PRESENT

Councillor Daniel Collins (in the Chair)

Mr Forrest Alexander  Public Partnership Forum
Mrs Safaa Baxter  Chief Social Work Officer (Professional Executive Group)
Mr Stephen Devine  Staff Partnership Forum Co-Chair (East Renfrewshire Council)
Councillor James Fletcher  East Renfrewshire Council
Councillor Roy Garascadden  East Renfrewshire Council
Councillor Barbara Grant  East Renfrewshire Council
Mr Peter Hamilton  NHS Greater Glasgow and Clyde Board (Vice Chair)
Mr George Hunter  Director
Mrs Melanie Lambert  Public Partnership Forum
Dr James MacRitchie  Professional Executive Group
Dr Alan Mitchell  Co-Clinical Director
Councillor George Napier  East Renfrewshire Council
Dr Leslie Quin  Co-Clinical Director

IN ATTENDANCE

Craig Bell  CHCP Finance Manager
Eamonn Daly  …  Principal Committee Services Officer
Tim Eltringham  …  Head of Health and Community Care
Julie Murray  Head of Planning and Health Improvement

APOLOGIES

Mr Gordon Anderson  Staff Partnership Forum Co-Chair (NHS)

ACTION BY

44. EAST RENFREWSHIRE COMMUNITY HEALTH AND CARE PARTNERSHIP – MINUTE OF PREVIOUS MEETING

There was submitted and approved the Minute of the meeting of the East Renfrewshire Community Health and Care Partnership Committee
(CHCPC) held on 11 October 2006, a copy of which had been issued previously to each member.

45. **CARE GOVERNANCE SUB-COMMITTEE**

There was submitted and noted the Minute of the meeting of the Care Governance Sub-Committee held on 27 November 2006, a copy of which had been issued previously to each member, and which forms Appendix 1 accompanying this Minute.

46. **BARRHEAD HEALTH AND SOCIAL CARE RESOURCE CENTRE**

Under reference to the Minute of previous meeting, (Item 37 refers), there was submitted report by the Director of the Community Health and Care Partnership, a copy of which had been issued previously to each member, reporting on progress in relation to the development of the Barrhead Health and Social Care Resource Centre.

The report explained that the schedule of accommodation had now been largely finalised, that based on costings provided by capital finance specialists a total capital cost of approximately £3,000 per square metre had been used as a guide, and that the Project Board had been working to an overall capacity of approximately 6,000 square metres.

Having given details of the services to be located in the new centre, the report provided details of how public involvement in the development of the new centre was being taken forward. The report also explained that in accordance with NHS procedures a site option appraisal had been carried out. A group of 15 service providers including medical, clinical and managerial stakeholders had taken part in a facilitated workshop reviewing the site options with the preferred site being that currently occupied by the former Carlibar Primary School.

In conclusion, the report gave details of the timetable for completion of the Outline Business Case (OBC) for the project, it being anticipated that a draft OBC would be available in early January 2007, with the target date for completion of the Centre mid-2010.

Prior to providing further information relative to the new centre, the Head of Health and Community Care reported that work on repairing the roof of the existing centre would commence on 8 January 2007 lasting for approximately 8 weeks, and that service providers in the centre were meeting with the architect and the contractor on 15 December to discuss any implications for service provisions as a result of the works.

The Head of Health and Community Care was then heard in further detail on the schedule of accommodation for the new facility explaining that he had held discussions about the possibility of minor surgery and dermatology services being provided there.

Details of the results of the initial public consultation exercise were given, it being noted that strong interest in podiatry and x-ray services being
provided had been expressed by the public. Discussions had taken place with Renfrewshire CHP about the possible sharing of podiatry services and the Head of Health and Community Care was confident progress could be made in this area. However, he explained that it may be more difficult for x-ray services to be provided, particularly as the Imaging Services Review that had been carried out had come down heavily against providing community based x-ray services.

He then explained that the Public Partnership Forum (PPF) would be hosting public meetings in February 2007 about the proposed new centre, and also gave details of the timescale for the project. He explained that further discussions had taken place around the timescale for the production of the OBC. Whilst the report indicated early January 2007, it was now the view of the Project Board that it would be better to take some additional time in the production of the OBC at this stage, which should help reduce the possibility of cost overruns at a later stage. Notwithstanding, this should not affect the proposed opening date of the facility in mid-2010. He explained that the Project Board was meeting on 15 December and further reports would come to the Committee in due course.

Having heard Councillor Grant on the importance of adhering to the budgets and timescales for the project, and Mr Hamilton on the potential for the delay in the production of the OBC to delay its submission to the Board, the Committee noted the report.

