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**ERCHCP(M) 07/2
Minutes 15-33**

**GREATER GLASGOW AND CLYDE NHS BOARD
EAST RENFREWSHIRE COUNCIL**

**Minute of meeting of the
East Renfrewshire Community Health and Care Partnership Committee
held at 10.00am on 18 April 2007 in
Eastwood House,
Eastwood Park, Giffnock**

PRESENT

Councillor Daniel Collins (in the Chair)

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

IN ATTENDANCE

Craig Bell	CHCP Finance Manager
Eamonn Daly	Principal Committee Services Officer
Tim Eltringham	Head of Health and Community Care
Ellen McGarrigle	Lead Nurse
Julie Murray	Head of Planning and Health Improvement
Erik Sutherland	Planning and Performance Manager

ACTION BY

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

There was submitted the Minute of the meeting of the East Renfrewshire Community Health and Care Partnership Committee (CHCPC) held on 14 February 2007, a copy of which had been issued previously to each member.

DECIDED:

That the Minute be approved.

16. CARE GOVERNANCE SUB-COMMITTEE

There was submitted the Minute of meeting of the Care Governance Sub-Committee held on 12 March 2007, a copy of which had been issued previously to each member, and which forms Appendix 1 accompanying this Minute.

NOTED

17. CHCP DEVELOPMENT PLAN 2007-2010

Under reference to the Minute of previous meeting (Item 10 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, seeking approval of the Development Plan for the CHCP for the period 2007-2010, a copy of which accompanied the report.

The Head of Planning and Health Improvement explained that guidance on the production and content of CH(C)P Development Plans had been issued by NHS Greater Glasgow and Clyde in November 2006, taking a medium-term approach over the 2007-2010 period with a requirement for more specific action plans for the 2007-2008 period. She indicated that the Development Plan that had been produced not only complied with that guidance but also aligned fully with the Council's Policy and Financial Plan, which would lead to more synchronicity between the work of the CHCP and the Council. She reminded members that a draft of the plan had already been considered at the previous meeting of the Committee, and clarified that the draft Plan had been the subject of consultation with the Staff Partnership Forum, Professional Executive Group, Public Partnership Forum and the Council's own area forums.

Referring to the Plan itself, the Head of Planning and Health Improvement explained that it was organised into six sections, details of which were given, together with examples of some of the issues that were addressed in each. She also referred to a number of key achievements reflected in the Plan, such as the positive nature of the report on the Council's Social Work services by the Social Work Inspection Agency, and the securing of funding for the new Barrhead Health Centre. Details of the CHCP's key priorities over the lifetime of the Plan were also listed, as well as reference being made to the key external relationships between the CHCP and the Acute Division.

In response to questions from Councillor Grant, it was explained that once the Plan had been approved, an easy to read summary would be produced. It was also clarified that whilst the Development Plans of all 11 CH(C)Ps would be considered by the Board, there would be no need for these plans to be submitted to the Scottish Executive, as the Board's own Local Delivery Plan, which would summarise the CH(P)P Plans, would be submitted to the Scottish Executive.

Councillor Collins explained that at yesterday's Board meeting he had suggested it would be helpful if common themes across all the CH(C)Ps could be identified and highlighted. He also explained that positive discussions on the Plan's content had already taken place with the Chief Executive of NHS Greater Glasgow and Clyde. Councillor Collins also thanked all those involved in the production of the Plan.

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DECIDED:

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| (a) | that the CHCP Development Plan 2007 be approved; and | Director of
Community
Health and
Care
Partnership |
| (b) | that the Plan be remitted to the Council for consideration | Principal
Committee
Services
Officer |

18. PWC GOVERNANCE AUDIT REPORT AND CHCP RESPONSE TO COUNCIL INTERNAL AUDIT REPORT

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, relative to the findings of the Price Waterhouse Coopers (PWC) Governance Audit report on CH(C)Ps, and the response to the findings of the Council's Internal Audit report on governance in the CHCP. A copy of the action plan addressing the Internal Audit recommendations and the PWC Governance Audit report accompanied the report

The Head of Planning and Health Improvement explained that Audit Scotland had produced a self-assessment tool entitled "Governance in Community Health Partnerships" and that a self-assessment had been carried out, the results of which were reported to the Committee in December 2006. She explained that the tool had also been used by the Council's Internal Audit Section in carrying out their audit, the results of which were reported to the Committee in February 2007. Furthermore, she clarified that although the actions set out in the action plan accompanying the PWC report were to be taken at Board level, there were implication for CH(C)P Directors.

