in effect, based on regional groups, so if vessels in a particular group decommission, the quota units are left with that group, which ensures that the local community has access to the quota units. That is the preferred solution.

John Scott: Would not it make just as much sense to establish a Scottish quota reserve that was held by the Scottish Executive, given that it is the Scottish Executive that is funding the decommissioning? Precedent exists with regard to the common agricultural policy; there is a national reserve for sheep and cattle quotas throughout Scotland, which can be used to help new entrants to agriculture. I presume that it would be relatively easy to promote the same principle, so that a central quota reserve that was held by the Executive from the decommissioned boats could be used to allow new entrants into the fishing industry.

Mr MacSween: That is a good idea. Whether that was done on a national or a regional basis, it would achieve the same ends. Somehow, some form of pool of quota units must be retained to enable people to get access, otherwise the quota units will be sold.

Currently, the people with the greatest access to finance and acquisition are probably the owners of Spanish fishing vessels, due to the courtesy of the British Treasury, which paid them £80 million in compensation. It would be the final irony if Scotland's fish stocks were sold to the Spaniards who are funded by taxpayers' money, but such things happen.

John Scott: To whom do the quota rights belong at the moment?

Mr MacSween: That is an interesting issue. According to current Government policy, they do not belong to anyone.

John Scott: How then can the rights be sold?

Mr MacSween: The Ministry of Agriculture, Fisheries and Food in London wants to say that the quota units can be sold and, in a sense, a new

policy will be created. The industry would not have debated it. Such a decision would have been brought about by administrative convenience. By allowing them to be sold, property rights would be introduced into the industry. It would be a fundamental change to the current situation.

John Scott: I presume that there are two sides to the argument. If quota rights were sold, those who currently own de facto their quota rights would want the most money for them. If it were then said that that quota would be ring-fenced in Scotland, it would be of less value than if it were sold on the European market. Are you taking all the fishermen—the boat owners—with you in that respect? They will want the maximum value.

Mr MacSween: The fishermen do not own the quota. They acquired it. The Government gave them quota units as part of their day-to-day business. They were issued free, gratis and for nothing. The proposition that is beginning to emerge is that, having been granted those fishing rights, they should be allowed to sell them. The majority of people in the fishing industry are opposed to that because such a policy will decimate the smaller ports, particularly on the west coast. Large fishing companies will buy the quota access. Small west coast and north-east communities face horrendous prospects. Future generations will not be able to fish, but will see fishing vessels from other parts of the European Community fishing along their coast.

John Scott: If the quotas have no value, they can only be held centrally by the Scottish Executive and allocated as it sees fit.

Mr MacSween: The danger is that the sale of quota units from decommissioned vessels will create a market. Be under no illusion—quota units will have a value. Spanish fishing vessel owners have spent the past 17 years arguing for equal access to British waters. If they have to buy quota units to gain that access, they will do it. A value will emerge.

Dorothy-Grace Elder: The situation is fraught with new legal complications. I wonder whether the removal last year from the jurisdiction of Scots law of some 6,000 square miles of Scottish waters and fishing grounds has any bearing on the matter. Could some of the quotas be sold via England and come under English law? Now that the sea border has been moved so much further north, which country owns Scotland's fish?

Mr MacSween: The access to fishing grounds in south-east Scotland is a different matter, which is problematic. Under the Scotland Act 1998, a Scottish fishing vessel is defined as one that is registered in Scotland. However, many Scottish-registered fishing vessels are based in England, because the registry rules were different at one time. For example, half the North Shields fleet is registered in Buckie. It would be ironic if the money that the Scottish Executive thought that it had set aside to decommission the Scottish fleet was spent decommissioning vessels that are registered in Scotland, but based in England. Many legal difficulties lie ahead.

Helen Eadie: To what extent do Scottish fishermen purchase quotas in Spanish, French or other foreign waters?

Mr MacSween: They purchase none.

Helen Eadie: Nothing at all?

