

# Final Report November 2005

## Redrawing NHS Boundaries in Argyll & Clyde: Public Consultation

Prepared for  
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Scottish Executive, St Andrews House, Regent Road, Edinburgh EH1 3DG







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# Overview by Pennie Taylor

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When I was asked to chair the public consultation on redrawing NHS boundaries in Argyll & Clyde, I wondered how many people would be willing to engage in what could be perceived as rather a dry debate. However it soon became clear that there is a real appetite for meaningful involvement among the public of Argyll and Clyde (and surrounding areas) in how their local health services should be managed into the future.

It was my intention that the consultation would break new ground by proving the value of involving the public, and to an extent it achieved that. The serious flaw in the process was a dearth of the hard information that people wanted, and which the Scottish Executive Health Department appeared unable to supply.

As a result there remain serious questions about the way funding has been allocated to NHS Argyll & Clyde, and how funding will be allocated in future to the successor Boards. During the meetings conflicting figures were given which caused confusion and allowed some participants to accuse the consultation of being a 'sham'. It became increasingly clear to me, and others, that there is a woeful lack of transparency about Health Board funding.

The impression was given that financial planning within the Scottish Executive Health Department is chaotic and unco-ordinated, which is damaging to the reputation of the Executive and to public trust. The popular jury is out on whether this is cock-up or conspiracy, but either way it is extremely regrettable and must be remedied as a priority.

I found it immensely stimulating to chair the series of 16 open meetings (see appendix 1 for detail) that were held to discuss the implications of redrawing NHS boundaries in Argyll & Clyde, and I would like to extend my personal thanks to all those who took part. At those meetings I gave my assurance that I would feed back the views I heard robustly and accurately, and I believe this report achieves that.

With the permission of participants in the meetings, audio recordings were made at all but one of the two-hour sessions, and those discussions can be heard in full on the public consultation website – [www.show.scot.nhs.uk/sehd/argyllandclyde](http://www.show.scot.nhs.uk/sehd/argyllandclyde). Only the Glasgow meeting was not recorded, at the request of the attendees, although written notes of the key points raised throughout are also available on the website.

This series of public meetings offered an opportunity to innovate, and that appeared to be welcomed. There was no 'top table' of speakers, no Powerpoint presentations, and no jargon allowed. Instead, senior representatives of the Scottish Executive Health Department joined the public to answer questions and hear comments, as did senior managers from NHS Greater Glasgow and NHS Highland (see appendix 3 for detail). Their participation and refreshing frankness was greatly appreciated.

Throughout the meetings there was overwhelming support for the NHS staff who are providing highly-valued local health services, and general agreement with the Health Minister's decision to redraw NHS boundaries in Argyll & Clyde. However there was also widespread concern about the lack of background information regarding the future managerial options and, most particularly, the financial arrangements. It cannot be over-stressed how damaging that is to public trust in the NHS.

Initially, there was public scepticism about the consultation, largely based on past experience, when people felt that their views had been ignored – 'consultation fatigue' was repeatedly referred to. But as dialogue developed, constructive participation grew. It soon became clear that the officials who attended the meetings were

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committed to openness, even if it meant admitting that they did not know the answers to some obvious questions...

### **What went wrong?**

At each meeting people wanted to establish what went wrong with NHS Argyll & Clyde. It was claimed by members of the public that the Health Board did not suffer financial problems until the Arbutnott funding formula was introduced in the late 1990s, and they wanted clarification. However that was not available. Many people were incredulous to hear that the reasons are not yet understood, and reacted with astonishment, suspicion and even anger.

Given the lack of understanding of the pressures that caused NHS Argyll & Clyde to consistently overspend, the role of the Scottish Executive Health Department was questioned. Assurances were sought that when that information is available it is shared with the public, and that central scrutiny of Health Board activity will be improved.

### **A woeful lack of detail**

As well as wanting to know where Argyll & Clyde's overspend stems from, the people who took part in the meetings wanted detailed information about per-capita allocation of NHS funding under the various options that were being discussed. This was repeatedly requested, but information did not materialise until the 11<sup>th</sup> hour.

There was deep dissatisfaction about the absence of that important data, with many members of the public expressing the justified view that they could not be expected to reach an informed decision without it.

The Scottish Executive Health Department was lambasted by the public for failing to provide figures, despite repeated calls for them to do so. And senior representatives of both NHS Highland and NHS Greater Glasgow conceded that the lack of such information made accurate planning difficult for them.

Because of the delay in providing the data, the initial deadline for the public consultation of 4 November 2005 was extended by one week to 11 November. Towards the end of the process, crude figures were presented which must be the subject of ongoing discussion<sup>1</sup>.

Early analysis of those figures indicates serious problems. It is being proposed that funding for the Argyll and Bute area will drop by £5m to £110m per annum, and there appears to be a shortfall of around £20m in meeting the costs associated with delivering health services to the Clyde area.

It is believed that unless there is extra support from the Scottish Executive to bridge these gaps, at least until robust alternative arrangements can be put in place, patient care for those communities will suffer, as will services for the inhabitants of the successor Boards.

Informed members of the Argyll & Clyde communities wish to continue to be involved in considering the future funding options, and in the interests of transparency and service stability, this should happen.

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<sup>1</sup> [www.show.scot.nhs.uk/sehd/argyllandclyde/financial\\_issues.htm](http://www.show.scot.nhs.uk/sehd/argyllandclyde/financial_issues.htm)

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## **The Arbutnott effect**

The Arbutnott Formula, the method by which NHS funds are allocated in Scotland, was the subject of a great deal of debate during the public meetings. Across NHS Argyll & Clyde, it is believed that the formula has unfairly served the local population in the past. This view was endorsed by the popular belief that NHS Argyll & Clyde's financial problems did not arise until after the introduction of the Arbutnott formula in 1999. There is a belief that because NHS Argyll & Clyde is unique, in that it serves remote and rural areas (including some 26 inhabited islands) as well as areas of extreme urban deprivation, it was historically underfunded.

The Scottish Executive and NHS representatives present at the meetings undertook to feed those views into the national group that is currently reviewing the formula so that the question can be examined more closely.

## **Patient flows and service stability**

At every meeting concerns were expressed about the potential for disruption to health service provision as a result of redrawn boundaries. People wanted guarantees that patient flows for specialist care would not change under any of the options, and those were given.

NHS Highland and NHS Greater Glasgow both pledged to honour existing patient activity, and committed to maintaining well-established cross-boundary patient flows. No patient from Campbeltown, for instance, would be expected to travel to Inverness for hospital treatment even if their health service was managed by NHS Highland; and there was a firm undertaking that services which are currently provided by NHS Greater Glasgow would be maintained.

There was also concern about NHS Argyll & Clyde's continuing implementation of its financial recovery plan, which it is feared could threaten existing service provision. It was stressed that the plan would be revisited, and that any changes to the status quo are now being discussed in detail with both NHS Highland and NHS Greater Glasgow, and the Scottish Executive. It was pointed out that local decisions can, and have been, overturned by the Minister if they are considered to be unacceptable.

People are concerned that change inevitably means reduction of services. They would prefer to see a new system operating before an old one is taken away, and are calling for bridging arrangements to ensure seamless transition.

It was explained that until the full picture is known, it is difficult to predict what the future holds. But assurances were given that any future service changes affecting local patients would have to be properly consulted upon.

## **Regional working**

Given the inter-dependence of services between Health Boards, people in Argyll & Clyde wanted to know whether they would be able to influence any future service changes proposed by a neighbouring Board area. Both NHS Highland and NHS Greater Glasgow pledged to include them in any such consultation that might arise.

There was a great deal of discussion about further developing regional planning, to allow better networking between clinicians employed by neighbouring NHS Boards.

The development of the West of Scotland oncology service, including the construction of a new Beatson Oncology Centre to serve the needs of the populations of all the

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west coast Boards, was cited as an example of good regional planning, although it was accepted that more could be done in other service areas.

Some people even called Scotland's national Health Board structure into question, and talked about the potential for wider boundary changes to reduce duplication and minimise administrative costs.

This was illustrated with references to the necessity to consider the needs of people living in parts of NHS Ayrshire & Arran where Inverclyde was identified as their local hospital. It was even suggested that health services in those areas be incorporated within NHS Greater Glasgow, to ensure their inclusion.

### **Perceived peripherality**

A key concern, right across the patch, is that of perceived peripherality. Whichever Health Board inherits parts of NHS Argyll & Clyde, local people are worried that they would be regarded as being of marginal importance within a larger organisation. Verbal assurances were given, and largely accepted, that that would not be the case, but people wanted to know how they would be represented on any successor Board.

NHS Highland and NHS Greater Glasgow outlined their thinking about revised governance arrangements, although it would have been preferable to have had very clear plans for ensuring local representation on the successor Boards.

Concern was also expressed about the perception of 'takeover' by a neighbouring Board. This was accepted as an unfortunate misconception, which would be reflected in name changes for successor Boards – for instance, NHS Glasgow and Clyde – and a commitment to inclusion.

There was some discussion about the best way to make nominations to Health Boards, with the opinion expressed that Board members should be elected. However that is not a view that is shared by all.

That led on to discussion about centralisation, which is not a popular concept and runs contrary to the thrust of the recommendations contained within the Kerr report on service change in NHS Scotland<sup>2</sup>, which advocates localisation where possible.

### **CHPs with teeth**

One solution to representation, which was the subject of intense discussion at each of the meetings, was the potential for local autonomy offered by the establishment of Community Health Partnerships (CHPs). These organisations are being formed across Scotland, and NHS Highland already has three CHPs in place which concentrate on serving, monitoring and developing the health needs of local communities.

Ideally, CHPs are co-terminus with Local Authorities to allow better planning and joint working between health and social care. The view was expressed that the Argyll & Bute area would lend itself to such an arrangement, allowing local people to influence the development of their local services. This is an attractive option, but only if it is genuinely influential.

People want their CHPs to have a strong voice at Board level, but there are concerns they could simply be used as window-dressing for local involvement unless significant

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<sup>2</sup> Building a Health Service Fit for the Future -  
[www.scotland.gov.uk/Publications/2005/05/23141307/13104](http://www.scotland.gov.uk/Publications/2005/05/23141307/13104)

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power is vested in them. Throughout the public meetings 'CHPs with teeth' were referred to, meaning that they should have decision-making capability and devolved budgets. There are opportunities here for demonstrating that local participation can work.

People are concerned about being overly remote from their NHS management. They want to know who runs their health services, and to have accountable individuals in their communities.

It was explained that an important component of CHPs is their affiliated Public Partnership Forums, which can harness public opinion. The people of Islay and Jura, who have built a strong Public Partnership Forum, wanted to know whether its role would be maintained. Indeed, it was explained, it could be an exemplar for the wider region.

There was also a call for CHPs to be future-proof – no matter what changes might take place down the line involving Health Boards or Local Authorities, people want some stability built in.

### **Community capacity building**

There is a strong feeling that if the management of local health services is to be devolved to CHPs, participants in that process have to be supported to develop the skills that will maximise their effectiveness.

There is impassioned opinion that the voluntary sector, in particular, needs to be resourced to deliver the community agenda, and there is a strongly-held view that it would benefit from capacity building. There is also a desire to see investment in public involvement, particularly when it comes to gathering the views of traditionally excluded groups.

### **Local services**

Wherever the public meetings were held, people expressed their total support for the staff who are providing their highly-valued local health services, and they are passionate about not only maintaining but developing them. In line with the Kerr report, and the subsequent implementation paper *Delivering for Health*<sup>3</sup>, there is an acceptance that very specialist services can only be offered in a limited number of centres, but there is a very deep desire to see more being available locally.

There is strong public commitment to local hospitals, and people wanted to know what the future held for them under the various options. Both NHS Highland and NHS Greater Glasgow gave assurances that none would shut, but explained that they could not commit to the detail of their future service profile until further work had taken place to determine their role within the new NHS organisations.

It was stressed that there could be real opportunities offered by being part of a larger organisation, which could allow better clinical networking and enhance teaching hospital status.

It was reiterated that any existing capital plans, for instance the redevelopment of the Rothesay hospital, would continue. Both Health Boards committed to ongoing public engagement about what services could safely be offered locally, and there was an expressed willingness to meet the decentralising demand.

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<sup>3</sup> *Delivering for Health* - [www.scotland.gov.uk/Publications/2005/11/02102635/26356](http://www.scotland.gov.uk/Publications/2005/11/02102635/26356)

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## **Modern communications**

The view was expressed that a great deal could be achieved in terms of making more services available closer to people's homes if there was greater investment in electronic communications systems. These could be used to link centres across a wide area and extend clinical networks to cover Scotland's most far-flung communities. However there are infrastructure demands as well as hardware and software issues.

Both NHS Highland and NHS Greater Glasgow shared concerns about asking their existing management and clinical teams to take on additional responsibility for new territories, when they are already working to full capacity to serve their existing populations. Good communications systems would help with that, allowing meetings and case conferences to be held without the necessity for face-to-face contact and the travelling time that would entail.

## **Transport issues**

The existing challenge of accessing services in NHS Argyll & Clyde was raised, particularly among the people of the West Dunbartonshire corridor and the Inverclyde area, who are dissatisfied with perceived centralisation of services in Paisley. There are no direct public transport routes, and in Dumbarton a question was raised about the necessity for ambulances to stop at the Erskine Bridge toll and pay to pass through.

The Scottish Executive gave information about the new Regional Transport Authorities (RTAs) and the new requirement for NHS plans to take transport issues into account.

Outwith Paisley, people wanted to know whether more could be done to return services to local hospitals or to create capacity within Greater Glasgow, which may be more easily accessed than Paisley. NHS Greater Glasgow gave an assurance to pursue the question, however it was stressed that the existing position would most likely have to be maintained until 2007, when capacity questions could be addressed.

On the islands, and the more remote areas of NHS Argyll & Clyde, concern was also expressed about ambulance and patient transport provision. Anomalies were cited that the successor Boards undertook to investigate.

In Oban, the focus was on the condition of road links between local communities and specialist centres based in large conurbations. The Scottish Executive explained that this also fell within the aegis of the RTAs.

## **Staff support**

The commitment of NHS staff in Argyll & Clyde was repeatedly commended, and concerns were raised about what the future holds for them. Although some people felt that the proposed changes were happening too quickly, the majority agreed that swift resolution was necessary to address flagging staff morale as well as recruitment and retention difficulties.

## **Addressing mistrust**

Where people expressed an interest in forming new NHS Boards to replace NHS Argyll & Clyde, it was explained that there is a belief such an arrangement would best protect local interests. This boils down to mistrust of larger and more remote Board structures. If it could be demonstrated that local communities can have a strong voice

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in a larger structure, there would be fewer people calling for separate organisations to be established, along with their attendant bureaucracies.

