

**INVOLVING PEOPLE COMMITTEE**

**Minutes of the meeting of the Involving People Committee  
Board Room 1, Dalian House,  
at 1.00 p.m. on Monday, 23 May 2005**

**PRESENT**

Peter Hamilton (Chair)

John Bannon MBE	Ally McLaws
Cllr Bob Duncan	Helen MacNeil
Ravinder Kaur Nijjar	Elinor Smith

**IN ATTENDANCE**

Anna Baxendale	Health Promotion Manager (Acting)
John Crawford	Principal Health Promotion Officer
John Hamilton	Head of Board Administration
Sue Laughlin	Women's Health Co-ordinator
Adrian Rootes	Regional Officer, Scottish Health Council
Jim Whyteside	Public Affairs Manager

**1. APOLOGIES**

Apologies for absence were received on behalf of Scott Bryson and Jessica Murray.

**2. CHAIRMAN'S REMARKS**

Peter Hamilton advised Members that Agnes Stewart MBE had decided to step down from the Committee. On the Committee's behalf, he thanked Agnes for the time and support she had offered.

Peter welcomed Elinor Smith to her first Committee meeting.

**3. MINUTE OF MEETING OF 15 MARCH 2005**

One typographical error was corrected: Scott Bryson had indeed attended on 15 March.

**4. MATTERS ARISING**

'Our Health 3' Event – following on from the Members' decision to proceed with the next event based on the theme of hospitals modernisation, a proposed event format had been fleshed out and presented to the Chief Executive for approval. It was proposed the event would be staged again in Glasgow Royal Concert Hall on 31 August 2005 – thereby allowing scope for it to dovetail with the Annual Accountability Review meeting scheduled for the same day.

**ACTION BY**

The format would consist of presentations followed by two sets of three 'clinic' sessions centred on Cancer Services and the new Victoria and Stobhill Hospitals. The first set of sessions would be relatively formal and structured around in-depth presentations and Q & A. The second set would be of an open space format, allowing more scope for one-to-one discussion and perusal of displays.

Elinor Smith was approving of the proposal as it tied in neatly with planned and ongoing Community Engagement activity in SE Glasgow.

Ally McLaws said that the Acute Services Community Engagement Team would be involved directly in providing displays for the event. He also indicated that a public information campaign was timed to begin in mid-June.

## **5. THE SCOTTISH HEALTH COUNCIL**

Peter welcomed Adrian Rootes, the Scottish Health Council's (SHC's) Regional Officer for Greater Glasgow, Argyll & Clyde and Dumfries & Galloway, and invited him to provide an overview of his organisation's role.

Adrian explained that he was only intending to offer an informal 'hello' – the Regional Manager for the area, Sheila McGoran, had broken her ankle and could not be present. Once she was well again, however, she and her colleagues intended to come before the Committee with a full presentation.

With the dissolution of Local Health Councils, the NHS Reform Act had transferred responsibility for patient and public involvement directly to NHS Boards. By contrast, the SHC's role was to provide assessment, support and feedback around the way NHS Boards discharged their duties.

The local SHC office was located in the former Greater Glasgow Health Council office in Florence Street. At national level there was to be a formal launch of the new organisation at the Lighthouse in Glasgow on 14 June.

A Local Advisory Group was being recruited act as 'eyes and ears' to support SHC reviews of NHSGG's PFPI performance. Thus far, insufficient numbers of applicants had made it through to shortlet stage in order provide the full membership complement of the group. Interviews would be going ahead early in June nevertheless and the SHC was committed to taking further action to solicit more applications.

Elinor Smith asked if either the advisory group of the SHC itself would be represented on the NHS Board. Adrian replied that they would not. Attendance with observer status was as far as they could go.

Ally McLaws said that the status of group members did not preclude close working with NHSGG. He offered assistance sharing the NHSGG Involving People database in order to assist the SHC in it efforts to recruit advisory group members.