47. COMMUNICATIONS

Councillor Collins reported on the recent seminar that had taken place, the purpose of which was to inform the development of a Communications Strategy for the CHCP. He explained that following the seminar, feedback would be analysed and used to develop the Strategy and associated Action Plan, with it being intended that this would be presented to the next meeting of the Committee for approval.

In response to comments from Councillor Grant, Councillor Collins confirmed that a summary of the discussions at the seminar would be issued to members of the Committee for their interest.

48. REVENUE BUDGET MONITORING

There was submitted report by the Director of the Community Health and Care Partnership, a copy of which had been issued previously to each member, advising of the current consolidated CHCP revenue budget position for the period 1 April to 30 October 2006.

The report, which was constructed on a client group basis showing consolidated budgets and spends for 6 care groups together with 4 non-client group specific services, explained that the budget and actual figures presented reflected the gross expenditure position with external funding and specific grants being excluded.
The report highlighted that against a phased budget of £41.9 million, there was currently an underspend £418,120, with there being no significant variances from planned expenditure levels, with explanations for the variances that had arisen being set out in the report.

Commenting on the report, the Director explained that although there was slippage on both the social work and health budgets, it was often the case that the winter months brought additional pressures on the social work budget by way of increased demand for home care services and increased care home admissions.

Referring to the health budget, he explained that pressure on the slippage was being experienced due to the current high numbers of people waiting for physiotherapy services beyond the target time for this service, it being highlighted that this target was outwith the control of the CHCP. It was also explained that the high numbers on the waiting list was not as a result of shortages of qualified staff, as figures from Glasgow Caledonian University indicated that only one third of physiotherapy graduates were in employment. Notwithstanding, he explained that there may still be some uncommitted resource at the end of the current financial year, and an exercise to identify priorities for spend would be carried out over the next few months.

Councillor Garscadden suggested that it may be useful for the Committee to be made aware of pressures on services as this in turn could help to inform decisions that would need to be taken about the funding of services. In reply, the Head of Planning and Health Improvement explained that services pressures and resource analysis would form part of the next seminar for Committee members.

The Director then explained that one of the advantages of running a fully integrated health and social care service was that he was able to ensure that decisions were not made in one side of the organisation which resulted in additional costs being imposed upon the other sector. Furthermore, he highlighted that in terms of the overall health budget, slippage of £100,000 was a relatively small amount. In response to comments from Councillor Collins on how the term “slippage” was misleading as it suggested that services were not being managed properly, the Director explained that it was largely due to non-recurring savings made as a consequence of the time it could take to fill vacant posts.

The Committee noted the report.

49. **PUBLIC PARTNERSHIP FORUM WORKING AGREEMENT**

There was submitted report by the Director of the Community Health and Care Partnership, a copy of which had been issued previously to each member, seeking approval for a Working Agreement developed by the Public Partnership Forum. A copy of the working Agreement accompanied the report.

Having referred to the requirement for CH(C)Ps to establish a PPF and set out the role of the PPF, the report explained that the PPF Interim
Executive had drawn up a Working Agreement over a period of several months. Based on Agreements in place elsewhere but adapted to reflect local circumstances, the purpose of this Agreement was to set out the agreed working arrangements between the PPF and the CHCP. These arrangements were intended to maximise the effectiveness of the PPF as the primary mechanism by which the CHCP engaged, communicated and maintained contact with, the public.

The report explained that the Agreement was based on 4 key principles, details of which were given, set out the obligations that the Agreement placed on the CHCP, and dealt with other matters including roles and responsibilities of the PPF, membership arrangements, and operational arrangements, amongst other things.

Furthermore, the report explained that support for the PPF was provided by the Planning and Health Improvement Team and the Council's Community Services Department, and highlighted that to ensure the arrangements put in place by the Working Agreement were effective, the Agreement would be reviewed by the PPF on an annual basis and the outcome of the review reported to the CHCP Committee.

The Head of Planning and Health Improvement was then heard in further amplification of the report and the Agreement, following which Mr Hamilton explained that the members of the PPF recognised that they were on a learning curve, that the Agreement reflected the first attempt to define the workings of the PPF and its relationship with the CHCP, and that it would be subject to annual review. He also thanked PPF members for their time and effort in producing the Agreement.

In response to a question from Councillor Garscadden on the main issues discussed by the PPF, Mrs Lambert explained that discussions had mainly centred on the establishment of the PPF, with discussions more recently focussing on the new Barrhead Centre. In addition, the Head of Planning and Health Improvement explained that although the CHCP did not have managerial control over hospitals, the PPF were keen to play a role in influencing hospital-based services, Mr Hamilton reporting that the PPF was represented at the recent launch of the consultation on the acute services review in respect of the Royal Alexandra Hospital in Paisley.

