

GREATER GLASGOW NHS BOARD
INVOLVING PEOPLE COMMITTEE

**Minutes of the third meeting of the Involving People Committee
Conference Room B, Dalian House,
at 1.30 p.m. on Tuesday, 15 March 2005**

PRESENT

Peter Hamilton (Chair)

John Bannon MBE Ally McLaws
Pat Bryson Jessica Murray
Cllr Bob Duncan Ravinder Kaur Nijjar
Bill Goudie

IN ATTENDANCE

Sandra Bustillo	Head of Communications, North Glasgow
Alex McIntyre	Project Manager, New Victoria and Stobhill Hospitals
Niall McGrogan	Head of Community Engagement
Jim Whyteside	Public Affairs Manager

ACTION BY

1. APOLOGIES

Apologies for absence were received on behalf of Helen MacNeil, Elinor Smith and Agnes Stewart MBE

2. CHAIRMAN'S REMARKS

Peter thanked Committee Members for their kind wishes during his period of hospitalisation and recuperation.

He welcomed Scott Bryson to the Committee as a full member for the first time, representing the interests of the Area Clinical Forum.

Peter advised the Committee that Elinor Smith, Non-Executive NHS Board Member, had also agreed to join the Committee. Elinor would be present at the next meeting in May.

3. MINUTE OF MEETING OF 11 JANUARY 2005

The minute had been previously circulated by e-mail. It was noted that Ravinder's name had been mis-spelt as 'Ravindar'.

4. MATTERS ARISING

With reference to page 4, item 8, Jim tabled a one-page summary of the current situation regarding the national NHS Scotland complaints system, written by Gavin Barclay, Head of Administration at the South Division.

5. PATIENT/PUBLIC INVOLVEMENT IN THE NEW VICTORIA AND STOBHILL HOSPITALS

In his opening remarks, Peter drew attention to the fact that the next ‘Our Health’ event, as agreed by the Committee, would focus on the New Victoria and Stobhill Hospitals. He then invited Alex McIntyre and Sandra Bustillo to describe how PFPI has been taken forward in respect of the design of the new hospitals.

Alex explained that involvement activity was essentially ‘chunked’ into three areas – design and physical space, clinical redesign and communications.

Although, some elements are a given, PFPI is actually embedded within the specifications of the new hospitals. Consequently it had been possible to:

- arrange input from groups representing disabled people to ensure that best practice around mobility and layout was incorporated;
- bring patient groups together with architects;
- organise a workshop for 22 faith groups to discuss provision of spiritual care facilities, and;
- initiate work on a ‘wayfinder strategy’ to ensure that internal signage is clear and jargon-free.

Alex pointed out that a final bidder contractor had not yet been confirmed and thus it was only possible to do so much around the design specification.

He also referred to work being carried out to look at the format of some of the less obvious aspects of ‘communications’, such as patient records and appointment cards, particularly in trying to let patients know in advance where in the hospital they would receive treatment.

Alex continued, mentioning:

- a longer term project, leading to the appointment of an Arts Co-ordinator, who would ensure local community input, links and use of artwork within the buildings, and;
- transport assessments to support the ‘Green Travel Plan’ that must accompany each new hospital – this would seek to improve public transport access plus patient access to timetables and information.

In terms of clinical service re-design for the new hospitals, a ‘mass event’ around PFPI was not anticipated. Various clinical teams involved in designing services would be engaging with patients.

Dr Brian Cowan, the NHS Board’s Medical Director, chairs a specialty/GP group which would oversee the changes in clinical practice required to make the new hospitals function. No ‘one-stop’ services exist at this time and Managed Clinical Networks and Planning Implementation Groups, which have patient representation, would be involved in the design process.

Peter observed that a major task would be communications with the public around the services provided by the new hospitals and acute services modernisation generally. Councillor Duncan agreed and said that clarity was needed around key issues, such as the situation in West Glasgow.

Alex explained that the long-term strategy was to develop the Southern General as the main specialist inpatient Southside Hospital, with the Glasgow Royal Infirmary taking on a similar role in the North and Gartnavel taking up the balance. At the moment there was great deal of ‘cross-boundary flow’ of patients between different sites. This would continue in the foreseeable future but clinical design modelling would be used to help reduce this.

Pat asked what this would mean for transport – patients currently flowing into the Southern General would be treated in future at the New Victoria Hospital. Niall McGrogan responded: patient transport is a Scottish Ambulance Service responsibility and public transport is planned by Strathclyde Passenger Transport. Neither issue was in the gift of NHSGG to take decisions upon but negotiations were being pursued with both organisations.

Alex said that the context was that the North and South Monitoring Groups often focused their time on transport issues. His own view was that once the new hospitals became a reality, public transport would realign to suit the new sites and services.

Sandra Bustillo set out some of the planned communications activity. It had been clear that the term ‘ACADs’ utterly confused the public and use of this term by NHS staff and in communications should be discouraged. The new hospitals were an unknown quantity in Scotland and there was a real challenge in introducing the concept.

It was now possible to deliver the central necessity of detailed computer-generated images which showed what the New Victoria and Stobhill Hospitals would actually look like. The scale and scope of the hospitals was immediately apparent on the images. They would support:

- staff presentations;
- presentations to elected representatives;
- advertising billboards and posters
- a leaflet, and;
- elements of the ‘Our Health 3’ event.

Niall added that he had been liaising with Alistair Tough of the NHS Board Archive, who had provided archive material to be used in a display to help launch the New Victoria and Stobhill hospitals and provide a tangible link with the past.

Sandra continued, adding that the communications activity would be staged from April and run on to the autumn. Roadshows would take information out to public areas in local communities.