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

Peter thanked Adrian for his presentation and wished him and his colleagues every success with the SHC's launch.

## **6. THE FUTURE OF PATIENT AND PUBLIC ENGAGEMENT: CHPS AND COMMUNITY PLANNING**

Peter welcomed Fiona Moss, Assistant Director of Health Promotion and a lead for the development of Community Planning.

Fiona delivered a presentation describing progress and context in Glasgow City towards developing public involvement arrangements for the new Community Health Partnerships (CHPs).

Fiona explained that her role was to maintain a 'bridge' between Community Planning and the emerging CHPs and enable coherence in the joint approach to engagement between the local authority and the NHS. Central guidance around public involvement for CHPs had been provided by the Scottish Executive, and this made the need for links with Community Planning processes explicit. It also explained that each CHP's Public Partnership Forum (PPF) could be 'virtual' – that is, based upon existing networks and community representation – but would have to identify and supply a single representative who would join the CHP board.

In Glasgow City, schemes of establishment had been agreed for five CHPs. These articulated a vision of the CHPs as 'inclusive' organisations, which had to engage with communities and the voluntary sector. It was also necessary for CHPs to address the needs of communities of interest that may have been in the periphery in the past – such as Black and Ethnic Minorities, the homeless and others. Ultimately, CHPs must become organisations 'skilled in engagement'.

Fiona said that as a vital part of achieving this, the Glasgow Council for the Voluntary Sector (GCVS) had been commissioned to produce a framework for engagement by Glasgow City CHPs. This would be based on stakeholder interviews. GCVS was sub-contracting local engagement to local voluntary organisations and a range of work was ongoing.

When PPFs were set up, each would also have to have its own executive group established. There would also be possible links between these and city-wide services, such as for young people, thereby necessitating representation at this level. Consideration was being given to setting up joint local authority/NHS PFPI teams to support this process.

Community Planning remained a statutory obligation but was still a broad concept. Nevertheless, in Glasgow City, £39 million had been spent through the Community Planning Partnership on regeneration. Whilst re-alignment of planning arrangements around CHP localities was foreseen, there was uncertainty in the interim period between the 'official' establishment of CHPs and their ability to deliver operationally.

The way forward for the Community Planning Partnership was still to be agreed. 20 focus groups had been organised in order to enable stakeholders to state their views, with particular emphasis on the most deprived areas.

This process also marked a great deal of upheaval for those voluntary organisations that had already established a presence at neighbourhood level. As part of the process of building new relationships, the Community Planning Partnership was being urged to adopt community engagement standards published by Communities Scotland – the intention was that new bodies and structures would conform to those standards.

The ‘hub’ for community engagement would be based on each Community Planning ‘area’ – each covering a population of roughly 70,000, although certain hubs might be based on communities of interest rather than the geographic variety. Groups would be offered options to be represented either at locality level or city-wide. Each hub would be responsible for community representation on the Community Planning Partnership.

Fiona concluded her presentation with some observations. The central issues were around standards and resources – currently there were quite different approaches to engagement between partner organisations. For CHPs and Community Planning to succeed, these matters would have to be subject to a much greater degree of coherence.

In turn, ‘NHS cash’ would have to be devoted to engagement, such as on the GCVS survey, as it was vital to know what communities were thinking before organisational structures coalesced.

Peter thanked Fiona for her presentation. He asked her to explain how the proposed Community Planning hubs related to CHPs and their PPFs.

Fiona replied that there would be one PPF for each CHP area, whereas Community Planning hubs served a smaller locality and therefore there would be at least two hubs in each CHP area. PPFs were different from hubs in that primarily patients’ and other health-related interests would have a route of expression through them, whereas hubs had much wider fields of interest.

Peter went on to observe that a central issue emerging from the second Our Health event on CHPs was that a single PPF representative on CHP boards would be insufficient to articulate patients’ and communities’ views. Fiona replied that there would be two PPF representatives – one from the community and one from the voluntary sector – but those people with concerns were making a fair point. The effectiveness of the representatives would depend on the way CHP boards chose to operate.