Whilst welcoming this information, Councillor Garscadden sought clarification whether the PPF would be involved as service users in discussions about the development of services, and not simply be one of a number of individuals and organisations that were asked to comment on proposals drafted up by health and social care professionals.

In reply, the Head of Health and Community Care pointed to PPF membership of the Project Board for the new Barrhead Centre as an example of what Councillor Garscadden was suggesting. In addition, the Head of Planning and Health Improvement outlined the level of public involvement in planning and strategy groups that were shaping services, that relationships with acute service providers were being developed, and the involvement of the PPF in these relationships could be investigated further.
The Committee:-

(a) approved the Working Agreement;
(b) agreed to seek an annual report on the effectiveness of the Working Agreement;
(c) agreed that the involvement of the PPF in discussions with acute service providers on service provision be investigated further; and
(d) agreed to record their appreciation of the PPF for the time and effort in producing the Agreement.

50. JOINT PERFORMANCE IMPROVEMENT AND ASSESSMENT FRAMEWORK – REPORT ON ANNUAL EVALUATION STATEMENT

There was submitted report by the Director of the Community Health and Care Partnership, a copy of which had been issued previously to each member, advising the Committee of the outcome of the annual evaluation of the Joint Performance Information and Assessment Framework (JPIAF) for East Renfrewshire.

The report referred to the publication in November 2000 of the report of the Joint future Group entitled “Community Care – A Joint Future”, the central recommendation of which was that social work and health should work more closely together to take forward joint resourcing and joint management arrangements. As part of this, the Scottish Executive requires an annual submission of evidence on the progress made at local level in implementing the Joint Future Initiative. To support this, a JPIAF has been developed, with progress having to be reported according to a range of criteria as specified in Scottish Executive guidance, with submissions being evaluated by a team comprising representatives from both Audit Scotland and the Scottish Executive Health Department.

The report explained that there were 4 key areas of performance that required to be evidenced in the 2005 JPIAF submissions, details of which were given. It was reported that the Annual Evaluation Statement (AES) for 2006 was one of “good progress”, building on the “steady progress” rating received in 2005 and the “significantly progressed” rating for 2004. However, the report explained that the AES had indicated a number of areas where further development was considered necessary, including the technical development of Local Improvement Targets and an extension of direct access to resources.

In conclusion, the report explained that the CHCP Performance Management Framework and CHCP Plan superseded the requirements of the JPIAF in terms of in-year performance monitoring and partnership planning, with significant revision of the JPIAF following the conclusion of the work of the National Outcomes Working Group likely.

Commenting on the work of the National Outcomes Group, the Director explained that it had been recognised that much of the data collected at present related to inputs and processes, not to outcomes. As a result, the
Working Group were developing a series of outcome measures based on patient experiences, although it was recognised that such measures would contain a subjective element. He reported that a 2-day event to discuss possible measures had been held, that the measures that had been identified were presently the subject of consultation, and that if agreed they would replace the existing JPIAF framework.

Councillor Garscadden enquired if it was proposed to set up a performance group to carry out further work on performance measures before they were brought to the Committee. In reply, the Director referred to current arrangements for reporting performance to the Committee, and explained that the various planning groups that had been set up would inevitably be examining performance issues. In view of this, it was not proposed at this stage to establish an additional group.

The Committee noted the report.

51. SOCIAL WORK INSPECTION AGENCY – INSPECTION OF EAST RENFREWSHIRE SOCIAL WORK SERVICES

There was submitted report by the Director of Community Health and Care Partnership, a copy of which had been issued previously to each member, informing the Committee of the outcome of the recent inspection by the Social Work Inspection Agency (SWIA) of social work services in East Renfrewshire.

The report explained that SWIA was undertaking performance inspections of all Scottish local authority social work services with East Renfrewshire Council being the sixth authority to be examined, and gave details of the inspection process that had been carried out. Furthermore, the report explained that the results of the SWIA inspection had been published on 30 October 2006 and had made 12 recommendations in respect of social work services in East Renfrewshire. To address these recommendations, it would be necessary for an Action Plan to be drawn up by officers.

The Chief Social Work Officer explained that the inspection process had been challenging for SWIA as they had in effect only been inspecting part of a fully integrated service, and it may be necessary for them to reconsider how future inspections were carried out. She also highlighted that although 12 recommendations had been made by SWIA, they had commended the Council for the high quality of social work services provided.