At the end of each public meeting, there was a greater sense of understanding the issues affecting patient care in NHS Argyll & Clyde. There may have still been anxiety about what the future holds, but there was an overwhelming sense that people are prepared to carry on pursuing solutions to the perceived problems – if they can believe they are really being listened to.

There is a sophisticated awareness among the public of the pressures that face the NHS in Scotland, and a commitment to do what they can to help to resolve them. This energy should be better harnessed for the benefit of patient care.

### **The options appraisal**

Although it was stressed that no option was off-the-table for discussion at the public meetings, the meetings tended to focus on the three options that had been developed by the Scottish Executive. Outwith Paisley, there was little public support for the retention of NHS Argyll & Clyde, and little support for the option of establishing a new Health Board to serve Argyll and Bute alone.

**Option 1** involves incorporating the Argyll and Bute council area within NHS Highland, and the rest of NHS Argyll & Clyde within NHS Greater Glasgow.

**Option 2** incorporates most of the existing Argyll and Bute council area in NHS Highland, with the exception of the West Dunbartonshire corridor (including Helensburgh) which would become part of NHS Greater Glasgow along with the rest of NHS Argyll & Clyde.

**Option 3** allocates the northern part of the existing Argyll and Bute council area to NHS Highland, with the rest of NHS Argyll & Clyde going to NHS Greater Glasgow.

My interpretation of the views expressed at the public meetings is that the least appealing option is No.3. Indeed, it has been described as the 'mistrust option' – supported by those who do not believe that redrawing boundaries will protect natural patient flows. This can be addressed by 'walking the talk' on regional planning.

The concern about option 3 is that by maintaining the link between providing services for remote and rural and island communities and some of the most deprived mainland urban communities in Europe, the historical problems that have dogged NHS Argyll & Clyde will continue. NHS Greater Glasgow, by its own admission, does not have the expertise to understand and address the issues facing remote populations, and that has to pose risk.

Option 2 reflects a desire among the people of the West Dunbartonshire corridor to relate directly to the Health Board (NHS Greater Glasgow) that will be responsible for the provision of their acute services. It is promoted by those who do not believe that the interests of the communities of the West Dunbartonshire corridor will be properly reflected if they are incorporated within NHS Highland.

The concern here is principally around the future of the Vale of Leven Hospital in Dumbarton, which some believe can only survive if it has a well-defined catchment population. Local GPs believe that the people they serve would have far greater clout within NHS Highland, as they would represent 42% of that Board's population, instead of being little fish in NHS Greater Glasgow's big pond, where they would represent just 2% of the population. But there is opposition to that view, or as one community representative put it: 'size doesn't matter if you are in the wrong pond. Why negotiate through a middleman?'

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Option 1 offers co-terminosity with the Local Authority, which is logical when it comes to forming an effective Community Health Partnership within NHS Highland. But it is also important that local people can influence NHS Greater Glasgow's plans for its service provision, particularly when it comes to considering the services that might be available at Vale of Leven Hospital in future. This could be achieved with proper regional planning, but that has yet to be proved to the satisfaction of all.

Most of the people within NHS Argyll & Clyde who attended the public meetings seem to favour options 1 or 2, although they believe the ultimate decision on that should rest with the views of people living in the West Dunbartonshire corridor. If co-terminosity between health and social services is indeed as important as it sounds, that would indicate a preference for option 1. But the mistrust of communities that perceive themselves as peripheral would have to be overcome by demonstrative action.

### **Better public consultation**

There is deep cynicism among the public about the value of consultation exercises, based on past experience. Instead of waiting until urgent issues arise, people would prefer to be kept informed of NHS progress on an ongoing basis.

They are understandably suspicious of consultation exercises that appear to limit their options to a small number of prepared scenarios, and would be willing to be involved at a very much earlier stage. The view has been expressed that in this instance, the public consultation process started too late.

Neither FMR nor myself were involved in the consultation process until the meetings were about to start, which is regrettable. The Executive had recruited an Advisory Group (see appendix 2) to support the consultation process, comprising voluntary sector representatives, Local Authority representatives and NHS personnel, and their input was invaluable. Together, we prepared a newsletter<sup>4</sup> outlining the options and detailing how people could feed their views in to the consultation.

The Advisory Group felt very strongly that no option should be excluded from discussion, so the three options identified by the Scottish Executive as the preferred options, plus the four others that had been discounted by the Executive, were outlined for public consideration in the newsletter. Importantly, people were also encouraged to consider any further options that they might wish to explore.

The Advisory Group helped to plan the schedule of public meetings, and the publicity programme. Two meetings of the group were held prior to the consultation deadline, and it is proposed that there will be one more meeting in order to review the process and identify learning points for future consultations. A report on this will be prepared, however some key messages have already emerged.

### **Interim public consultation recommendations**

- No public consultation should take place unless all the supporting information is in place: clear information about what led to the change, supporting information about the consequences of the options, and clear risk assessment. Otherwise, the integrity of the consultation is compromised.
- People want to be engaged in the debate about health service development on an ongoing basis. They would welcome regular briefing meetings, but only if their views are to be genuinely taken into account.

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<sup>4</sup> Redrawing NHS Boundaries on Argyll & Clyde public consultation newsletter – <http://www.show.scot.nhs.uk/sehd/argyllandclyde/COMPLETEnewsletterpages.pdf>

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- The public should be involved in the consultation process at the earliest opportunity. Options for consultation should be developed with their input.
  - Consultation should start much earlier in the process. People would have appreciated being asked whether they wanted the boundaries to be re-drawn, and to have been involved in the development of the options. They want public information to be far more extensive and engaging.
  - When service change is proposed it should not happen in response to crisis, but be carefully planned and implemented. Bridging arrangements should be put in place to ensure that old systems can continue to cope while new systems are introduced.

### **Keep it going!**

As a result of the public meetings, I would also like to recommend that there should be further engagement around two key issues affecting the whole of NHS Scotland. It became clear to me that there is not adequate awareness of the potential for developing Community Health Partnerships, which could offer communities far greater involvement in local health planning. And while there was a degree of awareness of the Kerr Report, Building a Health Service Fit for the Future, there are opportunities for better involvement of local people in working out what that report's recommendations might mean for them.

- Good public information should be made available about Community Health Partnerships, and there should be engagement about how members of the public can help to shape them.
- Communities should be actively engaged in considering the local implications of the Kerr report, and helping to shape local services for the future.



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# 1 Introduction

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NHS Argyll & Clyde has accumulated a substantial deficit since health boards were reorganised in 2001 and all debts were written off by the Scottish Executive. The accumulated debt is estimated to reach £72.5m by the end of March 2006 and the Auditor General has stated that it could reach £100m by the end of March 2007. No other health board has accumulated this level of debt in this period. A new management team was introduced in 2003 which has implemented a financial recovery plan and this is expected to bring spending to the level of allocations to the area by the end of March 2007.

However, on 19<sup>th</sup> May 2005 the Minister for Health and Community Care, Andy Kerr, announced his intention to dissolve NHS Argyll & Clyde on 31<sup>st</sup> March 2006. His view is that the inherent structure of the Argyll & Clyde area, with its mix of urban areas (with pockets of severe deprivation) and the polar extreme of remote and rural areas (including 26 inhabited islands), mitigates against any effective management. His intention is therefore to change the administrative boundaries of NHS Greater Glasgow and NHS Highland, as neighbouring health boards with expertise in successfully meeting the challenges of urban and remote and rural areas respectively, to take responsibility for different parts of the current Argyll & Clyde area. He has made the commitment to write off the accumulated deficit of NHS Argyll & Clyde and has sought the views of local communities via public consultation to inform his decision on the future management of NHS services in Argyll & Clyde.

This report details the findings of the public consultation on the options for the NHS management of the Argyll & Clyde area which took place from 5<sup>th</sup> August 2005 until 11<sup>th</sup> November 2005 (extended by one week from the original deadline for responses of 4<sup>th</sup> November 2005). The Scottish Executive consultation document was entitled "*Redrawing NHS Boundaries in Argyll & Clyde: A Consultation Paper*" and was available in both hard copy and electronic versions. The Scottish Executive had a website for the consultation at [www.show.scot.nhs.uk/sehd/argyllandclyde](http://www.show.scot.nhs.uk/sehd/argyllandclyde) which gave the public access to the consultation document and provided the capability to make an online response to the consultation.

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## 2 Method

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### 2.1 Overview of the process

The process was chaired by Pennie Taylor, an independent health journalist, supported by FMR Research, a Glasgow based social research consultancy and the Scottish Executive Health Department team. An Advisory Group also influenced the process, comprising representation from NHS Argyll & Clyde, NHS Greater Glasgow and NHS Highland, various voluntary sector organisations, patient representatives, the Scottish Health Council and Scottish Consumer Council (see Appendix 2). The Advisory Group first met on 1<sup>st</sup> September 2005 and then on 24<sup>th</sup> October. The Group will meet to review learning from the process at a later date.

The consultation had several key elements, as follows:

- 16 public meetings;
- 22 workshops with community and voluntary sector organisations;
- 10 depth interviews with key stakeholders;
- a focus group with key action groups; and
- 629 formal responses to the Scottish Executive (510 from individuals and 119 from organisations).

These are each discussed in more detail in the following sections. The consultation was informed by the Scottish Executive consultation document, which was available in hard copy and on the website, and a four page A4 sized summary of the consultation written by Pennie Taylor, with inputs from the Advisory Group. Copies of the summary document were distributed via public meetings, workshops and via NHS, Community Care Forum and/or CVS networks – a total of approximately 60,000 were distributed.

### 2.2 Public meetings

Sixteen public meetings were held around Argyll & Clyde and neighbouring areas and a full list of dates and venues is appended for information. The three largest islands of Argyll & Clyde were visited (Bute, Mull and Islay) and meetings in other areas, e.g. Oban and Campbeltown, were timed to suit ferries from other island communities as far as possible. The format of the meetings was as informal as possible, with no 'top table' and officers sitting with the audience. Pennie Taylor chaired each meeting, introducing the issue under discussion, the process and those present to respond to questions from the audience. The Scottish Executive Health Department was well represented at each meeting, with three representatives from the public involvement team and at least one from the performance management team. NHS Highland and NHS Greater Glasgow also attended meetings where possible. Those attending meetings are detailed in appendix 3.

All but three of the meetings started at 7pm (two started at 6.30pm and another at 7.30pm) and all lasted for two hours. As each meeting was open to the public, the largest local venue was used in each area as far as possible. Attendance varied from two (in Glasgow) to over 200 (in Oban). Each meeting was publicised using different media. Adverts were placed in the relevant local and some national press at the end of September and then the week immediately before each meeting to notify members of the public of the meetings. Nearly one thousand A3 sized posters were sent out to local post offices, supermarkets, grocers, libraries, venues and other public buildings, with a letter asking the recipient to display them prominently.

BSL interpreters were present at 6 public meetings or workshops. They were not present at all meetings due to a lack of availability. Two interpreters were required given the length of the meeting and the limited number of active interpreters in

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Scotland. An induction loop system was used at each meeting to assist those who were hard of hearing and wore hearing aids. Each venue was accessible for physically disabled people.

The public meetings were recorded (except Glasgow, as participants did not wish this to happen) and recordings are on the consultation website for those who were not able to attend to listen to, and to assist the transparency of the consultation generally. Key points were also noted on flip chart and summaries of these are also available on the website. Banner stands (2 metres by 1 metre) were used as a focal point at the front of each venue, illustrating current NHS boundaries, local authority boundaries, Options 1 – 3 as detailed in the consultation document and a map of Scotland with a big red question mark overlaid to reinforce the point that other options would be considered.

## **2.3 Workshops**

Twenty-two workshops were convened with community and voluntary sector organisations. A workshop was convened in each of the areas where a public meeting was held and additional workshops were held in Renfrewshire, East Renfrewshire and Inverclyde in order to make the process as accessible as possible to local people. Workshop participants were recruited with the assistance of local Councils for Voluntary Service (CVS) and/or Community Care Fora as they have existing networks of community and voluntary sector organisations in their areas. We would like to thank organisations for assisting with this and participants for attending.

The purpose of the workshops was twofold: to provide as much information as possible on the background to the consultation and the options proposed to community and voluntary sector groups, before then listening to what participants had to say about their concerns and preferences. Each session lasted around two hours and attendance was restricted to a maximum of thirty participants in order to give participants adequate 'air time' to give their views. Attendance varied from 2 to 32.

The workshops started with FMR consultants summarising the key points of the consultation around boundaries and the process which was underway, answering any questions which arose. Participants were then asked to outline their fears and hopes for the boundary review; their real priorities; the pros and cons for each option; whether there is a better option for the Minister to consider; and a preference for the way forward if participants felt comfortable with this. Feedback on the consultation process itself was also sought. Workshops with fewer participants stayed as one large group to discuss the issues and larger workshops had a mix of large and small group discussion. A2 colour copies of the maps outlined in the consultation document and/or the banner stands were referred to during the discussions. The workshop in Dunoon also utilised graphical recording to note participants' views.

Participants' travel and caring expenses were reimbursed and a buffet was provided for those attending the evening public meeting, where appropriate.

## **2.4 Depth interviews**

Depth interviews were conducted with a number of key stakeholders. Ten interviews were conducted, several with more than one participant, and their participation was appreciated. The majority were undertaken on a face to face basis and the remainder by telephone. Interviewees included the Chief Executives and Elected Leaders of local authorities affected by the boundary changes (Inverclyde Council did not participate as the acting Chief Executive had only just come into post following restructuring there and Glasgow City Council did not have diary availability during the consultation period), the Clinical Director of Argyll & Bute LHCC, employee directors of NHS Greater Glasgow and NHS Highland (there was no response from NHS Argyll &

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Clyde to several email and telephone requests for an interview), the Scottish Health Council and the Scottish Ambulance Service.

The depth interviews followed similar areas of discussion to the workshops.

## 2.5 Focus group

One focus group was undertaken by FMR in addition to the workshops and other dialogues detailed above. This was with representatives of two campaign groups based in the Helensburgh and Vale of Leven area: North Clyde Group and the Vale of Leven Hospital Services Forum. The discussion was an opportunity for the groups to hear more about the consultation prior to submitting their formal response and for FMR to gain a better understanding of their concerns early in the process. Eight people participated in the discussion over two hours.

Other organisations were offered the option of having a focus group, including the Association of Argyll & Bute Community Councils and the Local Area Medical Committee but declined as they felt they had achieved sufficient discussion of the issues at their own meetings, several members had attended public meetings and/or workshops and were happy to submit their own responses to the Minister directly.