Mr MacSween: The rules effectively preclude that. I suppose that it is another case of us playing by the rules, while other member states do not. It is virtually impossible for a person to buy and register a fishing vessel in Spain if he is not Spanish. Danish law precludes people from other member states from doing that. The United Kingdom and Ireland are the only two member states that have a significant proportion of their quota held by non-domestic fishing vessel owners.

Helen Eadie: Can Danish and Swedish fishermen easily purchase quotas in France or Spain?

Mr MacSween: No. The practice within Europe of buying quota and access to fishing grounds has been concentrated in the United Kingdom and Ireland. Spanish, French, Dutch and even Icelandic fishing companies are located in the United Kingdom, all of which have acquired flag of convenience companies. By so doing, they have gained access to quota. If MAFF's proposal goes ahead, it will take such action one stage further because, under competition law in Europe, Spanish companies will be able to buy the quota units that had previously been attached to Scottish vessels and will be able to fish there.

The Convener: Thank you, Mr MacSween. We will now discuss what steps to take with the petition. Obviously, we will keep you informed throughout the whole process. Big issues are involved. As members of the committee will see, the suggested action is that we seek the views of the Scottish Executive on the petition before considering what to do next.

John Scott: If the Scottish Executive is at liberty to do so, I suggest that it consult MAFF.

The Convener: The suggestion is that we ask the Scottish Executive to consult MAFF as part of the response to the petition.

John Scott: Fine.

Helen Eadie: I support that recommendation, but I suggest that we pass on the petition to the European Committee for information only at this stage. I was interested to hear Mr MacSween's

feedback on the report of the European Committee. I was pleased to hear it because I took part in the inquiry and it is good to know that fishermen were pleased with the report. I do not recall our going into detail on the topic that is under discussion today, so I think that the European Committee should be aware of it.

The Convener: We shall pass the petition to the Scottish Executive and ask for its response. We shall ask it to consult MAFF. We shall send the petition for information only at this stage to the European Committee. Is that agreed?

Members *indicated agreement*.

The Convener: Petition PE367 is about services for the diagnosis and treatment of those who suffer from sleep apnoea. Mr Eric Drummond will speak to the petition. The usual rules apply, Mr Drummond. You will have three minutes to address the committee, after which time the meeting will be opened up to questions.

Mr Eric Drummond: Thank you, convener, for your prompt reply to the sleep apnoea clinic in the Lothians area in respect of the petition on sleep apnoea, and for allowing me to speak this morning. I have been a sleep apnoea patient since 1992. At that time, an appointment—a night in the sleep laboratory—identified that I had sleep apnoea. I went home with a sleep apnoea machine and, after two days, it was as though a miracle had happened. My health improved dramatically within three months.

I understand that, in 1992, 200 sleep apnoea patients were diagnosed per year. However, because doctors are now more aware of the problem, the number has risen to 1200 per annum. The health boards that use the Edinburgh royal infirmary for investigation and treatment are Lothian Health, Orkney Health Board, Shetland Health Board, Grampian Health Board, Tayside Health Board, Fife Health Board, Forth Valley Health Board and the Borders Health Board.

I understand that 30 per cent of patients are from the Lothians and that the rest are from other areas. I have corresponded with my MSP, Mr Iain Gray, regarding what is sometimes a two-year wait for patients and he is looking into the matter. However, the reason for the petition, which was organised by the Scottish Association for Sleep Apnoea, was that the Lothian University Hospitals NHS Trust had just sent out two letters, which the committee should have before it, that have made matters worse. Having already waited a longer time for an appointment then a test, sleep apnoea sufferers are now not getting a sleep apnoea machine at the time of diagnosis. They now have to wait in excess of six months, as per the letter that is before the committee.

11:15

I understand that all the health boards have taken the decision not to supply a sleep apnoea machine at the normal time—that is, at diagnosis. Sleep apnoea is not just a snoring problem. It is dangerous. Sufferers stop breathing when they sleep. That can result in brain damage and heart attack, which could be fatal. The sleep apnoea machine costs £230. Diagnosis requires one appointment and a night in the sleep clinic. If a patient were diagnosed positive, the modest financial cost of providing a machine would save money by reducing a sufferer's visits to their doctor.