Councillor Duncan asked what was happening outwith Glasgow City. Fiona said that the situation was different in different places. The central point was that schemes of establishment that had been submitted to the SEHD had not yet received Ministerial approval.

Elinor thought that it would important to ensure the CHPs were set up ‘properly’. Fiona observed that no additional resource had been offered by SEHD to help with their establishment – this meant the ‘gold standard’ might not be achievable but staff would do the best they could.

Ravinder Kaur Nijjar thought that the capacity for staff and communities to take forward engagement would have to be built up. Furthermore, volunteers could only achieve so much. Helen MacNeil offered Fiona congratulations for the most coherent of presentations she had yet seen on the subject. She went on to agree with Ravinder's point – none of this would be 'cost neutral' and the question was now one of getting the 'best bang for the buck'.

Peter asked Fiona a final question – what was the timescale attached to the processes she had described? Fiona replied that the CHP framework for engagement was expected around the end of July. Thereafter, it would take time to build the infrastructure, with local systems not likely to be in place before December. Ultimately a fully-working arrangement would not emerge for another 15-months.

## **7. INTERIM ARRANGEMENTS FOR PUBLIC AND PATIENT ENGAGEMENT – PROPOSED PATIENT / PUBLIC FORUM**

Jim Whyteside tabled and introduced Committee Paper 05/05, which summarised proposals for establishing an interim NHS Greater Glasgow Patient/Public Forum, as had been agreed by the Committee at its previous meeting.

Jim explained that Tom Divers, Chief Executive of NHSGG had ratified establishment of the forum on condition it dovetailed with the forthcoming engagement infrastructure described by Fiona Moss. Following a meeting with Fiona, it had been clear the forum would have an important role in the 15-month period before the new arrangements bedded down.

Ally McLaws elaborated that the proposed forum format would make use of existing resources and integrate existing engagement structures. Elinor said this reassured her that an 'industry' was not being created – there were many people around Greater Glasgow who had the willingness and knowledge to input positively to the running of NHS services – it would be 'madness' to lose that resource.

Peter reminded the Committee that the new forum would not be a permanent resource but expected that many of the people who agreed to join it would be integrated within new engagement structures in the future. Helen MacNeil agreed the forum would be a good basis for the work Fiona Moss had described.

Jim confirmed that the Director of HR for NHSGG, Ian Reid, has agreed that Danny Crawford, currently attached to the NHS Board, would take forward the outline business case and initial recruitment of the forum. Jim was to speak to Danny about the details soon.

## **8. SPIRITUAL CARE, ACUTE SERVICES MONITORING GROUPS AND THE PFPI FRAMEWORK FOR STROKE, CHD AND DIABETES MANAGED CLINICAL NETWORKS**

John Hamilton introduced Committee Paper 04/05. He explained that the dissolution of the Greater Glasgow Health Council had led to the withdrawal of former Health Council Members from a variety of steering groups and fora. In the short-term, this presented a serious difficulty for such groups in ensuring that the 'patient's voice' could be projected into their thinking.

In particular, the North and South Glasgow Monitoring Groups, established by the Minister for Health and Community Care, had a key role in monitoring 'named services' at Stobhill and the Victoria Infirmary. It was important that patient representation was re-established and there were concerns about continuity. John had been tasked by the Monitoring Groups to seek an arrangement to deal with this issue as a matter of urgency.

John understood that Pat Bryson and John McMeekin, the former Health Council representatives on the Monitoring Groups, were both keen to continue involvement with the NHS and join the proposed Patient/Public Forum previously discussed.

On this basis, the Committee agreed to adopt a course of action that would allow Peter to contact Pat Bryson and John McMeekin to be contacted invited to be the first bone fide members of the new forum. In turn, this would allow them to continue to serve on the Monitoring Groups and any other groups as per their willingness and availability.

