

GREATER GLASGOW NHS BOARD
INVOLVING PEOPLE COMMITTEE

**Minutes of the first meeting of the Involving People Committee
held in Meeting Room B, Dalian House,
350 St Vincent Street, Glasgow
at 2.00 p.m. on Wednesday, 10 November 2004**

PRESENT

Peter Hamilton (Chair)

John Bannon Helen MacNeil
Ally McLaws Jessica Murray

IN ATTENDANCE

Jim Whyteside Public Affairs Manager

1. APOLOGIES

Apologies for absence were received on behalf of Councillor Bob Duncan, Bill Goudie, Ravindar Kaur Nijjar and Agnes Stewart MBE.

2. CHAIRMAN'S INTRODUCTION

Peter Hamilton welcomed Members of the Committee to their first meeting.

He explained that the Board had agreed to establish the new committee – a formal sub-committee of the Board - on 20 July 2004. Previously, an 'Involving People Group' had been in existence from April 2003. The group had carried out valuable work in identifying, supporting and developing Patient Focus and Public Development (PFPI) activity across NHS Greater Glasgow; however, with officers composing the greater part of group membership, and much time spent on 'planning and doing', its structure and role was not felt to be right for the changing environment of PFPI.

Peter went on to say the NHS Reform (Scotland) Act was responsible for this changed environment. This would lead to the dissolution of local health councils to be replaced by a single Scottish Health Council with a new assessment role. It also placed an obligation on NHS Boards in terms of public involvement and community engagement. This was further demonstrated by the decision of the Minister for Health and Community Care to convene future accountability review meetings in public.

He concluded by saying that the new committee, with a mainly non-executive membership, would therefore devote the greater part of its time to governance – ensuring that NHS Greater Glasgow delivered the PFPI agenda.

ACTION BY

He believed there would still be scope for the Committee to pursue some of the ‘planning and doing’, where appropriate e.g. arranging “Our Health” events.

Ally McLaws agreed. He felt the Committee would be ‘missing a trick’ if it did not take the opportunity to influence the delivery of PFPI rather than simply monitor it. It was a fine line, but the Committee would have to work with officers to achieve the correct balance. John Bannon supported Ally’s comments and recognised the scale of the challenge.

Jessica Murray enquired if there were a formal segment of NHSGG’s organisation which was responsible for delivering PFPI. In reply Ally explained that responsibility was fragmented around the system and Peter said that, ultimately, PFPI should be the responsibility of all managers and staff.

It was agreed that the Committee would have to take on some of the practical issues around PFPI in these circumstances.

Ally said that the ways in which PFPI was co-ordinated and managed would become more of an issue as NHSGG progressed through its coming re-organisation. It would be important to ensure that PFPI was not sidelined during the period of the shake-up.

3. REMIT AND RESPONSIBILITIES

Discussion took place around Committee Paper 01/04, which summarised the Involving People Group’s remit and range of responsibilities as approved by the NHS Board on 20 July 2004.

Having commented that the range of responsibilities was daunting, Helen MacNeil expressed Glasgow Council for Voluntary Services’ (GCVS) gratitude at having the opportunity to be represented on the Committee through her.

Given that so many different people were taking forward NHSGG’s PFPI agenda, she wondered how the Committee could link with them. Were there proper resources to obtain information and help with decision-making? What, for example, was the relationship with the Acute Services Community Engagement Team?

John shared these concerns. It was not clear to those trying to deliver better services how the Committee would support them. Ally thought this was up for discussion – there were various options as to how the Committee could function. Peter felt it would be helpful for staff leading on aspects of PFPI, such as the Community Engagement team to come before the Committee and set out their operating arrangements. It would then be up to Committee Members to offer questions and comment.

Ally felt it was useful for the Committee to reflect that it could not do everything and there were key milestones in the short-term – such as the acceleration of the acute services strategy, restructuring, consultation on smoking in NHS buildings and car parking – but it should be borne in mind that concentration on those alone may miss out underlying patient concerns. It was noted these issues would be touched upon in the action plan and the arrangements for linkages with staff PFPI leads would also have to be addressed.

Jessica thought that the remit fell into three broad categories: ensuring PFPI is implemented; monitoring, and; liaison with key interests. She wondered if it would be helpful to think in those terms and who the Committee would have to work in relation to each theme.

Ally noted that the Performance Assessment Framework (PAF) on PFPI was evolving and the Committee would have to deal with the criteria described in it. Jessica asked if the Committee's job was to sustain a framework for PFPI and, if this was the case, if it should then concentrate on those services or issues where not enough was happening.