Some sufferers are unable to work because of their condition. All sufferers are unable to drive. If driving had been their main employment, that would be an added problem to the patient.

Funding the increased demand on Edinburgh royal infirmary would seem to be a complex issue. I understand that an audit review is in progress which will, I hope, address the increase in demand and increase the service.

I ask the committee to consider those points along with the documentation that I have provided and to take action to encourage the health boards to treat the sleep apnoea clinic properly by funding it according to demand, to reduce waiting times for an appointment and test in the sleep laboratory, and, if required, to supply sleep apnoea machines at the time of diagnosis.

The Convener: Thank you very much, Mr Drummond. You made your statement well within the three minutes.

I will begin the questions. Is the clinic at Edinburgh royal infirmary a national clinic?

Mr Drummond: It deals only with patients in the areas that I listed. The west of Scotland has its own system.

The Convener: Is that system separate?

Mr Drummond: It is similar. I assume that Glasgow royal infirmary deals with sleep apnoea patients in the west of Scotland, but the areas that I mentioned are the ones that are dealt with from Edinburgh. Fifty per cent of those cases come from the areas that I mentioned and 50 per cent come from Edinburgh.

The waiting times for a first appointment have increased dramatically. I was involved in politics a number of years ago and one of my constituents waited for two years for the treatment that I waited three months for.

The committee must be aware that sleep apnoea is not just about snoring. I have nearly killed my wife and myself a couple of times when driving the car. I have written to Sarah Boyack and

Iain Gray to say that commercial drivers—lorry drivers and bus drivers—should be tested for sleep apnoea. They could have the condition and not know it. Consider the number of road accidents in which people say that the driver fell asleep. We could bet our boots that that would be something to do with sleep apnoea. It is crucial.

I am disappointed that the service in Edinburgh, which was extremely good, has deteriorated from the three-month waiting period that I had. I did not drive for three months when I was told after my first appointment that it was more than possible that I had sleep apnoea. Doctors recommend that sufferers do not drive. However, they are going further now, as the correspondence that I have given the committee shows. If a patient's test shows without doubt that they have sleep apnoea, they are told not to drive. If driving was a patient's job, that would be extremely difficult for them.

I heard this morning that a Grampian Health Board patient had a four-year wait. I have made the point that an appointment, a night in the sleep laboratory and a machine that costs £230 have improved my life dramatically. Without that, I would not be speaking to the committee today, I have to say, because I have other health problems. With those added to the sleep apnoea, I would have been in a box years ago, had it not been for the machine.

For some reason, the health boards have not been able to get their act together. They have failed to take account of the demand for treatment. The situation has been made worse by the recent decision not to give patients the machine on the day of diagnosis. That is the last straw.

Dorothy-Grace Elder: Thank you for appearing before the committee. Sleep apnoea is an important problem. As you say, it represents not only a disturbance to the person who suffers from it and to their bed partners, but a potential hidden danger to the general public, because of sufferers' excessive fatigue.

You mentioned that each machine costs £230. Approximately how many patients in Scotland need that equipment? Is it possible to issue it to them all, or are some not suited to it?

Mr Drummond: As far as I know, the number of sufferers has risen from 200 to 1,200 a year. Every year that number is increasing and more people are using the sleep laboratory.

Dorothy-Grace Elder: We are not talking very big bucks, even if there are 1,200 sufferers.

Mr Drummond: I do not think that we are. If members want a laugh, I can show them how the equipment works.

The Convener: We can always do with a laugh in this place.

Mr Drummond: I take this machine with me everywhere. Once I have put the mask over my head my wife knows that we are going straight to sleep.

Helen Eadie: Can I take a photograph for the *Official Report*? [*Laughter.*]

Mr Drummond: The machine blows air into the airways. I visit the sleep apnoea clinic once a year so that the machine can be checked. That does not cost very much.

Dorothy-Grace Elder: So the equipment that you use is long-lasting.