## 2.6 Formal responses to the Scottish Executive

A total of 629 formal responses to the consultation were submitted to the Scottish Executive by the deadline of 11<sup>th</sup> November 2005. 510 individuals and 119 organisations made a response. The responses varied from the very brief, e.g. "Option 1", to very detailed, lengthy responses and the responses are available on the Scottish Executive website, where respondents have given their permission for this. The profile of responses by organisation area and sector and individual area of residence is shown in the tables below:

**Table 1** Count of responding organisations by area

Alexandria & Dumbarton	11
Bute, Cowal & Dunoon	12
Glasgow	22
Helensburgh & Lomond	16
Highland	12
Kintyre & Islay	6
Mid Argyll	10
Oban & Mull	9
South of River Clyde	8
Other & unspecified	13
Total	119

**Table 2** Count of responding organisations by sector

NHS	34
Community Council	29
Voluntary and community	30
Other public sector	26
Total	119

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**Table 3**      **Count of responding individuals by area**

Alexandria & Dumbarton	20
Bute, Cowal Peninsula & Dunoon	35
Glasgow	4
Helensburgh, Lomond, Roseneath & Cove	158
Highland	11
Kintyre, Campbeltown, Islay, Jura	22
Mid-Argyll	47
Oban & Mull	39
South of River Clyde	39
Unspecified/anonymous	132
Other	3
Total	510

UNISON, a key trade union representing NHS and other public sector organisations, organised a postcard campaign and 234 postcards were received by the Scottish Executive by the deadline of 11<sup>th</sup> November 2005. Jackie Baillie, constituency MSP for Dumbarton, also ran her own consultation survey, and submitted the responses to her questionnaire.

## **2.7 Other consultation**

FMR, Scottish Executive and NHS Highland attended a conference held by ACUMEN (Argyll & Clyde United Mental Health Network) in Inveraray on 28<sup>th</sup> September 2005, and discussed the options with participants.

In addition, other organisations and individuals have arranged their own consultations around the boundary for management of NHS services in Argyll & Clyde. For example, Cowal Community Care Forum focussed on the issue at their conference and AGM on 2 November 2005 and conducted a range of focus groups with local groups in order to inform their own response to the Minister.

## **2.8 Analysis**

Whilst the consultation document presented three preferred options, the discounted options were still open for comment and the formal consultation response template was completely unstructured, i.e. no specific questions were asked. It was also not appropriate/possible for members of the public to vote for a preferred option at the public meetings and workshops but these provide a much greater understanding of the concerns and priorities for NHS services which local people have. The outputs of the formal response, public meetings, depth interviews, focus group and workshops were qualitative in nature and so MAXQDA, a qualitative analysis software package, was used to analyse responses given to the consultation. Outputs from each of the elements of the consultation were imported and a coding frame developed to reflect the contributions made. The analysis team was kept to a minimum to ensure consistency of approach but involved more than one person, to allow peer-review of coding to be done to address any unintentional individual bias.

The following section details the issues raised by participants in the consultation before drawing conclusions and recommendations for the Minister on the boundary issue and the Scottish Executive more broadly on the consultation process. Participants' own words have been quoted, anonymously, to bring the points made to life, where appropriate. Numbers have been quoted where possible to give some indication of the strength of feeling but this was a qualitative consultation not a structured, quantitative exercise so this should be taken into account when interpreting the findings.

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## 3 Key findings

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### 3.1 Introduction

#### 3.1.1 Interpretation of the findings

It should be noted that the findings reported below came from public consultation and not structured research, so cannot be seen to be representative of the wider population. The views expressed below are therefore those of individuals and organisations who chose to participate in the consultation and this must be borne in mind when interpreting the findings. There may well be issues raised by individuals or organisations which others would hold to be factually inaccurate. Responses are recorded faithfully here as misinterpretation or misunderstanding of the facts is a finding in itself and will inform future communications.

#### 3.1.2 Public mistrust

One issue must be raised before any findings are reported – that of public mistrust, both in the consultation process and that services and patient flows will not change, as the consultation document states. Many individuals and organisations stated that they think the Minister has already made the decision on where the new NHS boundaries will lie. Participants have found it difficult to believe that this is genuine consultation, particularly as previous experiences have been perceived very poorly. For example, many participants reported having taken the time to give their views on previous consultations but the Executive was not perceived to have taken on board any of the views expressed by local people.

*“There have been all sorts of consultations that have taken place recently, where the unanimous opinion of the public has been totally and utterly ignored at the end of the day! It doesn’t matter what we say it seems things will just happen!” Helensburgh workshop*

This is a substantial barrier for the Minister to overcome, particularly as some people felt that the Executive’s tactic is to “wear people down” until they do not give their views in future.

There was also a degree of mistrust that services would not change, and this was the most significant concern that many members of the public had. Misunderstanding on patient flow issues, or the belief that it will change in the longer term if boundaries change, undoubtedly influenced the way in which some people expressed a preference on the options. Options 2 and 3 were called ‘the mistrust options’ by some people.

#### 3.1.3 Views on the decision to dissolve NHS Argyll & Clyde

Whilst many participants accepted that the Minister had taken the decision to dissolve NHS Argyll & Clyde and very few people at the public meetings felt that NHS Argyll & Clyde should remain in its present form, there were some strongly expressed negative views around the decision. There were three key reasons for this. Firstly, some participants felt that the decision to dissolve NHS Argyll & Clyde should not have been taken in isolation but the structure of all health boards in Scotland should have been considered at the same time. Many participants were aware of the increased emphasis on regional planning and that there is a suggestion that Scotland will have 3, 4 or 5 health boards in future. Unison established a postcard campaign to the Minister and 234 postcards were received with the following message:

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*"Dear Mr Kerr*

*The 3 preferred options within the consultation paper Redrawing NHS Boundaries in Argyll & Clyde do not provide any evidence that successor Boards will be able to address the issue of retaining health service provision locally.*

*The current structure should remain until the Executive responds to the National Framework for Service Change and then we can consider NHS Scotland as a whole.*

*Please let me know your response to this."*

The second reason given for a negative view about the timing of the decision and consultation on the way forward centred on the cause of the problems with NHS Argyll & Clyde. Many participants in the workshops and public meetings in particular expressed the view that it is *"only common sense"* to establish the nature of the problems within NHS Argyll & Clyde which have resulted in the degree of overspend which has been evident before a solution can be sought. If this is not done, the restructuring of boundaries may not solve any problems and NHS Highland and NHS Greater Glasgow may then face similar problems of accumulated deficit and/or cuts in service to local communities.

*"...nobody has actually any idea what you're going to do differently until you get behind the figures. That's going to take time and even then there are no guarantees that you are going to come up with something new that Argyll & Clyde haven't already thought about. The leap of faith that people have to take is that services will be sustained and not held back in that process as we go through implementing a ministerial decision." Paisley public meeting*

Thirdly, several people felt there should have been consultation on the dissolution of NHS Argyll & Clyde. Allied to this was the suggestion that the new management team had not been given adequate time to address the problems and were in fact on track to do so.

*"Surely consultation with the public about their health board should have come first!"*

*"Firstly we are concerned about how this decision to dissolve Argyll and Clyde Health Board was reached as there was no consultation with the public or staff within the area. (We) would like clarity on the legal basis which allows the Scottish Ministers to abolish NHS Boards, and why this was done with no consultation with either NHS Argyll and Clyde or the public." Organisation, health focus*

### **3.1.4 Delay in financial information and timing**

The delay in the release of financial information must also be taken into account when interpreting the findings of the consultation. Participants often did not feel sufficiently informed to make a decision although many offered a preference based on what they did know. (48 individual responses perceived that there was a lack of information upon which to make a reasoned judgement, and the vast majority of these referred specifically to a lack of robust financial data. This issue was also raised by organisations and during interviews, workshops and public meetings.)

An excerpt of the relevant financial information provided by the Scottish Executive late on 7<sup>th</sup> November 2005 is shown below:

Estimated figures for the three options are now available. The figures in Option 1 have been calculated using the same process currently used in the allocation of health boards' unified budgets which is consistent with Arbutnott principles. It proved difficult to adopt the same method when estimating the figures for Options 2 and 3, as expenditure figures were not available separately for the populations covered by these options. The best available alternative population split was therefore used.

General Medical Services funding is not included in these estimates because it is calculated in a different way and is not affected by boundary changes.

The actual allocations that the enlarged health boards will receive in 2006-07 will vary from the estimates because the budget available to NHS Scotland will be larger, and further work to refine the estimates will be completed when the Minister has chosen and announced the selected option.

The estimated figures in the tables below have been rounded to approximately the nearest 1%.

Table 1: Financial allocations to enlarged Boards under options 1, 2 and 3 (rounded)

	2005-06 allocation (£000)	Option 1	Option 2	Option 3
Argyll & Clyde	515,000	-	-	-
Greater Glasgow	1,140,000	1,545,000	1,575,000	1,625,000
Highland	270,000	380,000	350,000	300,000
Scotland	6,010,502	6,010,502	6,010,502	6,010,502

Table 2: Financial allocations per head to enlarged Boards under options 1, 2 and 3 (rounded)

	2005-06 allocation per head (£)	Option 1	Option 2	Option 3
Argyll & Clyde	1230	-	-	-
Greater Glasgow	1310	1290	1290	1290
Highland	1300	1270	1290	1300
Scotland	1188	1188	1188	1188

Dividing the current Argyll & Clyde allocation between the proposed enlarged NHS Greater Glasgow and NHS Highland does not appear to address the issue of perceived under-funding as many hoped it would. It is understood that the Scottish Executive has also intimated to NHS personnel since the consultation closed that funding has been recalculated taking into account the overspend and this has not been done on the basis of the Arbutnott formula (as stated by the Scottish Executive throughout the consultation). This must cause huge concern for the successor boards and suggests the need for 'bridging' funding for them prior to the financial recovery plan breakeven point.

In addition, whilst we can never know on what basis individuals and organisations have made their decisions (although we do know that some formal responses were made on the basis of thinking they would have to go to Inverness for treatment, which is not the case), we do know that some respondents changed their preference on sight of the financial information at the very end of the consultation period. Once there is clarity around finances and reasons for over-spending, we have to assume that others may also change their minds.

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The timing of the release of limited financial information provided was criticised roundly by all parties and does not help convince the public that the Scottish Executive is open and transparent. The subsequent communications on finances since the closure of the consultation give further cause for concern.

### **3.1.5 Support for frontline staff**

Another point which must be made clearly is the support for NHS frontline staff which was evident from discussion throughout the consultation. NHS management were criticised for the problems faced by NHS Argyll & Clyde and the quality of some hospitals was criticised but there was generally substantial support for frontline health staff delivering services.

### **3.1.6 Acute health services**

The majority of health services are provided locally (around 90% has been quoted) but this was not what people immediately started discussing when starting to talk about health services: the acute services are the ones which stir emotions and which people automatically focus on. These are not used as often, but people were very clear that when they need to be used, access needs to be appropriate and safe.

## **3.2 Key concerns**

### **3.2.1 The Arbutnott formula**

The issue of the Arbutnott formula was raised by 26 individual respondents and was discussed at length during public meetings, workshops and face to face interviews. Many people considered the root cause of NHS Argyll & Clyde's deficits to be chronic underfunding due to the way that the formula calculated its per capita allocation: it was perceived that the area's (urban and rural) deprivation, sparsity and many island communities, including the influx of population over the summer months, were not sufficiently taken into account by the formula's mechanisms. The two extremes of urban and rural service provision, which were both perceived to be expensive to provide (although there was some disagreement over which 'bit' of Argyll & Clyde was most expensive) were considered to be "cancelled out" by the formula, making the area appear 'average' and not facing two quite distinct challenges.

*"One thing has become obvious from the 'overspend' situation of recent years, that possible mismanagement aside; there has been a severe under funding of this area." Individual, Lochgoilhead*

*"We do not have an ambulance service sufficient to our needs, especially when in the summer we have a great influx of tourists and holiday home residents." Individual, unknown location*

*"There was a drop in the number of children in the census because of the closure of the Polaris base and this is affecting provision. We also have a significant holidaymaker population in summer." Dunoon workshop*

Several respondents believed that if NHS Argyll & Clyde were to receive similar per capita funding levels as NHS Greater Glasgow and NHS Highland, it would not have experienced the deficits that it did:

*"If all of our patients were to receive the same allocation as Glasgow or Highland we would pay off nearly £50m in one year!" Individual, Paisley*

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*“These are not new financial problems, the Executive have had plenty of warning on the A&C situation. It is not adequately funded compared to other areas.” Organisation, local authority*

People’s fears that the Arbutnott formula was at the root of NHS Argyll & Clyde’s deficits were fuelled by the fact that the deficits appeared to start in Argyll & Clyde as soon as the formula was implemented. The fact that the formula is presently under review (with the outcome of the review expected around mid-2007) also contributed to these suspicions.

The financial information was issued far too late to gain much of an impression of public perception of it, however the limited reaction received was negative.

Given the concerns around adequacy of funding, whatever option is selected, it was suggested by a number of participants that the Scottish Executive must monitor and properly review the new arrangements to establish if funding is still a problem:

*“A public audit and review of the new arrangements should be carried out after the first year of operation and appropriate changes made, including increased funding if that is a problem.” Individual, unknown location*

### **3.2.2 Local service delivery**

Fears about the erosion/further erosion of local hospitals and services were raised throughout the sixteen public meetings and workshops and were a prominent feature of the formal responses to this consultation.

*“We want to stop the cuts in the services that are happening. We can’t sit through a consultation, with the emphasis on the word ‘con’, which is what the last consultation was: 5 hospitals were closed overnight in the Argyll & Clyde area.” Dunoon workshop*

#### **Dunoon Hospital**

There was concern in the Dunoon area of the loss of services from Dunoon Hospital in recent years, and how the redrawing of boundaries might affect the local hospital services available to them.

*“A & E in Dunoon is the minimum requirement for an area such as Cowal - A & E in Paisley is far too far. Making this link in the survival chain so far away reduces people’s chances of surviving heart attacks etc. With the growing population of Cowal and the amount of new building going on, it is most urgent that Dunoon Hospital has more facilities.” Individual, Dunoon*

#### **Inverclyde Royal Hospital**

There was a strongly perceived threat to this hospital, fuelled by the view that the hospital’s services were being eroded and specialist services lost. For the people currently served by this hospital their fear was that if it closed they would find themselves having to travel considerable distances for treatment (to Paisley or Glasgow) in what they perceived were often adverse conditions. While the advantages of being able to access centres of excellence and teaching hospitals in Glasgow were recognised, the debate in Greenock often focused on the importance of maintaining IRH as an acute hospital.