Councillor Grant sought clarification of the SWIA recommendation relative to risk management. In reply, the Chief Social work Officer explained that the recommendation related to the need for risk assessment forms to be centrally retained and easily accessible, it being made clear that the recommendation did not relate to issues of clinical governance, Councillor Collins explaining that lengthy discussions on the subject of risk management in a clinical governance context had taken place at the recent meeting of the Care Governance Sub-Committee.

Referring to recommendation 12, Mr Devine suggested it was clear that SWIA had in his view failed to understand the nature of the CHCP, and
that the need for a Communications Strategy to be developed had already been acknowledged prior to the SWIA recommendation.

The Director explained that the report produced by SWIA had been at the time, and continued to be, the best report given to any local authority in Scotland.

The Committee noted the 12 recommendations made by SWIA and instructed officers to develop an Action Plan to be submitted to a future meeting of the Committee for consideration.

**ACTION BY**

52. **CHCP AND ACUTE DIVISION – INTERFACE ARRANGEMENTS**

There was submitted report by the Director of the Community Health and Care Partnership, a copy of which had been issued previously to each member, providing details of the emerging system-wide arrangements for interface with the Acute Division and the specific role of the CHCP management team in planning and service delivery.

The report explained that one of the main priorities driving the redesign of the NHS in Greater Glasgow and Clyde was to strengthen and develop the relationship between primary and community health/care services and acute hospital services, to develop a single-system approach. It was explained that to date, management activity had been focussed, in general, on the establishment of the CH(C)Ps and the development of integrated health and social care systems.

However, attention was now turning to the development of the relationship with the Acute Division, and the report explained that there were 3 programmes of work that would be led or co-led by the Director, details of each of these being given, and as part of which the Director, relevant Heads of Service, and Clinical Directors would sit on a number of Board-wide groups.

Furthermore, the report explained that “twinning” arrangements had been made between Clinical Directorates of the Acute Division and CH(C)Ps, with East Renfrewshire CHCP being twinned with the Surgical Division. In these arrangements, twinned CH(C)Ps would take responsibility to ensure there was a strong primary and community care perspective across their twinned Directorate’s activity. As part of the arrangements, CH(C)Ps would have direct engagement with Directorate management teams, and contribute capacity and expertise to the Directorate planning process, both in general terms and relative to specific pieces of work.

The Director explained that the new arrangements had been put in place to acknowledge the difficulty in every CH(C)P having links with every Acute Directorate. He emphasised the importance of there being good communication links in place between CH(C)Ps to ensure there was a good quality flow of information between lead CH(C)Ps and their counterparts, to allow discussions in other areas to be influenced by non-lead CH(C)Ps.
Further discussion took place on the number of integrated partnerships across Scotland, the different models of integrated CH(C)Ps and the potential for non-integrated CHPs to expand services in future.

Councillor Garscadden suggested that only time would tell if the new arrangements would be successful and sought clarification of the level of involvement of GPs in the new process, and the views of the GPs on the Committee of where there were problems with current service provision. Dr MacRitchie indicated that a delay in access to diagnostic imaging services created problems for patient flow. He explained it was unsatisfactory that GPs were being asked to prioritise patients for scans which were in most cases needed immediately. Dr Quin agreed, acknowledging that this was due to limited resources, and explained ways in which services were being redesigned to make the best use of these resources, referring in particular to changes to rheumatology services.

Councillor Garscadden emphasised the importance of the CHCP being involved in any discussions about service reconfiguration in order to ensure that GPs were not disadvantaged. In reply, Dr Mitchell confirmed that GPs were involved in discussions on the current redesign of diagnostics. It had already been agreed that there would be equity of access to these services for both GPs and hospital-based doctors. He explained that also as part of the service redesign, increased opening times for MRI/CT scanning was being explored, such as in the evenings and at weekends. However, support arrangements would also require to be changed to reflect the new arrangements were they to be introduced.

In response to a comment from Councillor Grant supporting the extension of opening times for services, Dr MacRitchie highlighted that the costs of providing these services did not simply relate to the cost of the equipment but that the cost of providing support staff also had to be taken into account.

Mr Hamilton enquired how it was intended the communication links between the CH(C)Ps would operate in response to which the Director reported that correspondence had been received from Catriona Renfrew which acknowledged that although arrangements were in place further consideration as to how they would operate in practice was required, the Director suggesting that this could be built into performance reporting arrangements.

The Committee noted the report.