Mr Drummond: Aye. I have just had mine replaced after nine years. Occasionally I get a new mask, but in my view the equipment is inexpensive compared with some drugs and major operations. It should be fairly easy to provide.

Dorothy-Grace Elder: Are you saying that Scotland is going backwards on this issue, having been quite advanced in dealing with it, particularly in the Lothians?

Mr Drummond: There is no doubt that Professor Douglas in the Lothians is the leading authority on the subject in the UK. However, his staff numbers have not increased. I waited three months before being seen and was not able to drive for two months. Now the waiting time can be two years in some instances. Sometimes it is less than that—I do not know why. This morning I was told that a patient in Grampian waited for four years to be referred.

The Convener: Something is interfering with our sound system—perhaps it is the machine.

Mr Drummond: It will be my wallet. The machine has made a huge difference to my life. Two days after I received it, I rang the hospital to tell the doctor that I felt like a new man. People do not normally do that after an operation. All that I needed was sleep. That was in 1992. The bad news for some people was that I was able to go back into politics for a while.

Dorothy-Grace Elder: That should have sent you to sleep.

Mr Drummond: Without the machine, I would not have been able to do it. I was beaten in 1992 and people thought that that would be good for my health. However, my health deteriorated until I was given the machine, which made an unbelievable difference. People who suffer from sleep apnoea are still driving buses, which could lead to all sorts of problems. Sarah Boyack needs to look into the issue—there should be some sort of test. I tried to get something going when I had responsibility for policing in Edinburgh, but I was unable to follow it through because my health packed up. This is a major issue.

When the convener said that the committee cannot tell trusts or boards what to do, I wondered whether I was at the right meeting. The committee needs to bring this issue to the attention of someone who can fund the treatment that I have described.

There is an argument within Edinburgh royal infirmary that sleep apnoea can be treated another way—with a pill or something. However, I do not believe that. Professor Douglas knows the right approach to take and it must be properly funded. Without treatment, people will be off work and claiming welfare or they will be unemployed because they are unable to work. I was in a mess. I could not do a day's work without going into a car park to sleep. People do not think of telling their doctors that they are tired. I would be grateful if the committee could do something. The petition would have been larger but it was completed in only a week and a half. People are suddenly frightened when they have been diagnosed and are told that nothing could be done for them.

The Convener: Regardless of size, all petitions are treated seriously by the committee.

Dorothy-Grace Elder: If all 1,200 sufferers were issued with the equipment whether or not they wanted it, the sum involved would be just more than £0.25 million—unless my maths is way out. The cause must be given a higher profile. It is not just the money that is the problem—some health boards have to be re-educated.

Mr Drummond: The treatment is funded in a complex way, as a result of which Edinburgh receives a raw deal. I think that block money comes from other authorities and Edinburgh ends up with £300,000. The shortfall is causing the problem. Edinburgh considers that it is paying for sleep apnoea sufferers in other authorities, and the patients are caught up in the internal politics within the hospital. That is the issue.

The Convener: That is fine. If there are no more questions, we shall now discuss what action to take with the petition. Do not worry; the committee will treat it seriously.

The suggested action is that we ask both the Scottish Executive and Lothian Health to respond to the petition. We must ask, in particular, how the clinic in Edinburgh is financed. We must also send a copy of the petition to the Health and Community Care Committee for its information.

Rhoda Grant: I suggest that we contact Greater Glasgow Health Board to find out how it deals with the illness. It might not have a problem and a solution could be staring us in the face.

Dorothy-Grace Elder: Perhaps we could also ask the Executive if it has any indicators of provision throughout Scotland, although its usual reply to such questions is, "This information is not held centrally."

The Convener: It sounds from the evidence that we have heard this morning that there are two national centres, so we would expect the Scottish Executive to have such information.

Helen Eadie: I wish to say how nice it is to see Eric Drummond again this morning. I worked with him on the Edinburgh airport advisory committee. It is good to see him looking well. I support the recommendations, but do you, convener, consider it worth while writing to Fife Health Board and the Borders Health Board? It would be good to hear their views as well as the Lothian side.