People’s fears about Inverclyde Royal Hospital were exacerbated by an irresponsible remark made by a non-executive director of NHS Argyll & Clyde at a meeting outwith

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the consultation process, to the effect that if Inverclyde was adopted by Greater Glasgow NHS the IRH would be knocked down. Whilst it is understood that it was meant flippantly, it was not received in this way by local people.

### **Lorn and the Isles Hospital (and Belford Hospital)**

This hospital has only recently been built, and there was concern in this area that if NHS Highland took over the management of their health services it might be closed and services transferred to Fort William. Similar fears were expressed in the Highland area about the Belford Hospital in Fort William, reigniting recent debates and campaigns to save this older, Victorian hospital.

*"We have a recently built hospital in Oban, what would happen if we went into Highland area, I mean it's more modern than the Fort William hospital, would we chance losing that? Definitely not?" Individual, Mull*

### **Royal Alexandra Hospital**

Whereas the comments around the other 'local' hospitals tended to reflect people's fears about closures or erosion of core services, respondents' fears about the Royal Alexandra Hospital were generally about having to go there at all, particularly from residents of Helensburgh, Dumbarton and the surrounding area. This was on the basis of transport difficulties (particularly for those relying on public transport) but also around the perceived quality of care provided.

*"The health board seem to be ignoring the patient groups that exist. The maternity services are under strain and Paisley has an atrocious record and reputation." Individual, Cairndow*

*"Dumbarton goes into Glasgow with every option and there is real antipathy to Paisley here, and about having to go to hospital in Paisley." Individual, Dumbarton*

*"From the point of view of patients and their visitors, RAH is not the hospital that one wants to travel to." Individual, Dumbarton*

### **Vale of Leven & Victoria Infirmary (Helensburgh)**

The Vale of Leven and the Victoria Infirmary (Helensburgh) were highly regarded and residents of the surrounding area were fiercely protective of these local hospitals, particularly the Vale of Leven.

*"Many of us don't have time to hang around till 2007/2008. I want to see things happening now - we need our hospital, we want our hospital, we demand our hospital - we're not asking nicely, we demand to hold our Vale of Leven District General Hospital." Dumbarton public meeting*

Members of the public wanted commitment (particularly from NHS Greater Glasgow's Chief Executive, as their aspirations were to be managed by Glasgow) that sufficient support would be given to the integrated care model in order to support their local hospital, and retain services there.

*"Helensburgh residents want three major improvements in its hospital services - provision North of the Clyde, the reversal of the rundown of the Vale of Leven Hospital and more services available locally." Organisation, community council*

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### 3.2.3 Impact of boundary change generally

The proposed boundary changes were recognised to have implications for the management/senior management of the successor boards (as well as for NHS Argyll & Clyde's management). There was concern that managing the transition/integration will place an additional burden on management time, which might impact on issues such as patient flow (where so many reassurances have been given) in unforeseen ways. The transition and integration of NHS Argyll & Clyde into a successor board or boards was not widely commented on during the consultation, but those (in management, primarily) who did comment on it felt the issue needed a higher profile:

*"The integration of two Board areas is a significant undertaking, which cannot and should not be underestimated. The potential impact on services for Highland patients, already challenging budgets, the significant impact on senior managers and senior lead clinicians must be supported in order to ensure the integration does not impact on either the development programme for NHS Highland patient services or on any development for NHS Argyll & Clyde." Organisation, public sector health focus*

*"Council is concerned that the consultation paper fails to recognise the implications for the successor Health Board to deliver sustainable and high quality health services while trying to manage the debt inherited from NHS Argyll and Clyde." Organisation, local authority*

*"We trust that whatever option is agreed that the needs of service users and staff are kept to the fore during the unavoidable disruption as the new structures are evolved." Organisation, public sector health focus*

### 3.2.4 Co-terminosity

The issue of co-terminosity arose in all strands of this consultation. Of the three 'favoured' options discussed in detail in the consultation paper, option 1 is the only one to address the issue of co-terminosity with local authorities as it places the entire Argyll & Bute Council area within the management of NHS Highland. The move towards co-terminosity (and the efficiencies of administration and consistency/equity of service provision which go along with this) was the second most common argument for option 1, after arguments around NHS Highland's expertise in managing rural areas.

*"Co-terminosity with the local authority boundary of A&B should remain in line with the development of CHPs. This is thought to be particularly relevant in respect of Joint Futures and Community Planning agendas. Co-terminosity would avoid complications and duplication of workload for the CHPs, having to work across two health and two local authority systems." Organisation, public sector health focus*

*"We agreed that Option 1 would be the preferred option. This is because we believe that the way forward for health and community services is through very close working with the local authorities and moving towards joint management systems to reduce duplication and bureaucracy. This is very much in the direction of current SEHD Joint Future policies." Organisation, public sector health focus*

As the quotations above indicate, the co-terminosity resulting from placing Argyll & Bute Council's area entirely within NHS Highland was also viewed as being hugely important from the perspective of enabling an effective Community Health Partnership to be established in that area. NHS Highland currently have three CHPs covering their area, and a fourth one comprising Argyll & Bute Council would fit in well with

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Highland's model (its population of around 91,000 is comparable to NHS Highland's other CHPs).

*"Option 1 would allow joint working with social work to continue. This is especially important in care of the elderly, mental health provision and child care." Staff, public sector health focus*

Where representations for an Argyll & Bute CHP have been made there are typically strong caveats to the effect that the CHP must be empowered, autonomous and in control of its own budgets.

*"It is essential that Highland give A&BC substantial autonomy, with its own Arbuthnott calculated budget." Organisation, community council*

*"The autonomy of the Argyll & Bute CHP must be protected." Organisation, community care forum*

*"I'm not sure any of the options are best for NHS Argyll & Clyde, but if (I) have to vote for one it would be option 1 with an empowered CHP." Individual, unknown location*

As well as the creation of co-terminosity being a strong argument in favour of option 1, the loss of (the opportunity to have) co-terminosity was a strong argument against the other options, particularly option 2.

*"Option 2 would weaken Argyll and Bute CHP and complicate the development of integrated primary, community, social and children's care with the emphasis on health improvement that the local authority working with a single organisation would bring." Individual, Argyll and Bute*

The loss of co-terminosity was regarded as being more problematic for NHS Greater Glasgow than for NHS Highland however:

*"I think the problems in option 2 would be more for Glasgow: we would still be working with a single local authority and an area that would be big enough to be a CHP area in its own right. The problem with option 2 is how you would get an integrated care approach for the very small area of the West Dunbartonshire corridor. Glasgow would have another local authority to deal with, adding to its long list!" Organisation, public sector health focus*

### **3.2.5 Natural communities**

The issue of natural communities was one of five factors identified by the Scottish Executive, prior to issuing the consultation paper, as having a bearing on where administrative boundaries should be drawn. In particular the consultation paper refers to *'the need to recognise the very close links of the Helensburgh and Lomond areas with Glasgow.'* This formed a large part of the argument in favour of option 2:

*"It is perfectly clear to me that Helensburgh and Lomond form a natural community through Dumbarton with Glasgow ... Helensburgh itself is in the Greater Glasgow conurbation. Helensburgh feels itself an organic part of Greater Glasgow." Helensburgh focus group*

*"Every connection from Helensburgh is with Glasgow. On any dimension that you want to speak of, Helensburgh's natural community is with Glasgow - that's where a lot of people work, go for entertainment and leisure." Helensburgh workshop*

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*“The Helensburgh strip is part of Greater Glasgow.” Helensburgh public meeting*

The opportunity to have co-terminosity through option 1 was perceived by many to be outweighed by giving proper recognition to the issue of natural communities:

*“Option two would split the Council areas and involve reorganisation of Council services, however it would recognise the links that Helensburgh and the Lochside have with Dumbarton and Alexandria. This would address some of the resistance that may exist within the community and with health care teams.” Organisation, health focus*

*“The area up to Loch Lomond is very much part of the 'suburbs' of Glasgow and this over-rides the desirability of keeping an artificial council area intact.” Individual, Helensburgh*

The remainder of Argyll & Bute was perceived to have a distinct identity as a natural community, justifying its empowerment as a strong CHP, although it was not necessarily considered to be ‘Highland’.

### **3.3.6 Understanding of rural issues**

It was widely regarded that NHS Highland has proven expertise in managing services in rural areas, while NHS Greater Glasgow specialises in managing urban and suburban areas. NHS Highland’s perceived expertise in managing rural areas was the most prevalent argument in favour of option 1 and also an argument in favour of option 2.

*“The meeting acknowledged the experience within NHS Highland of managing services across mixed, urban, rural and island communities, and felt that this was a common feature with Argyll & Bute.” Organisation, local authority*

*“NHS Highland, while having the experience to manage rural areas well, has also developed strategies for urban areas (e.g. Inverness) and we therefore see them as being able to manage the remaining urban areas within Argyll and Bute.” Organisation, non-specific health focus*

*“The socio-economic profiles in Argyll and Bute are similar to those of Highland. The two areas face similar geography, travel and transport infrastructure and therefore share the same challenges in respect of providing safe and sustainable local health and social care.” Organisation, public sector health focus*

NHS Greater Glasgow’s perceived lack of rural expertise, which was acknowledged by NHS Greater Glasgow itself, was a strong argument against option 3.

*“We are aware that there are proposals to put the Kintyre area under the control of Greater Glasgow Health Board. It is the opinion of this medical practice that this would be disastrous, as Glasgow has no experience of running medical services in a remote and rural area.” Organisation, health focus*

*“We don’t want to go in to Glasgow – a rural place like this would get lost in Glasgow.” Campbeltown workshop*

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### 3.2.7 Transport

The issue of transport emerged as a major concern for respondents throughout the consultation, and not just in rural areas. Various different issues transpired with regard to transport – concerning whether patient flows would change resulting in more travel for patients, travel costs and problems with travel arrangements of patients (emergency and non-emergency) and partners/parents/visitors presently.

Despite assurances that patient flows will not change, some respondents still worried that if NHS Highland took on the Argyll and Bute area, they would be required to go to Inverness for acute care.

*“(Our) members are primarily concerned about the effects the redrawing of boundaries will have on the patient’s journey. Nurses in Campbeltown are concerned that the links which have been set up with specialist centres within Greater Glasgow would be lost if the decision is taken for this area to go in with NHS Highland. Our members are concerned that vulnerable patients with serious medical conditions will have to build new relationships with staff in Inverness.” Organisation, health focus*

One of the main issues with regard to current transport provision was the lack of public transport available to Paisley:

*“There’s not even a bus route from here to Paisley – you need to get a taxi. If you need to rush to that hospital, you’ve got the motorway and the traffic.” Greenock public meeting*

Views were also expressed over the need for patients to have support from relatives with them, the difficulties that were expressed in terms of travel and cost of travel for relatives was also a common theme:

*“Should anyone need hospitalisation in Glasgow, Paisley, etc., then relative support is out the window, rural transport inadequate, if private transport used, then parking provisions are inadequate for the relatives to use. Overnight accommodation costs are very high.” Individual, Campbeltown*

*“Travel costs haven’t been considered today and on those in the most vulnerable sections of society. They fall on the least financially capable people in our community.” Helensburgh public meeting*

There were several comments with regard to how the change in boundaries would affect staff, who would have further to travel for meetings, if not to have overnight stays:

*“Well I think that some of it is simply organisation in Argyll and Clyde, organising a meeting for 9am, well how can we be there? How can they expect it to be easy for someone from Paisley to attend a 9am meeting and for us it means that we’ve got an overnight away from home and we’re on call anyway.” Islay public meeting*

The provision of transport was considered to be vital to improving health care, both by individuals and organisations:

*“We believe that improved transport arrangements to health facilities must be a key consideration of the Scottish Executive’s objective to improve access to health care, and (we) already work(s) closely with health service providers to deliver enhanced accessibility to health*

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*facilities.” Organisation, non health focus*

People very much appreciate the emergency travel arrangements from very remote, rural and island populations for patients, but there is a recognised issue for visitors:

*“When it comes to acute services we are well off here, in my experience it took longer to get from the emergency room to the ward than from here to the hospital! We are better off here getting an air ambulance to the hospital for acute services than people getting an ambulance from a residential area of the city to the hospital, because of traffic and restrictions etc. Jura is pretty good as well.” Islay workshop*

The issue of transport was also raised in relation to Option 1, where it was suggested a few times that:

*“Highland NHS has much knowledge of the difficulties of patient and visitor transport to distant hospitals and understands the necessity of effective transport links.” Individual, Helensburgh*

### **3.3 Priorities**

The consultation highlighted a number of priorities for patients, staff and service providers, which are discussed in this section.

#### **3.3.1 Maintaining and improving current service levels**

Participants at all levels of the consultation consistently placed high priority on the need to maintain or improve current service levels, and expressed concerns about the erosion of services and especially local services.

*“It is the opinion of this group that the overriding concern must be for the patients to be served within the redrawn Health Board Boundaries and that whichever option is selected should cause minimal disruption to the provision of locally based services.” Organisation, public sector health focus*

Although there were many assurances given that patient flows would not change as a consequence of boundary changes, a related concern was that the flow of clinicians (e.g. Glasgow clinicians performing outreach work in Argyll) might change following changes to boundaries.

*“One of my concerns was about the outreach services being provided by consultants from Greater Glasgow, you know they go out and see people in their own localities. Is there an absolute assurance that they won’t pull back and say well that area is not my problem now; it’s not within my area, it’s Highland’s problem? Is there an absolute assurance from those guys that the status quo will continue until such a time as is clarification on the tertiary agreement?” Inverness workshop*

#### **3.3.2 More local service delivery**

Throughout the consultation process, people talked of their fears about further diminution of local services; the restoration of local services that had been wound-down; and the increase in delivery of local services through partnership approaches (enabled by CHPs for example). The Kerr report prioritises local service delivery and this was supported consistently during the consultation.