53. **CHP GOVERNANCE AUDIT**

There was submitted report by the Director of the Community Health and Care Partnership, a copy of which had been issued previously to each member, advising of the results of the exercise to apply locally Audit Scotland’s self-assessment tool “Governance in Community Health Partnerships”. The results of the exercise accompanied the report.

By way of background, the report explained that in May 2006 Audit Scotland had produced their self-assessment tool as part of their series of publications “How the NHS works”. The report further explained that the
tool, which was designed as a checklist against which auditors could evaluate the arrangements that had been put in place to ensure sound governance of CHPs, was being used as the basis of a Board-wide internal audit of all 11 CHPs’ governance through Price Waterhouse Coopers, and local internal audit under the Council’s Audit Committee.

Having given details of those areas focussed on by the self-assessment tool, the report indicated that initial self-assessment and preliminary audit indicated a relatively positive position in relation to governance, although a number of areas, details of which were given, had been identified. Furthermore, it was highlighted that in carrying out the exercise, it had become apparent that the Audit Scotland tool had been designed for health-only CHPs, with this resulting in some peculiarities against the integrated CHCP model. Nonetheless, the self-assessment exercise had been considered useful, and the results of the audits being carried out by both Price Waterhouse Coopers and the Council’s Audit Committee would be brought before the Committee early in 2007.

Commenting on the report, the Director explained that in general the CHCP had performed satisfactorily, and in response to a question from Councillor Grant on areas that had not been covered in the audit, suggested that at this stage it would be more appropriate to wait until the audit had been concluded. However, the Head of Planning and Health Improvement did suggest that if the audit questionnaire had been designed for a CHCP and not CHPs, different questions may have been posed.

Referring to the comments in the audit relating to risk assessment, Mr Hamilton suggested that they appeared contrary to the information that had been provided at the recent meeting of the Care Governance Sub-Committee. In reply, the Director clarified that the information referred to in the audit related to clinical governance systems that had always been in place. However, he explained that there were a number of non-clinical risks associated with the operation of a CHCP, such as political risks to the Council by providing services through the CHCP, that did not fit into the current risk assessment system and in respect of which risk assessments would be required.

The Committee noted the report, and that the final audits from Price Waterhouse Coopers and the Council’s Audit Committee would be submitted early in 2007.

54. TELECARE DEVELOPMENT PROPOSALS – FUNDING SUBMISSION

There was submitted report by the Director of the Community Health and Care Partnership, a copy of which had been issued previously to each member, providing details of an outline bid for funding for the development of telecare, submitted to the Joint Improvement Team.

Having explained that telecare was a term covering those devices installed in people’s homes that could trigger a pre-determined, escalating chain of responses from a call centre, the report gave details of the type of such services currently available in East Renfrewshire, where over 1,500 people were supported by the Council’s community alarm scheme with a
response provided, where necessary, by the community alarm assistants or the rapid response home care team.

The report indicated that IT developments were continually extending the scope for telecare to support people with health and social care needs to remain in their own homes, and that funding for telecare developments by health and social care partnerships was being made available through the National Telecare Programme. East Renfrewshire CHCP was eligible to receive £125,000 of an £8 million capital fund based on a population pro-rata basis, subject to the submission of a satisfactory proposal to the Joint Improvement Team.

Details of the funding bid accompanied the report, it being noted that if the project was successful, there was an expectation it would generate efficiencies in care packages, and that further work was still required to develop the Telecare Strategy and Implementation Plan.

Having heard the Head of Health and Community Care explain that JIT were minded to release the funding but had asked for some supplementary information, Dr Mitchell sought details of the revenue implications for the proposals.

The Director explained that the monitoring arrangements would be linked into the Council’s current community alarm contract with Bield Housing. However, the main revenue costs would be associated with how to respond to calls. He acknowledged that in many cases family members were happy to respond to calls, but that it still may be necessary for additional staff to be employed in the Council’s response teams.

Councillor Garscadden suggested that revenue consequences of the proposals were inevitable and it was important these were identified at an early stage. He also suggested that it was important to examine the proposed outcomes of the proposal to ensure officers were clear what was being delivered.

Acknowledging the comments of both the Director and Councillor Garscadden, the Head of Health and Community Care suggested that as the aim of the scheme was to allow people to stay at home this would theoretically free up resources that would have been used in placing people into care homes. Recognising this, Councillor Garscadden suggested it was essential that the project was funded in full as potential savings may not be achieved.

The Committee:-

(a) noted the bid for funding; and

(b) agreed that the proposed Telecare Strategy and Implementation Plan, together with details of how the project funding would be used to support the Strategy, be submitted to a future meeting of the Committee.