Commenting on both audits, the Head of Planning and Health Improvement explained that whilst there was more emphasis on clinical governance issues in the PWC report, issues relative to financial and performance management were similar in both reports, with the overall assessments being made in both audits being favourable. She explained that the PWC recommendations were largely compatible with those in the Internal Audit report. In particular, reference was made to the comments made in both reports relative to unified complaints procedures, it being explained that the Glasgow South East CHP had made some progress in this area and discussions with them regarding this were ongoing.

Referring to the audits, the Director explained that he had held a positive meeting with PWC. They had indicated they were keen to forge a close working relationship with the Council's Internal Auditors, which it was hoped would in turn lead to the development of a joint audit plan.

Mr Anderson explained that PWC had not spoken directly with Staff Partnership Forum representatives in the course of their audit, and questioned whether they would do so in the course of any future audits. This was supported by Mr Devine who expressed surprise that the East Renfrewshire model having been held up as an example of good practice, PWC did not actually hold discussions with anyone.

ACTION BY

Responding to these comments, the Director explained that having been the Board's external auditor for the last three years, PWC had now become the Board's internal auditor. As a consequence PWC now took instruction from the Board and had a different focus for their investigations compared to when acting as external auditor.

It was also clarified that the PWC report was Board-wide, whilst the covering report drew out matters relating particularly to East Renfrewshire CHCP.

Councillor Collins acknowledged the point made about the lack of contact with the Staff Partnership Forum by PWC, suggesting that these were matters that would hopefully be resolved satisfactorily in future.

NOTED

19. COMMUNICATIONS STRATEGY

There was submitted report by the Director of the Community Health and Care Partnership, a copy of which was tabled, relative to the production of a Communications Strategy for the CHCP. A copy of the draft Strategy and accompanying action plan that had been prepared accompanied the report.

Councillor Collins explained that the delay in circulating the draft Strategy had been due to the need for it to be further developed following the recent meeting of the Communications Strategy Group. He highlighted that approval was sought for the draft Strategy as presented to form the basis for consultation with appropriate organisations, with a final draft being submitted to the next meeting of the Committee for approval.

Referring to the proposed monthly briefing by the Director to all CHCP staff, Mrs Reid highlighted that although the Public Partnership Forum were external to the CHCP, receipt of this briefing would be very helpful. In reply, the Head of Planning and Health Improvement indicated that the PPF could be included in the list to receive the monthly bulletin.

DECIDED:

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| (a) | that the outline Communications Strategy be approved as a basis for a programme of stakeholder engagement over the next three months; | Head of
Planning and
Health
Improvement |
| (b) | that the final draft of the Strategy and accompanying Action Plan be submitted to the next meeting of the Committee. | Head of
Planning and
Health
Improvement |

20. REVENUE BUDGET MONITORING

Under reference to the Minute of previous meeting (Item 48 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, providing details of the projected outturn for the current financial year as

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well as providing indicative information in relation to the 2007-08 revenue budget.

The Director explained that against a combined gross revenue budget of £80.5 million, the projected outturn figure was £80.2 million, which equated to an underspend of 0.4% of the gross budget. He explained the main reasons for the underspend were that in terms of social work, single status had not been implemented, whilst in health the underspend had been due to savings achieved through the block purchase of prescribed drugs.

Councillor Grant expressed disappointment at the continuing reduction in "Supporting People" funding made available to the Council. In reply the Director explained that when this funding stream had first been made available, the budget was open-ended. A number of authorities, the Council included, had taken advantage of the funding by implementing a significant number of projects. However, the levels of funding available through the scheme were then capped by the Scottish Executive with funding being distributed to councils on the basis of a formula, the introduction of which had seen a 20% reduction in the grant funding available to the Council. As a result, the Council was underfunded for the number of projects it had introduced, whilst other authorities ended up with funding for which they had no commitments.