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### 3.3.3 Maintaining current patient flows

There was a widespread misconception among the public that the dissolution of NHS Argyll & Clyde, and the transfer of areas to NHS Greater Glasgow and NHS Highland, might change where received treatment. Participants in the consultation were generally very resistant to the idea that they might have to travel elsewhere for their treatment, and under option 1 for example, people were concerned that they might have to travel to hospitals in NHS Highland for treatment:

*“If we go with option 1 is there a danger we may have to go to Fort William or Inverness if we require to be seen at an Accident and Emergency Department?” Individual, Helensburgh*

*“If we go with option 1, we have a position of Highland commissioning services from Glasgow. We are a patient from Helensburgh and we are in Highland but we want to go to Glasgow: are we on an equal footing as a Glasgow resident? I’ve been trying to think of a better term than second class citizen, but I can’t find one. Am I as a patient of Highland, a second class citizen in Glasgow? Am I on an absolute level footing of a resident in Glasgow? Am I on Glasgow’s waiting list, is Glasgow bound to treat me the same as if I was a resident of Glasgow? That is what patients really want to know. The commissioning is the major issue.” Helensburgh focus group*

Patient flows remained a high priority and were viewed as being decisive to the process of redrawing the administrative boundaries.

*“Natural patient flows should be a deciding factor.” Individual, Helensburgh*

The concern was raised that despite the reassurances being given now, patient flows might change in future perhaps if the successor board/boards encountered financial difficulties of their own:

*“How can people believe that, because if your board did hit financial rocky water, you might not want to spend your money in Glasgow. You might want to spend your money in Inverness.” Individual, Oban*

Again reassurances were given to this specific point, however it is clear that there is a certain degree of mistrust among the public that means this issue will remain a priority despite any reassurances from NHS management or the Scottish Executive.

### 3.3.4 Reducing bureaucracy and being more patient focused

There was limited support for retaining the status quo and maintaining the current NHS Argyll & Clyde structure, with the majority of participants either explicitly or implicitly supporting the dissolution of NHS Argyll & Clyde. For those who explicitly agreed with the dissolution of NHS Argyll & Clyde, the reasons given were either about reducing the management costs of the NHS as a whole in Scotland, or were linked to negative criticism levelled directly at NHS Argyll & Clyde’s board: whichever was the case, these participants wanted to see less management and better services for patients.

*“As a former employee I am delighted that the board is to be disbanded. The NHS has deteriorated owing to more and more managers and the take-over of bureaucracy.” Individual, Helensburgh*

*“I must comment that I am glad to see the back of NHS Argyll and Clyde as services have been continually run down through its poor*

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*management especially at the Vale of Leven General Hospital in Alexandria.” Individual, Helensburgh*

### **3.3.5 Having more local management (ie. CHPs)**

Participants in the consultation generally appeared to be aware of CHPs, although this was variable depending on area. CHPs were a topic of discussion at all public meetings and were referred to frequently in official responses to the consultation. CHPs were understood by participants to provide a mechanism for health services to be managed and delivered at a more local level and for certain services (such as community care) to be delivered in partnership with other agencies.

CHPs were a priority for the public, to the extent that some perceived that CHPs would (or should) be more important structures than the parent health boards:

*“We are underestimating the CHP’s role in this. The board structure is slightly academic once CHP’s are brought in.” Individual, Cowal*

Some offered support for CHPs but with certain caveats, for example with the public/patients being properly represented on the partnership board:

*“I would have faith in the CHP if they had adequate community representation.” Individual, Barrhead*

There was also some cynicism about CHPs, with a fear that they might not be as effective as is being suggested and might in fact represent merely another layer of bureaucracy or, worse, that they will just be the next ‘fad’ of the NHS for five years before a further restructuring. The priority, therefore, has to be to ensure that CHPs are empowered, effective and efficient bodies that deliver what they set out to do:

*“CHPs are great and they sound good, but I mean how much democracy do we need and the reality is it will be the same half a dozen people that will turn up for community planning? I’m a realist, I know that if I stand again, I’ll be responsible to the people that elected me and you have to have that. I hate to see this, another tier of government, whatever level it’s at...there are so many acronyms about it, it’s really confusing!” Individual, Campbeltown*

CHPs were a priority not just for the public but for the potential successor health boards. NHS Highland currently operates three CHPs, but it was perceived that these were still in their developmental phase:

*“We are very much still in our infancy with the CHP’s, we are still getting members from the community at the moment. I would say that it is running fine at the moment but there are still a lot of centrally based issues and the infrastructure is not there at the moment.” Inverness workshop*

### **3.3.6 Ending the uncertainty**

The uncertainty over the future management arrangements for NHS Argyll & Clyde, and the impact any change of administrative boundaries will have on patients and staff, came through in the consultation as being strongly negative on trust and morale. For example:

*“There are a lot of plans to cut services and change where services are provided and we think ‘what’s going to happen to Inverclyde’, we’re sitting here with so much uncertainty above our heads and you just*

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*wonder what is going to happen, so many questions are unanswered.”  
Greenock workshop*

*“Crucial plans on future provision of support services (e.g. catering and laundry) will be prejudiced by the uncertainty around these planned changes.” Organisation, non health focus*

*“We want to reassure our own staff, make sure they know they aren’t going to take on extra work burdens: there’s uncertainty for them.”  
Organisational stakeholder*

*“(We are) concerned about the uncertainty surrounding this review, and the impact this has on staff. Staff are unsettled and this can cause problems for both retention and attracting staff into the NHS in this area. There is no assurance for example that staff will remain at their current place of work and given that the successor health board will have a wider geographical area to cover, this could lead to the problems (we have) becoming self perpetuating: a lack of staff causing a further erosion of local health services in the area.” Organisation, local authority*

The redrawing of the administrative boundaries was also adding to people’s existing anxiety over particular local issues, for example the new Rothesay hospital and the future of the Belford Hospital that serves the Lochaber area:

*“What really has to happen is that the uncertainty needs to end. (The spokesperson) said ‘you have my word’ and I respect that, but what the community needs is a written, very clear statement down from the Chair of NHS Highland to say what we are doing for the Belford Hospital - so people know about the future of their hospital.” Fort William public meeting*

### **3.3.7 Argyll & Bute Community Planning Partnership’s Peoples’ Panel survey**

Argyll & Bute Community Planning Partnership submitted the results of a recent Citizens’ Panel survey, which included questions pertinent to the boundary consultation. This survey had 629 respondents, and indicated the following priorities for the people of the Argyll & Bute Council area:

- 89% of respondents thought it was more important for health care decisions to be made locally;
- 86% thought that Argyll & Bute Council’s rurality made service delivery more difficult;
- 36% of respondents perceived that Argyll & Bute Council area would receive less funding if it became part of NHS Highland and 50% thought it would receive less as part of NHS Greater Glasgow; and
- 47% perceived that a standalone Argyll & Bute health board would bring more funding to the area.

In terms of Kerr Report principles, the order of priority for the 629 Argyll & Bute residents that were surveyed was as follows:

- keeping services as local as possible (68%);
- access to services (66%);
- improving NHS management and how money is spent (61%);
- safe and sustainable services to support rural communities (51%); and
- giving the public and patients a voice (33%).

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In terms of co-terminosity, views were split: 46% of respondents in the Argyll & Bute Council area thought that service delivery was hindered if service providers had different boundaries, whilst 45% thought that boundaries made no difference in this regard.

### **3.4 Opportunities**

#### **3.4.1 IT**

Throughout the consultation, the issue of IT (for meetings) and telemedicine opportunities and development was brought up regularly, particularly when Options 1 and 2 were being discussed:

*“Although Option 1 creates a very large geographical board area for NHS Highland this could be managed through creation of a devolved management structure and use of technology e.g. videoconferencing.” Individual, location unknown*

*“It will be difficult to get consultants to go to Inverness for meetings; you’ll have to get much better at video conferencing so that people don’t need to travel to these kinds of meetings.” Organisational stakeholder*

There was a split between respondents who thought that telemedicine facilities needed to be developed and expanded and those who thought that telemedicine was not an effective means of communication.

*“While video conferencing can on occasion be useful it cannot fully replicate partner agency staff meeting together particularly in the early days of forming new working relationships. Video conferencing facilities are not readily available in all areas.” Organisation, public sector health focus*

Substantial investment in IT infrastructure and training to use it would be required.

#### **3.4.2 Kerr Report**

The Kerr Report ‘Building a Health Service fit for the Future’, was welcomed by many respondents in the consultation as creating opportunities, particularly in terms of innovative ways of delivering services locally:

*“Kerr has opened up the debate on rural general hospitals and there is an opportunity for Highland here to become leaders in rural health care.” Organisational stakeholder*

There were comments regarding when it was going to be implemented:

*“It’s not the Kerr report that we want to see anymore, its implementation of it all!! It’s nearly six months since the report was published and we want to see it being implemented!” Dumbarton public meeting*

It was commented that the Kerr report was generally accepted by the public but it was questioned whether this was positive or not:

*“There is a general universal acceptance of the principles of the Kerr report; I don’t think anyone is disagreeing with anything that Kerr says. The other side of the coin, it’s seen to be something by everybody – does that mean it’s not going to work? I think that the idea is correct as to the management of the area.” Organisational stakeholder*

The Kerr report, alongside the boundary changes, was considered to present possible opportunities to the downgrading of hospitals which is currently evident in NHS Argyll & Clyde, e.g. Inverclyde Royal and Vale of Leven Hospitals in particular.

### 3.4.3 Shared learning about rural service delivery

Views were expressed throughout the consultation that NHS Highland would be able to share expertise and experience of delivering rural health care, due to people perceiving the areas to be similar. Suggestions were also given that an expanded NHS Highland would be able to enhance the research knowledge of rural health care:

*“It would facilitate the creation of more effective links between the NHS and clinical education providers to progress the development of a range of clinical education programmes designed and targeted specifically to support rural health care. There is also an opportunity to enhance the body of research knowledge into remote and rural health care.”*  
*Organisation, local authority*

## 3.5 The options

The consultation document states that the Scottish Executive has not reached any firm view of what the new NHS administrative boundaries should be in Argyll & Clyde but highlights three preferred options, from seven which were considered by the Minister for Health and Community Care. The number of formal responses for each option is shown in table 4 below:

**Table 4 Count of vote against each option**

Option	Individuals	Organisations
1	95	43
2	172	28
3	60	14
1 or 2	7	10
1 or 3	1	0
2 or 3	30	1
1, 2 or 3	0	1
4	8	0
5	45	6
No option selected/unable to choose	92	16
Total	510	119

Responses to the formal consultation were not required to give their full address but at least 158 individuals responded from the Helensburgh area. 48% of these expressed a preference for option 2, 19% for either option 2 or 3 and 18% for option 1 (the balance did not give a view). A further 55 individual responses expressed a preference for option 2 but their area of residence was not known.

41% of the public sector health related organisations (total of 41) expressed a preference for option 1, 15% for option 2, 10% for option 3, 10% for either option 1 or 2 and 22% did not give a view. Other health related organisations (total of 22) gave more mixed responses: 27% for option 1, 18% for option 2 and 23% for option 3. 36% of other, non-health specific organisations preferred option 1 and 32% option 2.

The Advisory Group felt strongly that no option should be closed off at the consultative stage, and the Minister also invites comment on the discounted options, so each of the

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seven options is discussed below. The geographic boundary of each option is first described, before points made during the consultation are discussed.

### 3.5.1 Option 1

*Option 1 suggests that the complete Argyll & Bute Council area should be included within the administrative boundaries of NHS Highland, with the remainder of NHS Argyll & Clyde (Inverclyde, Renfrewshire, East Renfrewshire, West Dunbartonshire) being administered by NHS Greater Glasgow.*

Options 1 and 2 are very similar, the difference being whether the Argyll & Bute Council area remains complete and moves to NHS Highland, or whether the Helensburgh, Lomond, Cardross and Roseneath Peninsula area is seen as a separate natural community and is managed by NHS Greater Glasgow. This was highly controversial with many, although not all, residents of the area in question expressing a different preference (option 2) to clinicians and the majority of local GPs (option 1).

Both options were described by various participants as the “logical” option, often without further comment! Members of the public in other areas of Argyll and Clyde were quite likely to give a response of “option 1 or 2” as they did not feel that it mattered to them which of these was pursued. This was considered to be rather simplistic to others, as the inclusion or exclusion of populations of this scale was perceived to have an inevitable impact on managing boards, with bureaucracy seen to increase and complications arise if areas are not co-terminous with local authorities.

Whilst many participants in the consultation accepted the principle of separating the management of urban and rural parts of Argyll & Clyde, there was some discussion around whether Helensburgh, in particular, was urban or rural and whether Highland or Greater Glasgow would understand their needs better. There was also some discussion around whether or not Highland and Argyll & Clyde had similar geography or not with specific reference to the number (26) of populated islands in Argyll & Clyde and the greater sparsity of rural population in Highland. Whilst the two areas may not perhaps exhibit exactly similar profiles in terms of density of population and island population, there is evident commonality and understanding of the challenges faced in delivering health services. This provides increased opportunities in terms of further researching, building expertise and generating innovative responses to the Kerr report in providing rural healthcare.

A strong proviso was made by many expressing a preference for option 1: the Argyll & Bute CHP must “have teeth”, i.e. be empowered organisations, with autonomy to make decisions and allocate budgets (having these allocated to A&BCHP by the Arbuthnott Formula so neither A&B nor the rest of Highland can be seen to be “stealing” from each other), including the commissioning of services. This was seen to ensure that there was local involvement, ownership by the community and clinicians, understanding of the issues, response to identified needs and local accountability.

*“(We have) decided that, of the options consulted on, the best future structure to best meet staff and patients needs is represented by option one. The majority of staff attending recent meetings voted for option one. The majority of local professionals in primary care and hospital services believe that Argyll & Bute should be a CHP within Highland with very devolved decision making powers.” Organisation, public sector health focus*

*“Option 1 is probably the most acceptable socially and politically and if local commissioning was accepted, could give almost the same benefits as creation of another Health Board.” Individual, Islay*

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*"I am increasingly confident that Highland will actually start working in a different way - I did have some concerns initially as they are quite Inverness centric and if you speak to people in Caithness or Skye or whatever, the focus is felt to be too much on Inverness. I think by having Argyll and Bute as part of that health board will help them work a bit differently." Organisational stakeholder*

Option 1 offers the 'simplest' solution in terms of management as it reflects co-terminosity with local authority boundaries. As a result, the suspicion has been expressed regularly throughout the consultation that this is the Minister's favoured option! Co-terminosity with local authority boundaries was perceived to be important, particularly with the introduction of CHPs as these bring together the NHS with local authorities in delivering community based health and caring services. This was considered to be essential for such things as community planning, 'A Joint Future', integrated children's services, and health improvement more widely. Having contiguous boundaries was therefore seen to be beneficial as this reduces bureaucracy and ensures consistency of approach and service provision as far as possible. Lorn & Isles Locality Management Team, Argyll & Bute LHCC, Argyll & Bute Council and many other organisations and individuals supported this option overall, primarily because of the benefits of co-terminosity and NHS Highland's understanding of rural issues, including those based in the Helensburgh and Lomond area. This was seen to be in place already in the area and to be recommended by other areas where co-terminosity was appreciated to bring benefits, e.g. in Highland.