Peter thought this suggestion chimed with inferences drawn from work done in compiling information for the action plan – the priorities alone came to twelve or thirteen main items and the Committee could not 'swallow an elephant' and do everything.

Ally felt that the Committee could make its responsibilities as complex as it wanted but was not attempting a 'cold start' – much was already in place to allow effective monitoring and to develop existing initiatives like 'Our Health'. He noted the concerns about linkages; as Designated Director for PFPI he had a role to play in that respect. Given the coming re-structuring, the Committee had an opportunity to help guide and shape the arrangements for management and co-ordination of PFPI across NHSGG.

The committee were reminded that assembling NHSGG's response to the PAF would be an early issue, with the first draft to be submitted to the Scottish Executive by December.

Helen felt that the tack should be to consider what outcome or added value the Committee would be expected to generate – how would success be measured? At this stage, it seemed to be about providing a shape and framework for PFPI at pan-Greater Glasgow and local level.

Peter concluded by confirming that he had thought it unlikely that the Committee would resolve its response to its remit in a single session of discussion. He looked forward to further debate with all members of the committee in attendance.

4. 'OUR HEALTH' FEEDBACK AND FOLLOW-UP

Ally McLaws tabled Committee Paper 02/04, which summarised workshop sessions at the first 'Our Health' event as staged at the Glasgow Royal Concert Hall on the morning of 23 September 2004.

He explained that the concept of the event had been to ensure Board Members could interact with the public and to let public and patient representatives express their opinions freely. The workshop-led format, based on a range of general topics, themselves built on the outcome of earlier 'scoping' research, had been designed to support this objective.

Ally suggested that most of the common themes and issues emerging from discussion, particularly in relation to PFPI, were consistent with previous comment. The fundamental points were about trust and the visibility and honesty of NHSGG decision-making.

NHSGG had been able to deliver immediate response to some of the points raised in the workshops by preparing for early consultation on making all NHS premises smoke-free.

In summary, Ally's view was that the public had no expectation that their comments would either be listened to or acted upon. This, perhaps, was the overriding issue that the Committee would have to tackle.

Some NHS professionals had expressed a fear of raising public expectations – this was misconceived - the NHS should not be afraid of this as in reality expectations were low.

Peter thanked Ally for his useful report. He added that he had spoken with people after the event who spoke in very positive terms re the organisation, conduct and topics covered in Our Health. They had also expressed the strong hope that the event would be followed up.

The final report on Our Health would be forwarded to all delegates following some minor design changes.

It was agreed the date of the next event would be confirmed when issuing the report.

Following a short debate about the merits of staging the next event in community-based venue, it was agreed that this would exclude people from other communities and limit the scope of discussion. It was decided that "Our Health" events in this series would be held in the city-centre as this was a fairer and more equitable location when pan-Greater Glasgow topics were the main themes.

When it came to the subject matter of the next event, Helen was of the view that NHSGG would have to find some way of agreeing and communicating with the public and patients just what was 'up for grabs' in terms of influencing decision-making. There were clear points that would have to be addressed:

- does NHSGG have real principles for engagement with the public and patients?
- usually, there is no 'blank canvas' around service reform – but it is never made clear what is actually changeable
- public, patients and staff needed the tools to push on with the PFPI agenda
- Community Health Partnerships (CHPs) were on their way. The voluntary sector had expressed concern about lack of engagement so far – would the Committee have to intervene here?

Jessica and Ally added that a particular issue emerging was that, whilst engagement and consultation structures received a great deal of attention, the need to improve patient focus at the front-line did not. Many patients felt intimidated by doctors and other staff and this was a real barrier to encouraging involvement in their own care.

John and Ally considered that CHPs were a useful topic in their own right. Few outside the NHS knew what they were (and fewer still had come to terms with the concept of LHCCs). Yet, the impact of CHPs would be far-reaching - in terms of the management and delivery of primary and other types of healthcare and as vehicles to completely transform NHSGG's means of public engagement and consultation..

Ally felt also that Ambulatory Care Hospitals (ACADs) again represented a revolutionary development in healthcare that could trigger discussion and input across a range of areas, such as signage, transport and access. Now would be the time to engage with people around ACADs as there was a real chance of influencing the final configuration.

Peter therefore proposed that there was a basis for two follow-up Our Health Events. The first focusing on CHPs, the second on ACADs, given the longer lead-in time for the delivery of the latter. The second event would benefit from close liaison with Community Engagement Team

DECIDED

That the next Our Health event will be staged no later than the end of February 2005, again in Glasgow Royal Concert Hall. The subject matter will be CHPs. The event will last for half a day

**Public Affairs
Manager**

That the report from the 23 September 2004 event will be formatted and circulated to delegates and Board Members with a covering note from Peter Hamilton announcing the February event.