Councillor Fletcher explained that the distribution formula was one agreed by COSLA and that if the Scottish Executive's own formula for grant distribution had been imposed the effects on East Renfrewshire would have been more severe.

Commenting on the projects funded through Supporting People, the Director explained that it had been possible to manage the position in the first two years of savings due to carry forward of funds from previous years. However, this was not possible for the coming year and careful financial management would be required.

Mr Millar referred to the underspend on drugs, explaining that this was an issue over which the CHCP had no control and had not been in any way due to the actions of practitioners. The reduction in the price of drugs had been due to a government decision to reduce the price of generic drugs. In reply, the Director confirmed this to be the case, explaining this was why the CH(C)P Directors had agreed to continue to operate a risk sharing approach to GMS contracts and prescribing budgets. However, efforts were still being made to make prescribing patterns more efficient locally with the Clinical Directors looking at these.

In response to a question from Doctor Mitchell on the carry forward of funds, the Finance Manager explained that the circumstances in which this could occur were limited, such as funding from an external agency for a specific project. He reported that he had recently met the Council's Director of Finance to agree the carry forward of funds for mental health projects.

NOTED

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

Under reference to the Minute of previous meeting (Item 7 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 the development of the Barrhead Health and Social Care Resource Centre.

Referring to the report, the Head of Health and Community Care explained that following approval of the Initial Agreement by the Scottish Executive Health Department Capital Investment Group on 6 March, the Outline Business Case (OBC) had been completed and approved by the Board's Performance Review Group on 20 March and thereafter forwarded for consideration to the meeting of the Capital Investment Group held on 17 April. He indicated that there had as yet been no feedback from that meeting, but a positive response was anticipated.

The Head of Health and Community Care then explained that a Full Business Case would be submitted to the Health Department in September 2008, and gave details of all the design and development work to take place in the interim. This included the appointment of a design team who would take forward the Centre design over the next 5-6 months and as part of which a number of opportunities for public consultation would be built into the design timetable. He explained that it was hoped to start work on the Centre in November 2008, and thanked officers from health and the Council for their efforts to date in the production of the OBC, copies of which could be made available to members of the Committee. In addition, he reported that the roof repair works to the current Centre had now been completed.

Having indicated in response to Dr MacRitchie that a date for clearing the Carlibar school site had not yet been set, the Head of Health and Community Care, in reply to Mr Devine, confirmed that the Staff Partnership Forum would be involved in the consultation exercises to take place during the design phase of the project. Staff to be located in the new Centre would also be consulted.

NOTED

22. **LEVERN VALLEY MENTAL HEALTH PROJECT INITIATION DOCUMENT**

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 Project Initiation Document and Transitional Funding Plan for the development of equitable mental health services in the Levern Valley area. The report explained that this was part of the wider redesign of mental health services in the Clyde area of NHS Greater Glasgow and Clyde, and that the PID summarised the total transitional resource required to establish comprehensive mental health services in the Levern Valley, in line with widely accepted benchmark levels of service.

Commenting on the report, the Head of Planning and Health Improvement explained that transitional funding amounted to approximately £300,000 per annum and provided details of the types of projects to be undertaken,

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highlighting that some of the services provided by NHS Greater Glasgow for the Eastwood side of the authority would now be provided across the whole of East Renfrewshire.

In response to a question from Dr Mitchell, she confirmed that the number of psychiatric nursing staff was being increased from 2 to 4.5, and that the recruitment process for the additional staff was already under way. Furthermore, the Director indicated that a chart showing the staffing structure would be made available.

Councillor Grant sought details of accommodation arrangements for staff in response to which it was explained that even though there was now sufficient space for all staff, efforts were still being made to co-locate social work and health teams across the entire area to maximise the efficiency and effectiveness of the services provided. In addition, the Chief Social Worker explained that innovative work practices such as “hot desking” would be seriously considered.

Councillor Garscadden sought clarification of who would be employing the staff referred to in the document, and it was confirmed that their contracts of employment would be with NHS Greater Glasgow and Clyde.

DECIDED:

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| (a) | that the Committee note the report and receive progress updates on implementation; and | Head of Planning and Health Improvement |
| (b) | that a staffing chart be produced for members' information. | Head of Planning and Health Improvement |

23. PERFORMANCE REPORT – QUANTITATIVE

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 an overview of performance for the third quarter of 2006/07.