*"Central to this is the principle of coterminous boundaries between agencies. While we recognise that this does not exclusively ensure cohesive service planning and delivery it does provide good foundations on which to develop." Individual, Appin*

*"... (we) would argue that dividing Argyll and Bute Council area along a boundary that no longer exists appears artificial and confusing and one that could lead to planning problems which co-terminosity with Argyll and Bute Council may well alleviate from the outset" Organisation, voluntary sector health focus*

*"Splitting and creating different boundaries between health and local authority agencies leads to fragmentation, duplication, unnecessary effort and lack of common identity." Individual, Appin*

A reason cited early on in the consultation process was that residents of Argyll & Bute would have more funding per capita with NHS Highland than with NHS Greater Glasgow. This has not been borne out by the allocation calculations provided by the Scottish Executive, however.

Option 1 was also preferred by many in Argyll & Bute as there was concern that Greater Glasgow would prioritise urban needs over its small rural population. The area was perceived to have more "clout" if managed by NHS Highland. The increased say that Argyll & Bute would have in Highland, rather than Greater Glasgow given the proportion of the new board they would represent was also raised by different organisations and individuals. Whilst this principle applies, the figures quoted varied (Argyll & Bute would represent 31% of the new Highland population as opposed to Helensburgh and Lochside constituting 2% of the increased Greater Glasgow population).

*"The total population of the Argyll and Bute area would give it 'clout' in decision making and financial benefit." Individual, Bute*

This was not universally the view in Helensburgh, however:

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*“Divided by rivers is bad, but divided by hundreds of miles of mountains is worse!” Helensburgh focus group*

Criticisms of all preferred options came from Inverclyde in particular around fear of downgrading or closure of Inverclyde Royal Hospital. There was a perception that the needs of Glasgow would be more important and *“Inverclyde would just have to fit in”*.

The need for adequate representation from the Argyll & Bute area in NHS Highland was also raised by a number of participants in the consultation and the logistical difficulties in getting people from Argyll & Bute to represent the area on the board because of the travelling involved were raised.

*“I think it may be difficult to attract good members who are willing to serve in NHS Highland, if you consider members from Campbeltown that have a 5 hour journey to get there. It’s another reason for the health board devolving as much decision making to some Argyll and Bute body – maybe more lay people, councillors can be involved in that.” Interview*

Another reason for support of option 1 was that it would have minimal impact on Greater Glasgow, of all the three preferred options. NHS Greater Glasgow was seen to have faced financial challenges recently with a drop in population (and resultant drop in allocation) and is a massive organisation undergoing considerable, and painful, structural change. Anything which could further de-stabilise Greater Glasgow was therefore perceived poorly, particularly by those based in or representing Greater Glasgow.

*“To summarise, (we) favour Option 1 and consider that options 2 and 3 have substantial defects which might perpetuate the problems clinicians are seeking to address. “ Organisation, public sector health focus*

The position of the Helensburgh GPs was criticised as being their latest ‘flirtation’, as the quote below illustrates:

*“Some GPs in Helensburgh have argued for NHS Highland to provide our healthcare. As I have the utmost respect for their professional ability, I considered their views at length. I regret that I remain unconvinced by their arguments not least as these were the same GPs who three years ago, insisted that we move into NHS Greater Glasgow; two years ago it was Paisley; last year they were adamant that they had to be part of the West Dunbartonshire CHP; and now it has to be NHS Highland.” Individual*

### **3.5.2 Option 2**

*Option 2 suggests that most of Argyll & Bute Council should be included within the administrative boundaries of NHS Highland, with the exception of the former Dumbarton District Council area, i.e. the west shore of Loch Lomond, Helensburgh, Cardross and the Roseneath Peninsula; with the remainder of NHS Argyll & Clyde being administered by NHS Greater Glasgow.*

Option 2 was also a popular option and the strength of feeling in the Helensburgh and surrounding areas is noted. The largest response to the consultation from any one location (174 responses plus Jackie Baillie’s survey) came from residents/organisations here and local organisations and groups encouraged local people to respond. It should be noted that this was not always appreciated, however:

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*“It is important that the views of the people affected by these decisions are the views of the people themselves and not those necessarily of the politicians, community councils or local authorities who have all been seen to have actively ‘lobbied’ the public in the street or at supermarkets. While public apathy has been a problem, perhaps overzealous enthusiasm by the concerned activist may make the opinions expressed not quite as independent and truly representative as people would like to think.” Individual, Helensburgh*

The management and delivery of health services in Helensburgh has been the subject of much discussion in recent years, with campaign groups established to achieve service delivery north of the river (North Clyde Action Group) and retention of services at the Vale of Leven Hospital (Vale of Leven Hospital Services Forum). A petition was submitted to the Scottish Parliament last year by the North Clyde Action Group, which consists of informed and articulate residents of the area, several of whom have played key roles in the governance of health services locally. The petition called for NHS Greater Glasgow to manage and provide services for Helensburgh and locality as it is seen to be a natural community with Dumbarton and the links of geography and transport are to Glasgow, not Paisley.

One of the issues expressed by residents living in Helensburgh was that they feel that they are on the periphery of NHS Argyll & Clyde. The fear of being small in terms of population (and therefore ‘say’) and being located geographically on the periphery was one which was expressed in a number of areas, not just Helensburgh.

Helensburgh and surrounding area was perceived by many participants (living in or supporting Helensburgh) to be more urban than rural in nature and to have a closer affinity to Greater Glasgow in terms of natural community than to NHS Highland. It must be remembered that residents of the Roseneath Peninsula and other parts of Lomond felt that they were rural and therefore preferred option 1. Health is a very emotive issue, and one which members of the public find difficult to think about without thinking of direct service delivery:

*“We heard from the GPs that by going into Argyll and Bute we would become 48%, which would be 48% in medical terms of nothing effectively. If I want medical treatment, I don’t want to go to Campbeltown, Inverness or God knows where unless I want psychiatric treatment. We wish to go to the nearest suitable hospital, it can’t necessarily be down the road, we don’t want to go anywhere else but Glasgow, who has the expertise and the skill and the concentration of expertise - I represent the people that want to stay alive!” Helensburgh public meeting*

*“NHS Greater Glasgow has expertise in serving urban needs, including areas of deprivation. Helensburgh and district is not rural and its natural connections are to the major urban area of Glasgow and therefore the residents of that area must join Dumbarton and the Vale in being managed by NHS Greater Glasgow.” Organisation, community sector health focus*

Many people living in Helensburgh felt that if services were delivered by NHS Greater Glasgow, they should be managed by NHS Greater Glasgow. People expressed a clear preference in local services being maintained at the Vale of Leven Hospital or going to Gartnavel or the Jubilee Hospital rather than the Royal Alexandra Hospital in Paisley as they are closer and easier to reach. The Vale of Leven was also perceived by some people to be more likely to “survive” and services to be retained if it was managed by NHS Greater Glasgow.

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*"I therefore feel strongly that Option 2 is the best outcome for my area - that we should be amalgamated with NHS Greater Glasgow and that, given the probable extra burden on Glasgow hospitals, the Vale of Leven Hospital should be restored to its former status in terms of staffing. This upgrading (e.g. as a blue-light hospital) would take care of much of the western extremity of the new NHS Greater Glasgow. Paisley should not come into the equation because of its situation and the difficulty of access for the people of the Helensburgh area."*  
Individual, Helensburgh

Co-terminosity was also raised by two transport organisations as an argument for option 2. Joint working between transport and health organisations was identified as important and option 2 was seen to be the closest fit to regional transport planning areas. SPT highlighted in their response that the west of Scotland travel to work area extends beyond this, to include Cowal and Bute, however.

Others could not understand why adding the more densely populated areas of Argyll & Clyde to NHS Greater Glasgow would be of benefit, it would be more of a challenge for NHS Greater Glasgow which was already seen to have a hard job to do.

Others stated that the people of Helensburgh were seen to have 'voted' to join Argyll & Bute Council and to be part of the community so presumed the reasons for that were still valid. Others considered the local authority boundary changes to represent "gerrymandering", however, and not to reflect the preference of local people.

The lack of co-terminosity with the local authority, and the benefits associated with this particularly given the high proportion of health care provided at a local level, was seen to be the major criticism of option 2. Jackie Baillie's response cites the decentralised structure of Argyll & Bute Council's service delivery and management, as presenting little problem on this issue, however, others highlight the inputs at strategic level and different standards of service/ways of working as being the problem, rather than the point of delivery being the issue.

The scale of NHS Highland was also commented upon and criticised by a number of participants for both options 1 and 2.

Local MSP Jackie Baillie also conducted her own survey of local views and the findings of this are presented below. There are a number of caveats which should be taken into account when considering these findings, however, as follows:

- It must be noted that the analysis provided by Ms Baillie did not match the data on the 711 questionnaires submitted (the results on 729 questionnaires were reported).
- There were actually only 678 valid questionnaires as 11 people had submitted two responses and 22 photocopies of responses were also submitted.
- The questionnaire did not mention boundaries other than in one specific question, but talked of NHS Greater Glasgow and NHS Highland having "responsibility for patients", that the consultation is on "the future provision of local health services" and that "This is an important opportunity for you to have your say on how you will access health care in the future.", contrary to the way in which things are expressed in the consultation document (accepting that there is mistrust and disbelief over what is stated in the consultation document). It also covers issues of service delivery.
- The questions asked can be open to criticism of bias as they are not asked in a neutral way, but seek agreement/disagreement to a particular standpoint.
- The wording of the last question on preferred options "would be covered by" is open to misinterpretation (and further complicates the evident misunderstandings around management of and access to services).

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- Some comment was also made by local people that this survey was not administered as inclusively as it could have been. Ms Baillie's covering note stated that questionnaires were distributed to local organisations, including community councils, tenants & residents associations and GP surgeries and their availability was advertised in the local press/radio and from time spent talking to the public outside supermarkets.

The findings reported here are therefore taken from the questionnaires submitted, with the exception of the duplicates. A large number of local people wished to give their views and these should be considered, provided these caveats in interpretation are observed. The topline findings from Jackie Baillie's survey are as follows:

- 80% strongly agreed that *"When planning health services, we should focus on natural patient flows rather than artificial boundaries"*. 16% agreed, less than 1% disagreed, 1% did not know and 2% did not respond.
- 66% strongly agreed that *"It is sensible to have the same Health Board to manage and provide our services"*. 21% agreed, 2% disagreed, 2% strongly disagreed, 5% did not know and 3% did not respond.
- 63% strongly agreed that *"Patients in Dumbarton and the Vale of Leven should be treated by NHS Greater Glasgow"*. 18% agreed, 4% disagreed, 6% strongly disagreed, 4% did not know and 3% did not respond.
- 58% strongly agreed that *"Patients in Helensburgh and Lomond should be treated by NHS Greater Glasgow rather than NHS Highland"*. 19% agreed, 5% disagreed, 5% strongly disagreed, 9% did not know and 3% gave no response.
- 71% strongly agreed that *"All health services should be provided north of the river"*. 13% agreed, 5% disagreed, 3% strongly disagreed, 3% did not know and 5% did not respond.
- 86% strongly agreed that *"As many services as possible should be provided at Vale of Leven Hospital and Gartnavel should be used for more specialist services"*. 9% agreed, less than 1% disagreed, 1% did not know and 3% gave no response.
- 70% of respondents expressed a preference for option 2 (bearing in mind the different wording of the question: *"Dumbarton, Vale of Leven, Helensburgh and Lomond would all be covered by NHS Greater Glasgow"*), 14% for option 1 (*"Dumbarton and Vale of Leven would be covered by NHS Greater Glasgow while Helensburgh and Lomond would be covered by NHS Highland"*), 8% for option 3 (*"This is similar to option B, but will include the Cowal Peninsula, Dunoon and Bute, Mid Argyll, the Kintyre Peninsula and the islands of Islay, Jura and Gigha all being covered by NHS Greater Glasgow also"*) and 7% gave no response.

Helensburgh Community Council's response stated that they had been seeking community views and 82% of people who had expressed an opinion to them were in favour of NHS Greater Glasgow managing local health services.

### 3.5.3 Option 3

*Option 3 suggests that just the most northerly part of Argyll & Bute Council area (Mull, Oban and surrounding areas) should be administered by NHS Highland, with NHS Greater Glasgow administering Inverclyde, Renfrewshire, East Renfrewshire, West Dunbartonshire, the west shore of Loch Lomond, Helensburgh, Cardross, the Roseneath Peninsula (as option 2) plus Dunoon and the Cowal Peninsula, Mid Argyll, the Kintyre Peninsula and the islands of Bute, Gigha, Islay and Jura.*

There was less support for option 3. The initial response many participants gave to option 3 was *"why is this an option?"* as it was not perceived to address the problem identified by the Minister of meeting the needs of both urban and rural populations within one health board area.

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*“This is just a continuation of the same non rural management for large areas of Argyll which has led to the problems Argyll and Clyde Health Board face.” Individual, unknown location*

The boundary was seen to be arbitrary, despite the Executive stating that it reflected patient flows, as it was not perceived to reflect patient flows fully (people within the southerly part which would go to NHS Greater Glasgow under this option were understood to use the hospital in Oban, for example).

There was also concern that if the remainder of the Argyll & Bute population was detached from Oban, then this might affect patient flow to Lorn and the Isles Hospital and this facility may then be under threat of closure/downgrading due to its proximity to the Belford Hospital at Fort William.

*“Option 3 is completely unacceptable: I have heard it described in many of the public meetings as the option that reflects patient flows. As a GP ... I know that where care cannot be delivered locally in L&IDGH then patients will travel to Glasgow rather than Inverness. Patient flow also happens from Lochgilphead and Campbeltown to Oban. Similarly mental health services are provided from Lochgilphead and this option would separate us from this excellent service.” Individual, Oban*

The lack of co-terminosity with local authority boundaries was also seen to be a drawback of this option for many participants in addition to it breaking up natural communities (whilst there is debate around whether Helensburgh is part of the natural community of Argyll & Bute, the rest of Argyll & Bute is perceived to feel part of one community).

This option did receive some support, however. For some participants, this was the “mistrust option” as they felt it would be harder for patient flows to change from Glasgow if NHS Greater Glasgow was responsible for managing health services in their area. There was a concern that those outwith NHS Greater Glasgow may not receive the same degree of priority as residents of Greater Glasgow.