The Convener: If we do that, we will have to write to 15 health boards. At the moment, there are two centres in Glasgow and Lothian. I think that we should ask them how the treatment is funded in other health board areas.

John Scott: The documents say that there is a six-month waiting list in Lothian before treatment is started. If other areas have shorter waiting lists, perhaps they can provide Lothian with a solution.

The Convener: I may have misunderstood the situation completely, but my understanding is that as other health board areas do not have their own sleep apnoea services, they send people to Lothian and Glasgow. There would therefore be the same waiting list for everyone.

John Scott: I have perhaps misunderstood the situation. I beg your pardon, convener.

The Convener: Thank you. Are we agreed on the recommendations?

Members *indicated agreement*.

11:30

The Convener: The next petition, PE363, is from Mr Stan Gregory. We do not have anyone to speak to the petition. Mr Gregory is calling for an independent consultation to be carried out to examine the structure and operation of Scottish councils. He is concerned that council taxes have increased as a result of increased administrative burdens on councils.

As members can see from the background research to the petition, the Local Government Committee is currently engaged in a major local government finance inquiry. In addition to that, the Scottish Executive, as part of its response to the McIntosh report, has announced the setting up of a leadership advisory panel. The panel will advise councils on reviewing their decision-making and policy development processes and the working practices that support those processes. The panel is expected to report next month.

Given that background, it is suggested that we request a response from the Scottish Executive on the issues that are contained in the petition. It is further suggested that we make a specific request for information on the progress of the leadership advisory panel and whether its report will address the issues that are raised by the petitioner.

Helen Eadie: I support that recommendation. The only concern that I have about the petition and the charter is that the charter is not set out in full. One of the major concerns with information technology and the digital world is that sometimes—

The Convener: You are addressing the next petition. We are discussing PE363.

Helen Eadie: I apologise.

The Convener: Are we agreed on the recommendation for PE363?

Members *indicated agreement*.

The Convener: The final new petition this morning is PE366 from Dr Andy McDonald, on behalf of Craigmillar Community Information Service. The petition calls on the Scottish Parliament to support its digital inclusion charter and asks the Scottish Executive to take a range of steps to tackle the problem of the digital divide.

In the petition, members will see the points that are made in support of the charter. As Helen Eadie says, the charter is not set out fully. However, CCIS gives an indication that it is looking for partnership with the private, educational and community sectors. It is interesting to note that petition PE366 was hosted for us on the international teledemocracy centre website. A lot of background on the petition is available to members if they would like to consult the clerks.

The suggested action is that we agree to seek comments from the Executive on the issues that are contained in the petition. We should ask whether the Executive's proposals and its digital Scotland initiative will address any of the issues that are raised in the charter by Craigmillar Community Information Service.

Helen Eadie: I can now make the point that I tried to make earlier. I am an enthusiastic supporter of IT. I am wholly behind anything to do with digital technology. However, one of my concerns, which I tried to raise in a motion but did not get support for from any MSP, is the issue of it being rare to reach a human being at the end of the telephone line when calling any of the public utility companies.

These days people have to go through various platforms: press asterisk; press 1; press 2. Ten buttons later, the person making the telephone call has still not reached the right person. Whilst I support digital inclusion, we have to ensure that people who are in the greatest need can access a human being. I believe that Scottish Power has a message on its machines that is activated by button 5 that says, "Sorry, we are too busy to deal with your inquiry. Please call back later." Are we going to get to a digital world where that happens on a universal basis? I support the suggested action that we seek comments from the Executive. I hope that someone will listen to an appeal from an ordinary human being who wants sometimes to talk to another human being in the world out there.

The Convener: I am not sure how we would handle Helen Eadie's appeal in relation to our consideration of PE366.

Helen Eadie: I will lodge another motion if the convener will support it.

The Convener: I am happy to support any motion that is lodged by Helen Eadie on that subject. I did not see her previous motion, or I would have supported it. The issue she raises is a real problem, but it is not part of the petition.