The report explained that performance had improved or levels been maintained in respect of 66% of indicators, with 78% of indicators performing above or close to target. However, it also explained that performance was more mixed than for the previous quarter, with there being areas where performance had improved, but also others where performance levels had declined. A copy of the full performance report, showing performance levels against agreed targets and performance trends, accompanied the report. In addition, in accordance with agreed procedure, exception reports had been prepared in respect of those areas where performance had been significantly below target, and copies of these reports were tabled.

The Planning and Performance Manager was then heard on a number of the indicators. He highlighted that the number of patients experiencing a

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delayed discharge of 6 weeks or more had reduced from 15 to 12, although patients exercising their statutory right of choice to remain in hospital whilst awaiting the availability of a care home place could negatively affect this indicator. He also highlighted improvements in the number of people waiting 18 weeks or more for inpatient or daycase treatment, reducing from 14 to 0, with the number waiting for an appointment from GP referral falling from 101 to 72. In addition it was highlighted that there had been a reduction in the numbers of people waiting for physiotherapy services. This had been down in part to the employment of agency staff. However the mismatch between demand and available funding had been referred to in the CHCP Development Plan.

Having commented on a number of the other indicators showing improvements in performance reference was then made to performance areas where performance had declined and the associated exception reports setting out the reasons for this.

Mr Hamilton referred to the exception report regarding the failure to meet the 100% target for 48-hour GP access and questioned why only 68.8% had been achieved. In reply, it was explained that this was due to local underreporting, but that of those practices that had submitted a return, 100% had been attained. In addition, the Director explained that for those practices that had submitted their returns late, 100% success had also been achieved. In reply to a further question from Mr Hamilton, it was explained that levels of physical activity were measured through both local and national lifestyle surveys. However, these were out of date and therefore caution had to be used in interpreting the results.

Mr Devine sought further information relative to the failure to meet the target for the completion of Community Service Orders (CSOs). In reply the Director explained that more drug-related offenders were being given CSOs by the courts. However, the increased levels of ill-health amongst drug users generally was affecting performance levels. As a result, it had been agreed with the Chief Executive to reduce the target as a result of the changing client base.

In response to a question from Mrs Reid on performance comparison, the Director confirmed that as well as comparing performance with the previous quarter, comparison was also made with the same quarter for the previous year. Referring in particular to absence levels, he highlighted that these were always higher during the winter months, but emphasised that short-term absence figures were low. He also explained that the figures given related only to social work staff as a system to give information relative to East Renfrewshire based health staff was not yet available.

Having confirmed that a robust approach to absence management was taken, the Chief Social Work Officer explained that the Council's absence levels compared favourably with other local authorities, although social work staff, particularly manual workers within the service, had traditionally high absence levels in local authorities.

Dr Mitchell reported that he had recently received the most recent figures for cervical screening indicating above 80%, a figure that compared well with other CH(C)Ps. He explained that procedural changes were being introduced at the end of May which may lead to variances in the quarterly

figures for this service but that the important figure would be that for the full year.

NOTED

24. NORTH STRATHCLYDE COMMUNITY JUSTICE AUTHORITY

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 North Strathclyde Community Justice Authority (CJA), which had been operating in "shadow" form since April 2006 and which became fully operational on 2 April 2007.

The report explained that Community Justice Authorities were created by the Management of Offenders etc (Scotland) Act 2005, with their primary purpose being to plan, co-ordinate monitor and report on the delivery of criminal justice social work services.

Commenting on the report, the Chief Social Work Officer gave details of those local authorities comprising the membership of the CJA, it being highlighted that each authority retained the statutory responsibility to deliver criminal justice social work services in their respective area. She explained that a Chief Officer for the CJA had been appointed by Renfrewshire Council, the lead authority for the CJA, and in conjunction with the CJA Implementation Group had produced the 2007-2008 CJA Area Plan in early September 2006. This plan had been approved by the CJA in late September 2006 and subsequently approved by Scottish Ministers in January 2007.