Geographically, it received good support in Inverclyde, where some viewed this option as giving Inverclyde Royal Hospital the best chance of having a viable acute service. Option ‘3A’ was suggested at Inverclyde public meetings, which added North Ayrshire to option 3’s boundaries as the population there also accesses Inverclyde Royal Hospital and this was considered to help ensure its future. Option 3 also received some support in the Inverness public meeting as it presented less of a risk to services and patients in the existing Highland area.

Two organisations and three individuals expressed support for option 3 on the basis that the resultant scale of NHS Highland would present the fewest difficulties in terms of transport, which is in essence the same as rejecting options 1 or 2 on the basis that the geography and transport would be problematic (options 1 and 2 were rejected frequently on this basis as discussed earlier in this report).

The absorption of just the most northerly parts of NHS Argyll & Clyde was viewed by one respondent as potentially positive for NHS Highland:

*“It would allow the strengthening of links in the West Highlands between Fort William and Oban, and would give a greater focus on the remote and rural issues for the northern part of the current NHS Argyll & Clyde.” Organisation, public sector health focus*

A relatively small number of official responses from outwith NHS Greater Glasgow’s proposed catchment (i.e. from Highland) area expressed support for option 3, on the

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basis that this option presented the fewest potential problems for NHS Highland and would cause least disruption to services in that area.

There was also support for option 3 from the area of NHS Argyll & Clyde that would be adopted into Glasgow on the basis that Glasgow was perceived as being much more accessible than Inverness. This support was based partly on concerns about bureaucracy and administration, but also on worries over changes in patient flows (despite the reassurances being given that these would not change).

There was a disproportionate response to the public consultation from people living in and around Helensburgh, largely attributable to the slight difference between options 1 and 2 applying specifically to that area. There was some support for option 3 from fourteen people living in Helensburgh, although with little rationale other than them wishing any option except 1 to be selected.

*“I can give my full support to Option 2 or Option 3 within the consultation document, both of which would see the Helensburgh and Lomond (H&L) area included within the Greater Glasgow Health Board area.” Individual, Helensburgh*

#### **3.5.4 Option 4**

*Option 4 is maintaining the current NHS Argyll & Clyde structure. This was rejected by the Minister as it was not seen to be appropriate to write off the accumulated deficit whilst maintaining the existing structure as it would not address the structural problems that are perceived to affect NHS Argyll & Clyde.*

Option 4 was supported by only 1% of responses. Whilst the Advisory Group was keen for the public to consider all seven options within the consultation document, the public did not generally think that this was an option as the Minister has made the decision to dissolve NHS Argyll & Clyde and they did not think this would be overturned which was confirmed by Scottish Executive representatives.

#### **Maintain status quo**

The loss of NHS Argyll & Clyde was not perceived negatively by the majority of participants in the consultation and very few participants expressed the desire for it to be retained, although there was comment on it being dissolved in isolation of a wider review of health boards across Scotland and before the reason for its financial failings is understood, as cited previously.

Nine responses did however feel that the retention of NHS Argyll & Clyde was the best option, particularly given what they perceived to be a lack of good evidence for its dissolution, uncertainty as to how redrawing boundaries would resolve the problem, and concern that the problems NHS Argyll & Clyde had experienced would simply be transferred to the successor board/boards. Coupled with this final point was a fear that adopting part or all of NHS Argyll & Clyde could be detrimental to a successor board.

*“There are no guarantees that the new health board/s will not have the same difficulties as Argyll & Clyde presently do.” Organisation, local authority*

Among those who felt that NHS Argyll & Clyde should be retained there was a common view that it had not been given sufficient time to resolve its financial deficit problems, and indeed was making positive progress with its recovery plan:

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*“The Argyll & Clyde Health Board area would have met the needs of the area, had it been given time to turn things around.” Organisation, public sector health focus*

It was also argued several times that there was insufficient justification to dissolve NHS Argyll & Clyde at the present time, which was reinforced by the fact that the Arbuthnott Formula is currently under review (and the belief that the review would lead to NHS Argyll & Clyde receiving more funding in the future).

*“If the Arbuthnott formula is changed in favour of some better system, Argyll & Clyde might be able to survive in its own right? Can we not hang on until then?” Individual, Isle of Mull*

*“I would ask that you reconsider...the complete paper. Remain with the status quo...improve management and increase funding and resources in the existing Argyll and Clyde structure.” Individual, unknown location*

*“The current structure should remain until the Executive responds to the National Framework for Service Change and then we can consider NHS Scotland as a whole.” Individual, Glasgow*

A small proportion of those participants who argued for the status quo also felt that neither NHS Greater Glasgow nor NHS Highland were equipped to take on the challenge, for example:

*“I think the plan to redraw the boundary is ridiculous. I don’t think that what goes on in South Argyll is really complementary with the culture in Greater Glasgow and I think that Glasgow has really got enough of its own problems, without adding another community’s problems. Most of the rest of Argyll is far too remote for Inverness.” Individual, unknown location*

### **Support for dissolving NHS Argyll & Clyde**

It was common in public meetings for there to be widespread support for the dissolution of NHS Argyll & Clyde. In terms of official responses to the consultation, as well as the respondents who wished for NHS Argyll & Clyde to remain, five called explicitly for it to be dissolved (in addition to those who supported other options and therefore implicitly accepted its dissolution). A subset of these respondents supported the general principle of reducing the number of health boards and what they saw as undue bureaucracy and administration within the NHS in Scotland. The following comments reflect the general views in this regard:

*“I worked for Argyll & Clyde Health Board for 29 years, and I raised three hearty cheers when I heard it was no longer going to exist. Nobody seems to be crying too hard!” Individual, Oban*

*“The Minister has determined to dissolve NHS Argyll and Clyde on the 31st March 2006. I applaud this decision.” Individual, Dunbartonshire*

*“As a former employee I am delighted that the board is to be disbanded. The NHS has deteriorated owing to more and more managers and the take-over of bureaucracy.” Individual, Helensburgh*

### **3.5.5 Option 5**

*Option 5 suggests establishing an NHS board co-terminous with the Argyll & Bute Council area. This was rejected by the Minister as it was considered to be a small board and not seen to fully address the structural problems of NHS Argyll & Clyde.*

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Option 5 was supported by few formal responses. There was some surprise that this option had been rejected by the Minister, as many participants felt that it was a more viable and appropriate option than option 3, particularly as it addressed the issue of co-terminosity with local authority boundaries.

*“The complete disregard to the Argyll and Bute option, an option that seems to be imminently feasible has been disregarded completely. There is no explanation for this.” Oban workshop*

This was only raised by participants as a possible option in the Argyll & Bute Council area, as might be expected. Argyll & Bute Council voted on their preferred option and the Council was found to be in favour of option 1 (18 votes, versus 10 votes for option 5 and 2 votes for option 2), however, it has been suggested that councillors were influenced by the fact that the Minister had discounted option 5 so there was seen to be no point in voting for it.

*“My question is why did you discount the option of an Argyll and Bute health board? What you are saying to this is that it is due to size and that it would be inefficient. You asked us to consider the factors of natural communities, size, rural issues and geography, co-terminosity: these factors make Argyll and Bute the best option. If we go with Highland there is a fear of being marginalised.” Individual, Argyll and Bute*

*“A really exciting possibility, not covered in this consultation, would be for a co-terminous health and local authority area, which could work towards a much more closely integrated social and health care entity. This is, I believe, the direction in which Joint Futures, demographic considerations and Professor Kerr’s report are all pointing, and I expect it to be endorsed by the 21st Century Social Work Review.” Individual, Ayrshire*

Argyll & Bute Council felt that discounting option 5 was a missed opportunity, as they saw a great deal of potential around sharing procedures and accommodation with an entirely co-terminous Argyll & Bute health board:

*“It would be more efficient, not less, to have an Argyll & Bute health board as this would fit with efficient governance reform and the two organisations [i.e. the health board and local authority] could share audit and standards committees, etc. It would be more complex with Highland, but we could work together in terms of estates, cleaning, catering, etc. We could also share office accommodation and help to rationalise the office accommodation here - it would be an opportunity which we won’t get if NHS is not completely co-terminous with the Council. There would be no gaps in governance or consultation if we were one body and budgets were pooled.” Stakeholder interview*

There was significant discussion around whether a health board was required at the Argyll & Bute level or whether a Community Health Partnership (CHP) would suffice. An Argyll & Bute CHP, managed by NHS Highland, was seen to be the “second best” option if an Argyll & Bute health board was not possible, but there were conditions attached to this for local people:

- it must have high levels of autonomy to make budgetary decisions, and decisions about structure and service delivery appropriate to Argyll & Bute, which may not reflect models of other CHPs in Highland;
- it must have local people governing the area, as they know the geography, the culture and the problems facing their communities; and

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- a CHP with the power to purchase and commission was viewed as desirable, however it was argued that this was unprecedented and therefore not a factor on which to base a preference.

*“The doctors seem to think they will have a lot of power by belonging to the Argyll and Bute CHP, they say they will be able to purchase and commission services. At this moment in time in Scotland, CHP’s don’t have any power of purchasing or commissioning and it doesn’t matter what the Argyll and Bute CHP decides, the power will lie with the health board, the health board in Inverness.” Helensburgh workshop*

The extent of the support for options 1, 2 and to a lesser extent 3 can be viewed as an implicit rejection of the Argyll & Bute health board option, however, some participants lodged explicit objections to option 5.

*“There has been a suggestion that there could be an NHS Argyll and Bute. This has emanated from some Councillors who seem hell-bent on laying the dead hand of bureaucracy on the health service. Under option 2 we’ll constitute approximately one third of the population of the new NHS Highland, which will ensure that fair representation on the NHS Highland Board takes place.” Individual, Tarbert*

There was an awareness of the agenda to move the NHS in Scotland towards fewer boards, and the idea of an Argyll & Bute was recognised to be contrary to this:

*“Option 5 is not sustainable - if 15 health boards are too many then why do it?” Organisational stakeholder*

*“I think in Scotland the general opinion is there are too many Health Boards... therefore to introduce a new, inevitably very small Health Board, would be complete folly!” Oban public meeting*

*“Argyll & Bute would always be an expensive option. In my job I’ve tried to discuss with people what models of management would work. I still think that an Argyll and Bute health board would be very expensive.” Islay workshop*

There was also a fear that an Argyll & Bute health board would lack the critical mass to retain its district general hospital:

*“The population would be about 98 to 100,000: that would not be a sufficient population to have a district general hospital and we’d lose the Lorn [and the Isles]. That would be the fear of a health board of that size.” Isle of Mull public meeting*

### **3.5.6 Options 6 and 7**

*Option 6 suggests NHS Greater Glasgow administers the entire NHS Argyll & Clyde area. Option 7 suggests NHS Highland administers the entire NHS Argyll & Clyde area. These were both rejected as they do not address the complexity of managing a mix of rural and urban communities.*

There was very little comment on these options, with only a couple of responses expressing a preference for one or the other. Others recognised that options 6 and 7 did not address the challenges faced by NHS Argyll & Clyde in addressing both rural and urban needs.

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### 3.5.7 Other suggestions

Participants to the consultation were invited to give any other suggestions, outwith the proposed options and rejected options stated in the consultation document. There were several comments suggesting an extension of NHS Ayrshire and Arran to take on parts of the current NHS Argyll and Clyde area:

*“I think Ayrshire and Arran taking in Inverclyde could have been a possibility and it seemed to get ruled out early on – I think it could have been worth having that debate about whether Ayrshire and Arran could have taken some of it on.” Interview*

*“I would have thought that inclusion of Renfrewshire and Inverclyde in the Ayrshire and Arran region would have made more sense, in terms of both geographic and demographic balance.” Individual, Renfrewshire*

Several suggestions were made, specifically to NHS Ayrshire and Arran taking in Inverclyde or alternatively, *“Ayr and Arran coming in with Argyll and Bute – North Ayrshire, make the river the boundary.” Johnstone workshop*

A couple of views were put forward that Option 3 should have the *“additional inclusion of Largs”*, this was a view put forward particularly at the Greenock workshop and the Largs public meeting.

There were a couple of views put forward for creation of health boards which were quite different to the options stated in the consultation document – primarily given for geographical reasons or because an extended NHS Highland was perceived to be too large. One health board with rural and island expertise was suggested by a few participants, but not selected as their preferred option.

### 3.6 The consultation process

It is readily acknowledged that no research or consultation programme is perfect and there are always real world constraints which impact on the way in which programmes are conducted, but it is important to reflect upon the process, identify areas for improvement and mitigate against these in future. It is understood that an evaluation of the consultation will be conducted but there is some initial feedback which can be considered at this stage. Members of the public who attended the public meetings gave spontaneous feedback on the process and those participating in workshops and depth interviews were asked specifically about their opinions on the process and if there were any ways in which it could be improved. Whilst there was much positive feedback on the way in which the consultation was conducted, and it was perceived to be a substantial improvement on previous Scottish Executive consultation, there was also criticism of specific aspects of the consultation which should inform future consultation.

In terms of positive feedback on the process, the appointment of an independent chairperson was received well. Pennie Taylor’s approach was praised very highly by a range of different participants and she was seen to handle difficult meetings, with challenging personalities, very well and kept both the discussion and timetable on track.

*“Meeting well run and informative. Lesson for NHS to learn – this formed MUCH better forum than last round of consultations run and ‘chaired’ by NHS staff (who on own admission are not good communicators).” Individual, Helensburgh*

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*"I think the whole day has really raised issues that some of us didn't think of before and I think we have had more debate and chance to ask questions and I think we'll make a more reasoned decision now." Islay public meeting*

There was a small amount of criticism, however, as one MP would have liked there to have been presentations at the start of the meetings (this was decided against deliberately). Another participant suggested that there was perhaps some bias towards the Highland option. This was reported second-hand, however, so could not be explored further.

The wider consultation process was appreciated as a substantial improvement on previous Scottish Executive and NHS consultations. The public meetings were generally perceived to be a useful way for people to hear more fully about an issue, both from officials and other members of the public attending, and express their views. The attendance of Scottish Executive personnel, with four or five in attendance at each meeting, was well received and it helped to show that the Executive is listening. The attendance of NHS Greater Glasgow and NHS Highland personnel was also well received, although full coverage of all meetings would have been appreciated. The absence of NHS Argyll & Clyde personnel was noted and criticised by some members of the public, however.

Efforts had been made to ensure as many members of the public as possible were made aware of the public meetings. Posters were sent out to local shops and offices, press advertisements were placed at the start of the consultation process and the week before each meeting and the meetings were publicised on the Scottish Executive website. Participants still reported not having seen any of these methods of communication, however. This is a common communications issue, not restricted to this exercise. When asked how else people could have been notified, no other suggestions were forthcoming once people were aware of the extent to which the meetings had actually been publicised.