Helen Eadie: I was just being creative or inventive.

The Convener: Absolutely. You are tempted to be so.

The suggested action is that we ask the Executive to respond to the petition and ask specifically whether its digital Scotland initiative will address the points raised by the petitioners. Is that agreed?

Members *indicated agreement*.

Current Petitions

The Convener: We will now consider current petitions and responses that we have received to them.

The first response is to petition PE302 from Mr David Brown, on behalf of the Greater Glasgow Private Hire Association. The subject of the petition is private hire cars in Glasgow. We took the issue up with Glasgow City Council. The response from the council shows that we have a result. The council has agreed to include private hire cars in traffic regulation orders. That will allow private hire cars access to all existing bus gates, contra-flow bus lanes and with-flow bus lanes. Access by private hire cars will also be included in promoting new traffic regulation orders that give priority to public transport and include taxis.

The suggestion is that we agree to pass a copy of the council's response to the petitioners and take no further action. Is that agreed?

Members *indicated agreement*.

Dorothy-Grace Elder: I would like to pay tribute to the drivers. They occasioned the first demonstration to Parliament in June 1999 and they drove 129 cars through from Glasgow. They have spent £60,000 of their own money fighting the council over the past few years just to get access to the bus lanes. That is for everybody's benefit. There will be less traffic.

To some extent, large housing schemes are dependent on hackneys and private hire cars for getting people into town. The existence of this Parliament and the fact that the drivers could come back to the committee has been of benefit to those extremely hard-working people. I declare an interest in them. I know them and like them and many are from the east end of Glasgow.

The Convener: And they have a result.

Dorothy-Grace Elder: They have, but they have worked so hard. Why did they have to spend £60,000? It is not fair.

The Convener: That is in the past. At least they will be in the bus lanes in the future.

The next response is to petition PE334 from Tony Southall, on behalf of the Scottish Campaign for Nuclear Disarmament. The petition calls for a review of emergency planning measures for nuclear submarine accidents. The committee will recall that we considered the petition at our previous meeting but decided to postpone consideration because we were not entirely satisfied with one or two points.

Since then, we have received a response from the Executive that tries to clarify the situation in relation to category 3 nuclear incidents and which is summarised on page 3 of the briefing paper before the committee. The Executive explains that only nuclear reactor accidents have a category 3 level of response and that, in the briefing's summary,

"the generic plan to deal with a Category 3 incident is no different from that dealing with other levels of response".

We are assured that the emergency plan would take all the necessary action in respect of an accident at Faslane as it would do if it were a category 3 incident. There is no difference.

Argyll and Bute Council and the Scottish Executive are satisfied that the plans for an emergency at Faslane are adequate and would deal with any likelihood that may arise at Faslane, but Nuclear Free Local Authorities (Scotland) and Scottish CND are unhappy and do not agree with the council and the Executive. There is something of a stand-off.

The suggestion is that we agree to pass a copy of the responses from Scottish CND and Nuclear Free Local Authorities (Scotland) to Argyll and Bute Council and ask it to take the comments into consideration when considering the draft Clyde plan and that we suggest to the petitioners and Nuclear Free Local Authorities (Scotland) that the concerns that they have highlighted in relation to reserved matters should be taken up with the relevant UK Government departments. It is also suggested that we pass a copy of the responses from Argyll and Bute Council and Nuclear Free Local Authorities (Scotland) to the petitioner and take no further action.

John Scott: Are those alternatives?

The Convener: No. The suggestion is that we take all those actions.

Dorothy-Grace Elder: I request that the matter is also passed to the Transport and the Environment Committee. Argyll and Bute Council has been extremely supine in its response and people must question everything about the nuclear situation, especially as we know that there are cracks in the submarines. Some of the reports from former employees at Faslane are horrifying. I received a report the other day.

The Convener: We would have to clarify that emergency planning would be the responsibility of the Transport and the Environment Committee. I believe that the justice department deals with the issue.