Director CHCP
55. **DATE OF NEXT MEETING**

The Committee noted that the next meeting would be held on Wednesday 14 February 2007 at 10.00 am, in Eastwood House, Eastwood Park, Giffnock.
Minute of meeting of the
East Renfrewshire Community Health and Care Partnership
Care Governance Sub-Committee
held at 1.00pm on 27 November 2006 in
Eastwood House,
Eastwood Park, Giffnock

PRESENT

Councillor Daniel Collins (in the Chair)
Safaa Baxter Chief Social Work Officer
Anne Dean Staff Partnership Forum
June Findlater Rehabilitation and Enablement Services Manager
Ellen McGarrigle Lead Nurse
Fiona Middler GP Contract Facilitator
Candy Millard Commissioning, Performance and Planning Manager
Mr Peter Hamilton NHS Greater Glasgow and Clyde Board
Dr Alan Mitchell Co-Clinical Director
Dr Leslie Quin Co-Clinical Director
Linda Tindall Senior HR and OD Manager

IN ATTENDANCE

Eamonn Daly Principal Committee Services Officer
Brenda Muirhead Clinical Risk Co-ordinator
Erik Sutherland Planning and Performance Manager

APOLOGIES

Mary Gallagher Operations Manager, Children and Families
Wilma Hepburn Senior Nurse, Adults
Cindy Wallis Mental Health and Partnerships Manager

ACTION BY

1. WELCOME AND INTRODUCTION

Councillor Collins welcomed those present to the first meeting of the East Renfrewshire Community Health and Care Partnership Care Governance Sub-Committee.
2. **WHAT IS CARE GOVERNANCE?**

Councillor Collins introduced Dr Alan Mitchell, Co-Clinical Director, and Saafa Baxter, Chief Social Work Officer, who made a presentation to the sub-committee entitled “What is Care Governance?”

By way of background Dr Mitchell explained that Clinical Governance had emerged in the NHS in the late 1990s, aimed at improving the quality and safety of clinical practice. At the same time, in local government, the Best Value regime had been introduced, the purpose of which was to ensure that local authorities undertook service inspections and performance reviews with the aim of achieving service improvement.

He explained that the term “Care Governance” had been developed to reflect the new partnership approach to health and social work service delivery between the NHS and the local authority, and that Care Governance was the framework by which the CHCP was accountable for continuous service improvement, safeguarding care standards, and fostering an environment where excellence could grow.

Dr Mitchell then set out the fundamental elements of Care Governance, highlighting that there were already in place a number quality assessment methods across both health and local government, carried out by a variety of organisations. Reference was then made to the seven pillars of Care Governance and to the reasoning behind the establishment of the Care Governance Sub-Committee as a formal sub-committee of the CHCP. The overall aims and terms of reference of the sub-committee were then outlined, it being emphasised that not only the sub-committee but also all staff within the CHCP had a role to play in ensuring quality assured practices and procedures were in place. This would be reinforced by the development of a Care Governance Work Plan to which staff at all levels within the organisation could contribute.

Dr Mitchell then set out a number of procedural matters relating to the operation of the sub-committee. He concluded by highlighting the broad and challenging nature of Care Governance, but that it was important that its development within the East Renfrewshire CHCP was progressed, with patients and clients being the benefactors in the long term.

Discussion then followed, and in response to a question from Mr Hamilton on representation on the sub-committee by the Public Partnership Forum, Dr Mitchell referred to discussions that had taken place at a meeting of the CHCP Committee when it had been considered that it was inappropriate for the PPF to be represented on the sub-committee.

Dr Mitchell advised the sub-committee that he had met with Health Board officials to discuss a work programme for the sub-committee in its first year. He explained that there was an expectation on the part of the Board that the sub-committee would undertake work relating to the development of risk registers and an audit of clinical/service practice. Furthermore, the Chief Social Work Officer highlighted that the Mental Health Partnerships also had targets and objectives to achieve, which would have an impact on East Renfrewshire. In this regard, Councillor Collins suggested that it would be helpful if the Care Governance Sub-Committees of all the CHPs...
and CHCPs in the Board area focussed on the same two pieces of work, and that there should be a standing item on the sub-committee agenda monitoring progress elsewhere and how it affected arrangements in the East Renfrewshire CHCP area.

Mr Hamilton having commented on the need for communication links between the sub-committee and the Board’s Clinical Governance Committee, Councillor Collins referred to the seminar on the creation of a communications strategy taking place the following day, which it was hoped would deal with issues such as this.

Dr Mitchell then referred to a Board sponsored Care Governance workshop for CHPs and CHCPs being held in January next year. This event, to which the Director, Clinical Director, and sub-committee Chair would be invited to attend, would hopefully provide a better understanding of how the sub-committee would link into the work of both the Board and the health service at a national level.