Workshop participants were recruited via CVS and Community Care Fora networks. Whilst this assistance was appreciated and it was the most effective means to reach organisations given the timescales, it is acknowledged that it is difficult to maintain the currency of databases and they may not have been fully comprehensive of all community and voluntary sector groups. It also took some time to arrange facilitation of a mailing with some umbrella organisations, which impacted further on the notice given to some groups to attend.

Whilst the consultation was seen to be more inclusive, there was some criticism that it was not even more inclusive, involving excluded and hard to reach groups more fully. The view was taken by the Advisory Group that the key excluded and hard to reach group in terms of this consultation was people living in remote and rural areas and the programme of workshops and public meetings was considered to address this as fully as possible within the timescales.

The two most significant and widespread criticisms focused on timescales and lack of information, particularly on financial data. The decision was taken by the Minister to dissolve NHS Argyll & Clyde in May 2005. Whilst it is recognised that the Scottish Executive liaised with the Consultation Institute and were advised by them not to consult over the summer months, this time could have been used effectively to plan the consultation, book venues, arrange mailings, and to inform the public about what was happening in more detail. The Advisory Group did not meet and the process did not kick off until 1<sup>st</sup> September 2005 – one-third of the consultation period had already passed at this point. This constrained the way in which the consultation could progress and members of the Advisory Group were very conscious of this. This also resulted in members of the public and organisations in some areas (those at the start of the schedule of consultation) having very little notice of the workshops and public

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meetings, a gruelling programme of meetings for the Chair and Scottish Executive representatives to attend and very little time for those areas at the end of the process to submit a formal response to the consultation, even with an extension to the deadline of one week.

*“The time given to let patients and public know about participating opportunities that were organised by NHS was far too short to allow us to take part in this way. News about the consultation meetings came out only four weeks before the closing date for responses. This does not allow time for information to go out through networks, to inform individuals and allow arrangements to enable understanding and discussion.” Organisation, health focus*

The Scottish Executive's consultation document was praised by some participants as being more accessible in terms of language used and print size, although others felt words like 'rurality' and 'co-terminous' were too jargonistic. However, it was heavily criticised for lacking substantive information in terms of the wider context in which health services fit, financial impacts of the different options and operational impacts on health services in Argyll & Clyde and those areas which will adopt responsibility for its management and governance. The lack of financial information was a particularly vehement criticism across all aspects of the consultation programme. Members of the public made it quite clear that it was unacceptable that the consultation document did not contain any financial information and no financial information was released until after close of business on Monday 7<sup>th</sup> November - after the original deadline for consultation. Participants strongly felt that they could not make an informed decision on the best future option for management of NHS services in Argyll & Clyde without adequate financial information, not just on allocations but detail on where the over-spending is occurring, and neither could the Minister.

*“It has been good having Pennie Taylor chairing the public meetings – she has done a good job (been focused and kept to time in difficult circumstances) but has been let down by the Scottish Executive team not providing information.” Interview*

*“(We) believe that, as part of the consultation process, consideration should also have been given to population projections, deprivation and health needs data and information. The Council feels that there is no detailed level of information included in the Executive's paper to give a better understanding of the complexity of health issues in the area.” Interview*

*“...this document is laughable if it wasn't involved in such a serious consultation. This looks as though somebody has put it together on their tea break and flung it out the door (applause), so that, as the gentleman from the Scottish Executive said 'we are seen to be consulting the public' and that's all this is. Despite what you say, Pennie, this is a publicity stunt.” Greenock public meeting*

*“With reference to the actual consultation process it has been complicated by the lack of substantive data on the underlying causes of the situation that brought about the Minister's decision. For a consultation to be truly valid all information necessary for a measured consideration of the options must be accessible by the consultees. In this case the reason for the change is financial and the implementation of the change will have long term financial consequences irrespective of the option chosen. However, no data on finance forms part of the consultation process. There is a concern that because the reasons for the continuing overspends are not yet understood, or if they are they are not part of the publicly available supporting data, changing the*

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*administrative arrangements may simply move the causes of the cost over run into another area to the detriment of that Board's budget."*  
*Organisation, public sector non health specific*

*"None of the options tell us in any way, shape or form what the consequences of picking a particular option will be. In other words we are being offered a pig in a poke." Individual, unknown location*

The way in which the options were presented (with three prioritised by the Minister and four discounted) also biased the consultation process.

*"It is perfectly acceptable for the Minister to state his option preferences, and it is right to have his reasons. However, the consultation document gives undue weight to those options and in doing so sets a biased agenda for the terms of the consultation."*  
*Organisation, community care forum*

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# 4 Conclusions & recommendations

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## 4.1 Conclusions

There was a good level of response to the Scottish Executive on the issue of NHS boundaries in Argyll & Clyde and excellent dialogue during the more participative elements of the consultation programme, which give some insight into local views, preferences, concerns and priorities for the future. There are a number of key messages for the Minister for Health and Community Care to consider as a result, both on this issue and more widely, as follows:

Members of the public feel strongly about their health services and many are suspicious of any change, on the basis that in the past this has equalled a cut in service rather than an improvement. This suspicion spreads to consultation, by both the Scottish Executive and the NHS more widely, as this has been considered to have usually been a 'sham' in the past, with the decision already made and no notice taken of local people's views. A lot of effort has been put into challenging this perspective and assuring the public that this is genuine consultation, so care must be taken to retain the integrity of this process and to rebuild trust on these issues. Honest feedback on the decision will assist with this.

Very different perspectives exist on the issue of NHS boundaries in Argyll & Clyde, for very different reasons. Some participants have taken the consultation document's perspective that this is about administrative boundaries alone and will not affect services at face value, whilst others have clearly related the two issues. Some of this will inevitably reflect misunderstanding of what is proposed, as has been illustrated in many discussions around having to go to Inverness to receive hospital treatment, for example, but others feel there will be a fundamental change in services as a result of boundary changes and consider the consultation document to be too simplistic and therefore misleading in this regard.

The overwhelming priority amongst both clinicians and members of the public is that good quality, safe, sustainable, accessible health services continue to be provided and are improved upon. The principle of providing more care locally, outlined in the Kerr report, was welcomed and was considered to be reassuring for many around the security of their local hospital services in particular, although there was concern that these would be so depleted by the time Kerr is implemented that it will be difficult to recover the level and range of services they wish to see provided locally. There was particular concern around the Vale of Leven and Inverclyde Royal Hospitals, although there was some hope that NHS Greater Glasgow may find other solutions to the challenges faced by NHS Argyll & Clyde given their critical mass and teaching links.

Option 1, with a strong CHP for Argyll & Bute, and option 2 have received most support. There was evident support for an NHS Argyll & Bute (option 5) in some areas of Argyll & Bute but the way in which the options were presented were suggested to have biased the final number of supporters of this option in the formal responses, including within Argyll & Bute Council. For those who supported option 5, a strong CHP within NHS Highland (option 1), with local autonomy, devolved budgets and good representation on NHS Highland's board, was generally the second choice. The Minister must therefore effectively choose between options 1 or 2, or defer his decision and re-consult once the reasons for NHS Argyll & Clyde's financial difficulties are understood, fuller financial information is available, an option appraisal has been conducted and the public can then make an informed choice. Given the need to end the uncertainty amongst staff and the public, the latter option seems unlikely at this stage but there was a call for this in some quarters.

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Many members of the public who did not live in the Helensburgh and Lomond area did not express a preference between options 1 or 2 as they felt it should be up to the people in that area. The majority of clinicians and organisations (including NHS Highland, NHS Greater Glasgow and local authorities) did feel a lack of co-terminosity would impact on others in Argyll & Bute and West Dunbartonshire (as the CHP is already established there) and so expressed a preference for option 1. The majority of those who lived in Helensburgh indicated a preference for option 2. The response from the Helensburgh and Lomond area was complex, however, as those in Helensburgh and Cardross considered Glasgow and West Dunbartonshire to be their natural community and not Argyll & Bute, but those in the more rural, northerly parts of this area expressed more affinity with rural NHS Highland (although there were obviously fewer of them giving this message). There was a lot more to many people's responses than boundaries, however, as previously debated issues of where services are delivered from were raised, with many local people objecting to going to Royal Alexandra Hospital in Paisley rather than Glasgow hospitals and seeking reassurance on future service delivery at the Vale of Leven Hospital. If service flows will not change following re-organisation of the boundaries, as has been intimated, this will continue to be an issue for local people. Whichever organisation takes over the management of health services in this area must consider responding to this expressed desire around patient flows.

Very mixed messages have been provided around the financial allocations to the area and the successor boards. There are serious concerns around the efficacy of the Arbuthnott formula in Argyll & Clyde and appropriate future levels of funding for successor boards, which must be addressed.

## **4.2 Recommendations**

This consultation has explored a very complex issue and the decision the Minister must make is not an easy one. It is recommended that the different perspectives illustrated in this report, with the greatest support expressed for options 1 and 2, inform this decision, although it is recognised that the feedback from public consultation is only one element the Minister must take into account. This consultation gives a flavour of public feeling but there are questions over the drivers of expressed preference, particularly given the dearth of financial data and the reason for NHS Argyll & Clyde's problems.

Recommendations about the consultation process can be made, as follows:

- Any consultation must genuinely be consultation, where views expressed are listened to, considered and influence the decision made. This consultation has been presented in this way but there is a lot of scepticism of this amongst the public. Every effort should be made to preserve the integrity of this process, with clear feedback given on why the eventual decision taken has been taken and ways in which the Minister will respond to expressed concerns.
- The public and NHS staff should be involved in developing options for consideration and those options should be presented in an equitable manner.
- Any consultation must be supported by adequate and accurate information. In this instance, the process would have been improved immeasurably if the reason for NHS Argyll & Clyde's deficit was clear and the financial and operational implications of each of the proposed options was specified in detail.
- Adequate planning and preparation time is vital in order to consult and engage with communities properly. The appointment of an Advisory Group was extremely useful but this should have met, with those conducting the consultation also appointed, much earlier in the process. Consultation is not ideal over the summer holiday period but preparation could have been done in

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this time to ensure the public had as much notice of the ways in which they could engage and time to consider the information as possible.

- Consideration should be given to providing some structure to the formal response template used by the Executive, whilst retaining the opportunity to provide supporting text, to ensure key information is captured. This could include preferences for different options and reasons for these, in addition to demographic information to enable responses to be compared to the wider population in terms of age, gender, ethnicity and geographic area.

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# Appendices

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Appendix 1      Public meeting details

Appendix 2      Public Consultation Advisory Group membership

Appendix 3      Public meetings participants

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## Appendix 1 Public meeting details

**Campbeltown – Kintyre Community Education Centre**  
Monday 3 October, 6.30pm-8.30pm

**Lochgilphead – Lochgilphead Community Centre**  
Tuesday 4 October, 7pm-9pm

**Largs – Vikingar Centre**  
Wednesday 5 October, 7pm-9pm

**Helensburgh – St. Joseph's Primary School**  
Thursday 6 October, 7pm-9pm

**Mull – Craignure Village Hall**  
Monday 10 October, 7pm-9pm

**Oban – Corran Halls**  
Tuesday 11 October, 7pm-9pm

**Dunoon – Queen's Hall**  
Wednesday 12 October, 6.30pm-8.30pm

**Fort William – Ben Nevis Hotel**  
Thursday 13 October, 7pm-9pm

**Glasgow – Glasgow Royal Concert Hall**  
Tuesday 18 October, 7pm-9pm

**Islay – Columba Centre**  
Thursday 20 October, 7.30pm-9.30pm

**Paisley – Paisley Town Hall**  
Monday 24 October, 7pm-9pm

**Greenock – Greenock Town Hall**  
Tuesday 25 October, 7pm-9pm

**Dumbarton – Denny Civic Theatre**  
Wednesday 26 October, 7pm-9pm

**Inverness – Tulloch Caledonian Stadium**  
Thursday 27 October, 7pm-9pm

**Rothesay – Rothesay Pavilion**  
Tuesday 1 November, 7pm-9pm

**Gourock – Gamble Halls**  
Wednesday 2 November, 7pm-9pm

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## Appendix 2 Public Consultation Advisory Group membership

We would like to thank the members of the Advisory Group for their assistance throughout the consultation.

<b>Name</b>	<b>Organisation</b>
Pennie Taylor (Chair)	
Lorna Ahlquist	ACCRG, Cowal Community Care Forum
Ann Brogan	ACCRG
Jae Ferguson	ACCRG
Houston Fleming	ACCRG, Dykebar Patients Council
George Gillespie	ACCRG
Councillor Anne Hall	ACCRG, Renfrewshire Council
Ann Marie Kennedy	ACCRG
Nell McFadden	ACCRG, Inverclyde Community Care Forum
Councillor Sandy Nimmo	ACCRG, Inverclyde Council
Provost Luciano Rebecchi	ACCRG, Inverclyde Council
Thomas Sanderson	ACCRG, Acumen
Nikki Bell	FMR Research
Moira Anderson	NHS Argyll & Clyde
Gordon Robertson	NHS Argyll & Clyde
Mandy Robertson	NHS Argyll & Clyde
Penny French	NHS Ayrshire & Arran
Bill Goudie	NHS Greater Glasgow
Niall McGrogan	NHS Greater Glasgow
Jim Whyteside	NHS Greater Glasgow
Brian Devlin	NHS Highland
Gill Keel	NHS Highland
Chris McIntosh	NHS Highland
Liz MacDonald	Scottish Consumer Council
Brian Beacom	Scottish Health Council
Jane Davies	Scottish Executive Health Department
Rosie Hewitt	Scottish Executive Health Department
Hector McKenzie	Scottish Executive Health Department
Margaret Totten	Voluntary Health Scotland

ACCRG = Argyll & Clyde Community Reference Group

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### Appendix 3 Public meetings participants

We acknowledge and thank the following representatives of NHS Greater Glasgow, NHS Highland and the Scottish Executive for attending and contributing to public meetings.

<b>Name</b>	<b>Organisation</b>
Robert Calderwood	NHS Greater Glasgow
Tom Divers	NHS Greater Glasgow
Catriona Renfrew	NHS Greater Glasgow
Roger Gibbins	NHS Highland
Malcolm Iredale	NHS Highland
Gill Keel	NHS Highland
Derek Leslie	NHS Highland
Gill McVicar	NHS Highland
Alistair Brown	Scottish Executive Health Department
Jane Davies	Scottish Executive Health Department
Rosie Hewitt	Scottish Executive Health Department
Hector McKenzie	Scottish Executive Health Department
Geoff Pearson	Scottish Executive Health Department
Carmel Sheriff	Scottish Executive Health Department