John Scott: What can we do? Scottish CND says that there is a problem and the authorities say that there is not. We are not in a position to judge, nor would we want to be in such a position. That would be a great responsibility. Who judges such things? How can we appeal to them to give a definitive view? Somebody who is technically

competent must be able to give a definitive view on the matter. We cannot.

The Convener: I would have thought that the Transport and the Environment Committee would be interested in the emergency plan and its safety, but if the justice department deals with the matter—

Rhoda Grant: Could we clarify which committee is responsible? We could then pass the petition to the relevant committee.

John Scott: I do not think that doing so would make any difference. We are all lay people; none of us is a nuclear scientist.

The Convener: At this stage, we could consult one of the justice committees and the Transport and the Environment Committee. We could ask their views and come back to the petition at the next meeting. Are members agreed?

Dorothy-Grace Elder: Yes. It would be advantageous to consult both committees.

The Convener: They may not be interested in considering the petition. We will to have to consult them first. That will leave the petition live.

Dorothy-Grace Elder: As John Scott rightly remarked, members are not experts, but we simply need people who can write with searching questions. Many searching questions must be asked. Members may remember the official response when Chernobyl went up. As the cloud was passing over Scotland, radio announcements were being made that milk was perfectly safe.

The Convener: We could consult the committees to find out if the petition is relevant to them and if they are interested in dealing with it. It has been pointed out to me that the opposition from Nuclear Free Local Authorities (Scotland) and Scottish CND related to reserved matters. Such matters are not the responsibility of this Parliament. We can consult the committees. If they are not interested, we will have to take the suggested action.

Dorothy-Grace Elder: Such matters may not be the responsibility of the Parliament, but it is our responsibility to ensure that the people of Scotland are not trashed by something happening at Faslane.

The Convener: Absolutely.

Helen Eadie: A constituent of mine raised a similar matter in respect of Faslane and Rosyth. Obviously, I am not qualified to comment on the issue, but I contacted the University of St Andrews. Experts at the university commented on the report that was given to me. I provided all their answers to my constituent and the convener of the Transport and the Environment Committee. The convener wrote back to me and my constituent to advise that the matter was reserved and was the responsibility of the Westminster Parliament. I share that as an explanation of what has happened in a local context. We are not free to change decisions, but we should be aware of the facts.

The Convener: We will consult the committees on the areas that are devolved to them. If they are happy with the responses, we will send those to the petitioners as suggested.

Members *indicated agreement*.

The Convener: The next response is to petition PE341 from Mr Martin Barnet, on behalf of the student representative council at Craigmount high school in Edinburgh. The petition is about the abolition of mandatory unit assessments in Scottish schools. The committee will recall the two school students who very effectively addressed the committee. We agreed to pass the petition to the Scottish Executive and we have received a response that deals in quite a lot of detail with the points raised by the student representative council.

Assessment is being considered under the review of national qualifications that is under way. The review will take into account surveys of teachers, students and parents and will report by the end of the current school session. The Scottish Executive has also responded to the point about standardisation of unit assessments and has highlighted the work of the national assessment bank and how it is used throughout Scotland. It has also responded to the petitioners' concern that students who failed a unit assessment would not be allowed to sit the final exam, and points out that

"there is provision for students who fail their assessment to be reassessed".

It appears that the concerns of the petitioners are being addressed through the current review of national qualifications. It is therefore suggested that the committee agree to pass a copy of the response to the petitioners and take no further action.

Members *indicated agreement*.

The Convener: The next response is to petition PE346 from Lawrence Fitzpatrick, on behalf of Scotland Opposing Opencast. At our previous meeting, we agreed to seek the views of the petitioners on the response that we had received from the Scottish Executive. Members can see that the petitioners are very unhappy with that response. There is clear disagreement. The petitioners are not content with the Executive's assurances that the national planning policy guideline 16 offers sufficient protection for communities and the environment. The Executive is content, and has pointed out that changes were

made to a draft version of the guidance following responses to a consultation exercise.