The sub-committee noted the presentation.

3. **RISK REGISTERS**

Councillor Collins introduced Brenda Muirhead, Clinical Risk Co-ordinator who had been invited to the meeting to discuss the development of a Risk Register for the CHCP, and other associated risk management issues.

By way of introduction, Ms Muirhead explained that her remit was clinical risk and so comments made by her were from a health-based perspective. However, this did not alter the fact that the challenge facing health and local authorities was to ensure that their respective risk assessment systems worked together satisfactorily.

Details of the systems and processes required to ensure that CHPs and CHCPs had in place a robust risk management system were given, in the course of which it was explained that all the CHPs and CHCPs in the Board’s area were at different stages of development and had adopted different arrangements.

It was highlighted that the Board was very keen on the development of risk registers as part of the CHCP’s overall risk management arrangements, with the purpose of the risk register being to reassure the director that all risks had been considered in order that he was comfortable with the level of risk with which the CHCP was prepared to operate.

Ms Muirhead then provided details of a risk register template developed by her, copies of which were circulated at the meeting. She explained that it was based on the “traffic light” system of identifying risk, and had been endorsed by NHSQIS, but that she was happy for it to be altered to meet local needs.

Councillor Collins explained that the system as outlined was similar to that used by the Council, and would assist in the identification of risks and the
production of an Intervention Plan to tackle those risks identified. He also highlighted the need for the CHCP, sooner rather than later, to be able to reassure patients and clients about the quality of services provided.

Mr Hamilton sought clarification of the procedure for dealing with risks the cause of which was considered to be outwith the control of the CHCP. In reply, Ms Muirhead confirmed that in such cases the matter could be elevated to Board level.

Commenting on an appropriate starting point for the risk register, Dr Mitchell suggested that the IR1 forms used in the health service for reporting adverse events could be used, as common themes could be identified from them. Ms Muirhead was then heard in further explanation of the IR1 reporting procedures. She highlighted a number of problems with the form, not least the lack of descriptors on the form and the lack of space for descriptive text. She also highlighted the time taken for the form to go through the system and that it was unsuitable for recording critical incidents. In view of these comments, Councillor Collins sought clarification of why the use of the form had not been discontinued. In reply, Ms Muirhead reported that the Board’s Head of Clinical Governance had prepared a paper seeking the introduction of a web-based electronic system, and that a business case had been presented to the Board, but it was unlikely that the new system would be in place for at least 12 months.

Referring to the proposed web-based system, the Commissioning, Performance and Planning Manager sought clarification of whether it had been designed on the basis of integrated services as provided by the CHCP or solely from a health perspective. In reply, Ms Muirhead explained that she would need to establish this with the Head of Clinical Governance.

Mr Hamilton sought clarification of whether, in view of the delay in the introduction of the web-based system, it would be possible to amend the IR1 form locally. In response, Ms Muirhead indicated that it was possible to do so, but that it would still be necessary for a standard IR1 form to be submitted to the Board’s Risk Division for the information to be recorded centrally as at present.

Further discussion then took place on the development of local systems. Mrs Dean highlighted that the introduction of a local form in addition to the IR1 form would not be welcomed by staff, and it was important to continue to encourage staff to complete IR1 forms.

Ms Muirhead outlined the benefits of developing local information systems if possible. She provided details of one she had developed based on the IR1 form explaining that as part of this exercise she had developed a number of local themes and categorisations. Under this arrangement, information was gathered locally from IR1 forms before they were passed to the Risk Division. This local system, which was also used for logging complaints, meant that it was easier to obtain an up to date local picture than was possible through the basic IR1 recording system.

Commenting on the system as outlined by Ms Muirhead, the Chief Social Work Officer explained that there was already a similar system in place in
the Council but that it would need to be reviewed to be able to deal with clinical governance issues.

Dr Mitchell suggested that there would be clear benefits from introducing local arrangements such as that outlined, and suggested that advice be offered to clinicians on providing additional information on IR1 forms which would be passed to him in the first instance to record the information before being forwarded to the Risk Division.

Following further comment on the differing practices adopted when completing IR1 forms, Councillor Collins, referring to the possibility of establishing a sub-group of the sub-committee to consider risk management issues, suggested that it would be inappropriate to adopt this approach, and that officers could undertake the necessary work and bring proposals back to the sub-committee for consideration.