Peter asked Anna Baxendale to comment on PFPI arrangements in respect of the Stroke, CHD and Diabetes Managed Clinical Networks (MCNs).

Anna tabled a draft PFPI framework paper for the Heart Disease and Stroke MCNs, which had been agreed in principle. She explained the intention behind it was to pull together a tighter structure for engagement with patients.

A key issue was need to draw clinical staff into the PFPI agenda.

Anna also observed that MCNs were a quick way to reach patients and other stakeholders on the basis of 'disease groupings'. Given the potential of developing PFPI around service change through MCNs in the long-term, Anna asked how it would be possible to merge the approach detailed in the framework with the role of the Involving People Committee.

Peter responded by saying that the paper tabled tied in well with the rest of the day's discussion – but, in all truth, there were no answers to the issues yet. Any and all options must be pursued in a situation where patient representatives from 75 NHSGG groups had been lost in the aftermath of the dissolution of local health councils.

Elinor agreed, saying it would be necessary to 'grab' everyone possible into the new forum before it was too late.

She too was of the opinion that increased clinical engagement with the PFPI agenda was vital. She also felt strongly about the need to engage effectively with hard to reach groups.

Jim promised to brief Danny Crawford on ensuring the proposed Patient Public Forum worked effectively alongside MCNs. Helen also stressed the importance of building links to voluntary groups – over 600 such groups provided services to over one million people.

Peter continued, saying it was proper for Anna's paper to be table to the Committee, as it's role was one of Governance. Anna asked if the MCNs could report back to the Committee as the framework developed.

Peter agreed and further suggested that he meet Anna to discuss the issues in more detail.

## **DECIDED**

That Pat Bryson and John McMeekin be co-opted as the first members of the new Patient Public Forum and the Chair would write to Pat, John and John Hamilton to confirm this.

That Anna Baxendale would report back to a future Committee meeting on progress with the MCN PFPI framework and that she would meet with the Chair for detailed discussion of the matter.

**Chair**

**Chair, Health  
Promotion  
Manager  
(Acting)**

## **9. FAIR FOR ALL / EQUALITY**

Peter welcomed Sue Laughlin and John Crawford and asked them to appraise the Committee of the current situation around co-ordination of NHSGG's obligations and policies in relation to Fair for All and equality issues.

Sue began by saying how useful she had found the foregoing discussion and that it was important that future engagement structures did not fail to recognise that the local population was not a homogenous one.

John asked the Committee and the Director of Corporate Communications what they had been doing to ensure equality of involvement for black and ethnic minorities. Peter explained that the purpose of the session was for John to tell the Committee of his work and how this connected to activity across NHSGG.

John produced a hand-drawn diagram to demonstrate thinking and initiatives he had developed two years ago by listening to black and ethnic minorities.

He elaborated on the context of his work: the NHS Board was obliged to produce an annual report on its actions to support equality; this arrangement had been closely followed by the introduction of Fair for All; it was planned between this year and 2008 to establish a single Equality Commission for Scotland.

John's view was that NHSGG could be 'ahead of the game' by adopting best practice destined to be taken up at national level. The outcome of a seminar staged two years ago, confirmed that many in minority groups felt they were not being properly listened to and that there was no evidence the NHS was responding to what they were saying. Effectively, people from minorities were 'lost voices' and often the NHS had no clue as to what it expected from consultation and what it would do in response to its outcome.

Peter observed that this was easy to say – but what was actually happening in NHSGG to address the issue? – who specifically was taking the Agenda forward? - was it John himself?

John referred to his diagram. He said there was no single correct way to ask for comments or to listen. Minority groups wanted individual dialogue with the NHS, in particular through a named person as their contact.

The key was to work through existing organisations on a multi-agency basis. Capacity building would be necessary both for minority groups and staff. The agenda must be led centrally and there were other issues around the lack of understanding by individuals of the complaints system.

These points, as represented on John's A4 page, had been taken from the report based on the seminar conducted two years ago. This in turn formed the basis of the NHS Board Race Equality Action Plan.