We have to decide whether to take no further action or whether to pass the petition and the related correspondence to the Transport and the Environment Committee for further consideration. There is a stand-off here.

11:45

John Scott: Yes, there is. We should pass this back to the Transport and the Environment Committee. We have done preliminary research and, even if the Scottish Executive does not believe, to use its words,

"the Scottish text to be weaker",

the companies who are doing opencast apparently believe that it is weaker. There appears to be a preponderance of opencast in Scotland, which is a concern to a huge number of people. The Transport and the Environment Committee should consider the matter.

Helen Eadie: I do not oppose what John Scott suggests. A way to test views on the matter is to have a debate. However, my constituency has a considerable amount of opencast, and a condition made by planning officials is that land is reinstated. I could take you to places where the quality of restoration far exceeds anything that you might expect; in particular, I would put Lochore meadows up in lights.

I know that the public is concerned about other issues to do with opencast, which is why I do not oppose John Scott's recommendation. However, the Transport and the Environment Committee will probably arrive at the same conclusion as the Scottish Executive. I do not want to pre-empt any discussion, but we have a stern regime in Scotland. The Minister for Transport and Planning, Sarah Boyack, used to have responsibility for the environment and has always had a reputation for being tough on environmental issues. I think that Sarah wanted the guidelines to be tough.

The Convener: So that was not opposition to passing this to the Transport and the Environment Committee?

Helen Eadie: No.

The Convener: Do we agree to do that?

Members *indicated agreement.*

The Convener: The final response that we have to deal with this morning came in late and was sent out separately to members. It is a response to petition PE362 from Jane Sargeant, on behalf of the People's Protest, calling for financial assistance for self-employed and small businesspeople in Dumfries and Galloway. We have received a response from Wendy Alexander setting out the actions of the Scottish Executive in response to the crisis in Dumfries and Galloway.

We should note that Scottish Enterprise Dumfries and Galloway intends to announce a package of financial support not next week but this week, following approval by its board. We need to consider whether the steps taken by the Executive are sufficient to address the concerns of the petitioners. It is suggested that the committee may wish to agree to copy the Executive's response to the petitioners to get their views, and that the response should also be copied to the Rural Development Committee and the Enterprise and Lifelong Learning Committee for their information.

John Scott: I do not know that the Executive response is enough. Its schemes are essentially loan-based. Many small businesses could go to banks and increase their overdrafts, but the thing about a loan is that it has to be paid back. Whether the loan is interest-free or not makes little or no difference. What many of those companies will need to help them to get through to autumn next year—not this year, but next year—is a grant. That is why I do not think that the Scottish Executive is doing enough.

The Convener: We do not yet have Scottish Enterprise's announcement on its package of financial support. By the time the petitioners get back to us, they will know what that announcement is and we might be in a better position to ask them to respond to what the Executive is saying.

John Scott: From what has been revealed to me, what the Executive is saying is not enough, given the scale of the problem.

The Convener: This is a moving situation, and we will certainly consider it again when we get a response from the petitioners.

Members *indicated agreement.*

Convener's Report

The Convener: We were expecting to host a visit from the European Parliament Committee on Petitions on 5 June, here in Edinburgh. However, because of the general election and the consequent unavailability of politicians, it has been decided to postpone that visit until after the summer recess.

It has been suggested that, because 5 June is just two days before the general election, we may not want to go ahead with the scheduled meeting of the Public Petitions Committee on that day. A number of members have indicated that they may find it difficult to attend, so we could leave things until the following scheduled meeting on 19 June.

Dorothy-Grace Elder: If we were inquorate, it would be simply terrible for the petitioners.

The Convener: Is it agreed that the next meeting should be on 19 June?

Members *indicated agreement.*

The Convener: That will be the last meeting before the recess, so it is likely to have a heavy agenda. We will pay for that postponement.

Because meetings of the conveners group have been suspended until after the general election, the request for a visit to Berlin to look at the petitions committee there was not considered. The request will be considered by the conveners group on 12 June.

Meeting closed at 11:51.

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