Mr Hamilton expressed caution in setting up a large bureaucratic process for dealing with a relatively small number of cases, and questioned whether the level of reporting in the East Renfrewshire area was considered reasonable. In reply, Mrs Dean suggested that there was underreporting of cases in East Renfrewshire.

Following further discussion and having heard Dr Mitchell, the sub-committee agreed that CHCP officers work with Ms Muirhead on the development of risk management recording and reporting arrangements and bring forward proposals to the next meeting of the sub-committee.

4. CARE GOVERNANCE MAPPING

There was submitted report by the Director of the Community Health and Care Partnership, a copy of which had been issued previously to each member, presenting to the sub-committee the results of an initial mapping exercise of Care Governance activity across the CHCP.

Speaking in amplification of the report, the Planning and Performance Manager explained that in order to develop Care Governance arrangements it was important to understand the current position, what additional development was required, and what practical steps could be taken to achieve these outcomes. He explained that there had been considerable activity associated with Care Governance with there being a number of areas of good practice. However, a number of significant developmental needs had been identified, details of which were given. The report further explained that this developmental agenda would require co-ordination and robust supporting structures, and highlighted that the results of the initial mapping exercise could be further developed into a Care Governance Action Plan for the CHCP.

Commenting on the results of the exercise, making particular reference to “A Safe and Reliable Service”, Dr Mitchell explained that the IR1 form did not extend to independent contractors. He highlighted that the vast majority of patient contact was with practitioners in the independent sector, suggested that dealing with this issue would be a real challenge for the CHCP, and questioned Councillor Collins and Mr Hamilton in their
capacity as non-executive members of the Board on the Board’s thinking regarding the adverse reporting of clinical incidents by the independent sector.

Councillor Collins and Mr Hamilton indicated that this was not a matter that had been discussed at the Board, but clearly was of great importance as the CHCP was responsible to the people of East Renfrewshire, no matter from which sector they obtained their services.

Dr Quin emphasised that such matters were taken seriously in the independent sector and that it was normally a partner in a practice that would deal with risk issues, however, the information was not shared with other practices or agencies.

Mrs Dean explained that many practices would possibly be reluctant to share information with others, as the anonymity of patients could possibly be threatened. In reply, Dr Mitchell suggested it was important to encourage independent sector providers to share information, and this could be done on the basis of highlighting that sharing of information would make the whole service better placed to tackle incidents in future should they arise.

Councillor Collins welcomed proposals to encourage independent providers to share information as they may already have in place good procedures that could be useful to other providers.

The sub-committee noted the report.

5. PROPOSED CARE GOVERNANCE ARRANGEMENTS

The Chief Social Work Officer made a presentation to the sub-committee on proposals for the Care Governance supporting structure.

The Chief Social Work Officer outlined the role of the CHCP Committee and the Care Governance Sub-Committee in delivering Care Governance, both of which would be supported by the CHCP Management Team. In addition, she outlined proposals to establish both a Care Governance Network and Care Governance Practice Forums, and provided details of how these groups would operate. Finally, she outlined how each of the respective groups would fit into the supporting structure for Care Governance. In particular, she explained that the Early Years Practice Forum would deal with all Early Years matters including health and social care, with representatives from the Education Department and Community Services Department serving on the Forum.

Commenting on the arrangements, Councillor Collins suggested that it was important to time meetings so that the opportunity to feed information into the system could be maximised.

Dr Mitchell having commented on the arrangements for meetings of the Care Governance Network, discussion took place on whether there would be an annual report on risk management arrangements in place. The Chief Social Worker confirmed that this would be the case, Dr Mitchell
suggesting that how this would be progressed could be included in the paper on risk management being prepared for the next meeting of the sub-committee.

Councillor Collins reminded the sub-committee that the forthcoming local government elections in May 2007 would have a bearing on the Council’s representation on the CHCP Committee which in turn would affect membership on the sub-committee. In view of this he suggested that it would be useful for a report summarising the work of the CHCP Committee and the Care Governance Sub-Committee to be submitted to the CHCP Committee meeting on 18 April 2007.

The sub-committee:-

(i) noted the proposed Care Governance arrangements;
(ii) agreed that discussions on the presentation of an annual report on risk management issues take place as part of the preparation of the report on proposed risk management recording and reporting procedures to be submitted to the next meeting of the sub-committee.

7. PROGRAMME OF MEETINGS

There was submitted report by the Director of Central Services, a copy of which had been issued previously to each member, with proposed meeting dates for the sub-committee in 2007 prior to the local government elections on 3 May 2007.

The sub-committee agreed the following meeting dates:-

(i) Monday 15 January 2007 at 10.00 am
(ii) Monday 12 March 2007 at 10.00 am