**Chair,
Public Affairs
Manager**

That the Our Health event in February will be followed up with a subsequent event based around the topic of ACADs,

**Public Affairs
Manager**

That an early meeting should be arranged with Elsbeth Campbell and Juli McQueen of the Primary Care Division to discuss the organisation of the February event.

**Chair,
Public Affairs
Manager**

5. PROPOSED ACTION PLAN: MAIN ISSUES

The Chairman invited Jim Whyteside to introduce Committee Paper 03/04.

Jim explained that, in preparing options for an action plan/priorities for the Committee and NHS officers to address, a meeting of senior officers two weeks previously had identified a range of issues and then sought to provide summary sheets setting out background and possible tasks.

The topics put forward related to:

- **NHS Reform (Scotland) Act** (Transitional arrangements to the Scottish Health Council, NHSGG patient/public database representation and communications)
- **Acute Hospitals** (Key service redevelopment, achieving patient focus, patient and public representation, car parking and Beatson Oncology Centre Phase 2)
- **Modernising Acute Care** (ACADs, A &E services and acceleration)
- **Children's Services** (Patient and public representation and children's A & E)
- **Mental Health and Learning Disabilities**
- **Community Health Partnerships**
- **Fair for All/Diversity**
- **Staff Training and Development**
- **Community Engagement** (De-jargoning project, community transport and volunteering)

Peter thanked Jim for his introduction and noted that the comprehensive package of topics would be a useful primer for the Performance Assessment Framework submission due in December.

Ally thought that the summary sheet format might be a useful way to provide starting point information to the Committee about any aspect of service activity it may wish to deal with in future.

Helen asked what NHSGG spent on consultation and engagement. Ally replied that it was difficult to quantify this but Corporate Communications had created a range of means, mostly produced in-house, such as the website and leaflet production which helped hold down costs. Other means of dissemination, like *Health News*, were offset through advertising revenue. As an example, hostile questioning from a segment of the media, much to their chagrin, came to naught when it was learned that the cost of the recent Maternity Services consultation did not exceed £70,000 – relatively little given its scale.

Peter asked if the summary sheets could form the basis of a properly constructed action plan relating to PFPI for the Committee. The first version may, in some cases, lack specific timescales and identified lead personnel, but later issues of the plan would address this.

Helen and Jessica commented that this would provide an opportunity to identify those performance measures which make clear what ‘success’ in delivering PFPI would look like. Ally wondered if this could be achieved by another piece of ‘scoping’ research, drawing in the opinions of partners, patients, public and staff.

John felt that demonstrating success would be helpful to say the least in respect of the accountability review meeting to be hosted by the Minister in 2005. Peter agreed that much of the action plan could be used to inform the Performance Assessment Framework submission.

He asked if the group of officers which had prepared the summary sheets would be the Committee’s link to service delivery and development. Ally said that the group had met only on a one-off basis. His opinion was that another group would have to be established - Directors of Nursing, ostensibly leading PFPI in Divisions, really did not have the time to spend on this level of detail.

DECIDED

That those papers still to follow will be gathered and forwarded to Committee Members.

That a draft action plan will be assembled on the basis of the summary papers and circulated to Committee Members.

That options for officer-led co-ordination of PFPI be assembled and proposed.

**Public Affairs
Manager**

**Public Affairs
Manager**

**Director of
Corporate
Communications**

6. FREQUENCY OF MEETINGS

Peter proposed that the Committee meet every two months. This was agreed, although some flexibility around specific events, such as Our Health, would be required.

DECIDED

That the Committee would meet every two months on the second Tuesday as follows:

11 January 2005

8 March 2005

10 May 2005

12 July 2005

All meetings would commence at 2.00 p.m. and would be staged in Dalian House.

That minutes of meetings would be circulated by e-mail to Committee Members and following any corrections received then submitted to the NHS Board for inclusion in the papers of the Board Meeting that follows each Committee Meeting.

That Niall McGrogan would be invited to the January Committee Meeting to give a presentation on the work of the Community Engagement Team.

That thought would be given to the possibility of the newly appointed Chair of the Scottish Health Council, Brian Beacom, being invited to attend a future Committee Meeting.

7. AOCB – COMMITTEE MEMBER INDUCTION

Helen asked if there were any possibility of a briefing or induction programme that would allow her to get up to speed with NHS practice and structures and the background to PFPI. Jessica said she too would appreciate this.

Peter agreed to arrange this.

DECIDED

That the Chair would consider how Committee Members might be offered an induction session.

The meeting ended at 3.40 p.m.

All

Public Affairs
Manager

Chair

Chair

Chair