Peter asked what had happened since 2003.

John replied that 'we have moved on in some ways but not in a systematic way'. Efforts had been made at capacity building through the 'Building a Bridge' initiative in order to ensure information was available to black and ethnic minorities in the preferred oral format. Minority organisations had been contacted on what they were doing around healthcare.

Sue moved the discussion on. There was an assumption that all Fair for All and Equality issues rested with either herself or John but, clearly, these were matters that affected all aspects of NHSGG. For example, women's needs had to be met through the gamut of service provision and not from a single locus – that was not feasible.

Peter agreed, observing that this echoed the fact that, in the early days of PFPI, many had the expectation that a single steering group would deal with the whole issue.

Sue continued, explaining that new legislation on gender and equal opportunities would be in place by the end of the year. This would require NHS organisations to have goals for equality between men and women, gender sensitive strategies and demonstrate specific actions achieved in delivering these strategies.

Sue went to describe specific modes in which NHSGG and its partners listened: around homelessness, where means were being developed to respond to this hardest of groups to reach; around maternity services, with dialogue through networks of organisations and individuals as part and parcel of decision-making, which in turn was generating better understanding of the issues and changing perceptions, and; around 'culturally competent gynaecology' in developing an integrated service for women.

Sue also mentioned the Equality and Diversity Toolkit developed by the SEHD which should be applied to all service and policy development by NHS Boards.

Peter suggested that the move to single-system NHSGG would lead to complications. Were there plans to marry up the various groups involved in promoting equality in a co-ordinated way?

John replied that if the issue was 'cross-cutting', such as interpreting services, this was a corporate responsibility. Otherwise, he wondered, would CHPs have to take the issues forward?

Elinor thought that lines of communication would have to be clarified – matters were complicated in that what seemed to be a local issue, such as in respect of mental health provision, may actually be a consequence of national priorities and policies. Unless NHSGG could influence SEHD, comments received locally could not be acted upon by NHSGG alone – but if influence could be achieved, there was potential for local comments to improve health at the national level.

Sue agreed, saying there was a danger that the organisation could regard listening to people as a burden, when it could actually make it more effective. Elinor’s view was that the experience of the initial period of the Acute Services Review showed it could have been done better – there had been no communications team then, no community engagement team and no structure for PFPI in place – now, the situation was that the infrastructure was in place to listen to communities and to respond to them.

Peter concurred, observing that many of the issues John alluded to in respect of minorities actually applied to the population as a whole. Helen echoed this point. The NHS had to ‘absorb and adapt’. New structures would improve matters but the way communities could influence priorities was key – there was a great deal of cynicism and fatigue but, nevertheless, the social and legislative environment was changing and practices would have to be shaped to suit.

Ally said that the NHSGG approach via the previous group and the current Committee was pushing the organisation in the right directions. Previously, the NHS had focused in on complaints rather than trying to help people solve problems. The Community Engagement Team had specifically targeted minority groups in an appropriate way in the course of delivering its responsibilities. This Committee was set up to determine what was being done by services, not to prosecute delivery of PFPI on its own. As a committee of governance, it could and would influence the NHS Board and highlight where momentum was lacking.

Helen suggested that it would be important for the committee with specific details about plans and initiatives being put in place around Fair for All and equality. Peter agreed and asked John to return to the Committee, this time with a full report and description of programmes either planned or in place.

#### **DECIDED**

That John Crawford would come to the next meeting of the Involving People Committee and describe in detail what had been achieved with regard to Fair for All and Equality across NHSGG in the last two years as well as further actions planned in future.

**Principal Health  
Promotion  
Officer**

#### **10. LAY REPRESENTATION ON AREA CLINICAL FORUM**

Peter held this item on the agenda over until the next meeting, as he felt it important for Scott Bryson to contribute.

#### **11. DATE OF NEXT MEETING**

To be advised.

The meeting ended at 3.10 p.m.