One of the main challenges was the changes in how funding would be allocated in future, it being explained that funds would be allocated to the CJA with each of the members of the CJA drawing down funds thereafter, based on "need". A Funding Group had been set up to examine how this would be taken forward, and was currently examining how existing resources were configured and how these should be deployed to meet the Plan priorities.

The Chief Social Work Officer explained that efficiency savings were being achieved through the delivery of some projects across the CJA. By way of example, reference was made to the Drug Testing and Treatment Team, employed by East Renfrewshire, but providing a service to Paisley, Greenock, Dunoon and Rothesay Sheriff Courts. Further consideration was to be given to extending other services, such as Community Forensic Mental Health, across the CJA.

Having heard the Chief Social Work Officer provide further details of the challenging work involved relative to those offenders who were the subject of a Drug Testing and Treatment Order, Dr MacRitchie suggested that there appeared to be political pressure to keep drug users out of jail. In reply, the Chief Social Work Officer explained that offenders were required to undergo an assessment to determine their suitability for the programme. It was not beneficial for unsuitable offenders to be placed on the programme as this had a negative effect on its credibility.

NOTED

25. **NORTH STRATHCLYDE COMMUNITY JUSTICE AUTHORITY – CRIMINAL JUSTICE SOCIAL WORK ALLOCATION 2007/08**

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 indicative level of grant funding available to the CJA for 2007/08.

The report explained that grant funding was divided between core and non-core services, with details of the type of projects in each category being given. The report explained that in respect of core services, Scottish Ministers had agreed a national increase of £2 million (2.5%) designed to reflect the overall increase in service workloads. However, due to the application of the agreed formula, the funding increase was not proportionate across all 10 CJAs, with details of some of the increases and decreases being referred to. Details of a number of the non-core projects being undertaken were also provided.

Commenting on the report, the Chief Social Work Officer explained that no additional funding was provided to take account of the ongoing job evaluation exercise in the Council or to fund annual cost of living salary increases above 2.5%. As a result, there was a net reduction in available funding.

Dr Mitchell sought clarification if the reduction in funding for the production in Social Enquiry Reports (SERs) would affect the ability of staff to produce these on time. In reply, the Chief Social Work Officer confirmed that the production of SERs would not be affected with some non-core funding being transferred if considered necessary.

NOTED

26. **CHANGES TO FOSTER AND OTHER CARER ALLOWANCES**

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, submitting for consideration proposals to upgrade the level of allowance paid to foster carers, reviewing and proposing an upgrade to all other allowances paid to carers, and proposing changes to the arrangements for annual increases to allowances.

The report explained the difficulties facing the CHCP in recruiting foster carers. This was due to a number of factors, not least of which was the growing number of private fostering agencies which recruited and retained foster carers by offering financial incentives and support packages, and also to the increased payments offered by neighbouring authorities.

The report highlighted that East Renfrewshire's recruitment problems had only materialised in the last two years, but that increasing numbers of young people requiring accommodation, including increasing numbers of sibling groups and older young people, had led to the current situation.

The report provided details of the poor response to the recruitment campaign carried out in April 2006 and gave details of the current allowances paid. The report set out proposed new rates for foster and other carers, also proposing that these rates be increased in line with

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inflation on an annual basis, and that a report be brought to Committee every three years with details of current level of payment and proposals, if any, for change.

The Chief Social Work Officer explained that one of the difficulties that had been identified in trying to recruit new carers was that many of those interested were in employment and the financial packages on offer were insufficient to allow them to give up employment and become full-time carers.

In response to questions from members, she outlined the benefits of attracting carers directly rather than through an agency, and that if the proposed new rates were approved hopefully the number of carers could be increased.

Dr Mitchell expressed concern that by increasing payments to carers, this would simply lead agencies to increase their charges to the Council. In reply, the Chief Social Work Officer explained that those carers working directly with the Council had cited the support mechanisms provided by the Council as one of the main reasons for maintaining that arrangement. It was hoped that by increasing the financial package on offer, more carers would be encouraged to work directly with the Council rather than through an agency.

In response to further questions, the Chief Social Work officer highlighted that the Council only used secure accommodation in those cases where this had been a requirement of the courts or where the child in question had been assessed as needing this type of accommodation. She also confirmed that no particular socio-economic groups had been targeted in the campaign, and that if people were discouraged from becoming carers after having expressed an interest, this tended to be more about the realisation of the amount of work involved in becoming a foster carer rather than the background checks made on them.