Niall suggested that Community Health Partnerships (CHPs) offered great potential for further community engagement on the links between local services and the new hospitals and, in particular, around changes to A & E services.

In response to a question from Peter, Alex confirmed that the working titles were the ‘New Victoria Infirmary’ and the ‘New Stobhill Hospital’. He went on to say that there was a ‘need to have a conversation with the NHS Board very quickly’ about this and other PFPI issues.

Peter then asked about the ‘soft spec’ of the building – if contracts were to be signed under PFI in the autumn, was there scope to ensure that best practice in signage and patient information was incorporated?

Alex was confident the architects would deliver what was necessary – they had long experience in healthcare.

Committee Members felt that the names of the hospitals had in some way to reflect their function. Alex suggested that the next ‘Our Health’ event might offer an opportunity to debate this and other issues.

Peter thanked Alex and Sandra for their presentation.

6. ‘OUR HEALTH 3’ EVENT

Peter asked Committee Members to consider a date and venue for the next event, which it had already been agreed would focus on the New Victoria and Stobhill Hospitals. It had been proposed that the event might be run on the same day as the Ministerial-led annual accountability review meeting, doubling up in a similar way to the first Our Health and the AGM in September 2004.

Ally said that the arrangement for the accountability review was not a ‘done deal’: the date of the meeting was understood to be 31 August 2005 and that would give time for more and improved graphics of the new hospitals to be available.

Ally did feel that it would be wrong to focus on the Victoria and Stobhill alone. The event was an opportunity to draw in wider issues around the reform of services and make clear that this was not just a matter of buildings but about ways of working too – in effect ‘the patient’s journey’.

Scott suggested that the example of Diabetes provided evidence of how Managed Clinical Networks had supported effective service redesign. This kind of example could be played into the event.

Councillor Duncan remarked that he was happy with the Glasgow Royal Concert Hall as a venue. Ally wondered if the event demanded a more ambitious venue – perhaps the SECC.

DECIDED

That the Our Health 3 event should focus on general acute services modernisation.

That a small steering group would be formed to plan and agree a format for the event.

That agreement would be sought as to whether the event would be staged on 31 August and precede the accountability review.

**Chair and Public
Affairs Manager**

**Director of
Corporate
Communications**

7. FEEDBACK FROM 'OUR HEALTH 2' EVENT: CHPs

Jim summarised feedback obtained from delegates attending the 24 February event. 253 delegates had taken part and reaction was broadly very favourable – there was a real thirst for knowledge about Community Health Partnerships and a clear demand that CHP development teams follow up the event in their locality.

Where there were complaints, they related mainly to venue issues, particularly noise bleeding between workshop groups, although some delegates from one group in particular seemed unhappy about the quality of facilitation, and the consequent monopolisation of discussion by a delegate with a personal agenda.

Scott observed that engagement with the event by clinical professionals had been minimal, although the event itself was very constructive and offered momentum to build upon.

Pat wondered if the event feedback should be disseminated via the media. Ally said that the subject and positive response by delegates would not be on the 'media agenda' – the task would be best left to a piece in the forthcoming *Health News*.

DECIDED

That lessons would be drawn from the second Our Health event and fed into the planning of the third.

**Director of
Corporate
Communications
and Public
Affairs Manager**

8. PFPI PERFORMANCE ASSESSMENT 2004/05

Peter said that he had attended a meeting on 7 March at which there was representation from Greater Glasgow Health Council, the Scottish Health Council, Voluntary Health Scotland, the Scottish Executive Health Department, the Spiritual Care Steering Group and NHS Greater Glasgow. The outcome had been positive and NHSGG staff had been praised for progress made in delivering a sustainable framework for PFPI.

The SEHD report as tabled made clear the main priorities that NHSGG was expected to address.

John asked if there were no supporting arrangements for complainants as of 1 April with the dissolution of Greater Glasgow Health Council. Pat Bryson said that she and others would welcome a continuance of their role in representing and support patients within the NHSGG framework. Councillor Duncan and Peter looked on this favourably.

Peter put forward two issues:

- There was a proposal that an idea originally postulated by the former Involving People Group might be revisited – that a 'patients' forum' might be set up based on former Health Council, lay advisor and wider public representation. This could be a consultative and advisory body in its own right but could supply individuals to represent the public/patient interests in a range of committees and steering groups.

As an interim arrangement, pending any new, systematic approach being adopted in the future, it would maintain existing planning and service development apparatus;

- The Head of Board Administration had made a formal request to consider how patient representation would be provided in the North and South Glasgow Acute Hospitals Monitoring Groups. Both existing Health Council representatives had expressed willingness to continue.

The proposals were received favourably by Committee Members and it was noted that there was a clear link between the two. Peter remarked that there was the possibility of a Project Manager being seconded to take forward the jury proposal on a fixed-term, full-time basis.

DECIDED

That a business case for a 'patients' forum' be developed and submitted to the Chief Executive.

That the Involving People Committee agrees a process for future representation on the North and South Monitoring Groups in view of the dissolution of the Health Council.

9. AOCB

Medical Division Group Letter to Health and Community Care Committee – Peter referred to the letter, which called upon the NHS in Scotland to adopt the English and Welsh practice of copying discharge letters to patients.

Councillor Duncan said he had had a pertinent experience: when discharged from the Western Infirmary he was promised a discharge letter would be sent to his GP; in the event no letter was sent. Scott agreed that the practice suggested would be helpful.

DECIDED

That the Committee supports the proposal that patients are provided with a copy of their own discharge letter.

10. DATE OF NEXT MEETING

1.00 p.m., Monday, 23 May 2005. Board Room One, Dalian House.

The meeting ended at 3.40 p.m.

**Chair and
Director of
Corporate
Communications**