DECIDED:

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| (a) | that the proposed changes in the fees for foster carers be approved; | Chief Social Work Officer |
| (b) | that the proposed changes in the range of fees and allowances paid to other carers be approved; | Chief Social Work Officer |
| (c) | that allowances be increased on an annual basis in line with inflation, with a report being brought to Committee every three years with details of current level of payment and proposals, if any, for change; and | Chief Social Work Officer |
| (d) | that the new proposals take effect from 1 June 2007. | Chief Social Work Officer |

27. MULTI AGENCY PUBLIC PROTECTION ARRANGEMENTS (MAPPA)

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 establishment of a MAPPA Implementation Group to establish local MAPPAs throughout the CJA area.

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By way of background, the report explained that the police, local authorities, health boards and the Scottish Prison Service were required to establish joint arrangements for the assessment and management of the risk posed by sexual and violent offenders (MAPPAs). From April 2007, MAPPA would embrace registered sex offenders and at a date still to be determined would be extended to cover violent offenders and other offenders deemed to pose a serious risk to the public.

The report explained that to facilitate effective implementation of MAPPAs, an Implementation Group had been set up, the role and purpose of which was outlined, with it being reported that the Group was suggesting that rather than one MAPP being set up to cover the entire CJA, each constituent authority should set up their own MAPP arrangements.

The report set out the purpose and role of MAPPAs highlighting that a key feature was the identification of the assessed level of risk posed by each offender considered under these arrangements. 3 levels of risk had been identified, with all cases being subject to regular formal review at a level of representation consistent with the assessed level of risk.

The Chief Social Work Officer indicated that £61,000 had been made available to the CJA to appoint an MAPPA co-ordinator, with details of the duties of this person being outlined, and related administrative support. However, the level of funding was insufficient and approaches for additional funding would be made to the Scottish Executive.

The report further indicated that underpinning MAPPA arrangements would be the adoption of common risk assessment tools and processes across Scotland, with training already under way, although concerns had been expressed that insufficient numbers of staff will have received the training prior to the MAPPA implementation date.

In conclusion, the report emphasised that effective communication and information sharing would be critical to the success of MAPPAs, and that they would ensure improved management arrangements of sexual and violent offenders within the community.

NOTED

28. **MEDIUM SECURE CARE SETTING**

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 interim arrangements that had been put in place for the development of medium secure mental health beds for the West of Scotland.

The report explained that a number of recent developments in UK law, UK Government and Scottish Executive policy, had a direct impact on the way services for mentally disordered offenders were provided for, and offered a sound foundation for joint work between health and criminal justice social work services.

In particular, reference was made to the 1992 Reed Report which amongst other things suggested that individuals should be held under

conditions of no greater security than was justified by the degree of danger they presented to themselves or others; that maximised their chances of rehabilitation; and in local settings which reduced the risk of worsening their condition by unnecessarily institutionalising them.

The report highlighted that the State Mental Hospital at Carstairs, had long been recognised as being inappropriate for a number of forensic psychiatric patients held there. As a result these patients were being moved into less secure local forensic psychiatric units. The report explained that the Orchard Clinic in Edinburgh had been serving the south east for over 5 years, that a unit for the north east of Scotland was in the early stages of planning, and that Rowanbank Clinic, located at Stobhill Hospital, would provide 74 beds for the west of Scotland.

Commenting on the report, the Director reminded the Committee that proposals to locate a local secure facility at Dykebar Hospital had been at an advanced stage prior to the dissolution of NHS Argyll and Clyde. However, it had now been decided to suspend these proposals to establish whether or not they would still be required in light of the opening of the Rowanbank Clinic.

Councillor Collins explained that at the time the proposals for Dykebar had been first mooted, the Council had opposed them. However he clarified that this opposition was not to the principle of establishing a local facility, merely to the process which had been used to identify Dykebar, which was considered to be flawed.

Mr Anderson explained that the operation of Wards 5 and 6 at Leverndale Hospital would be reviewed in the light of the opening of Rowanbank Clinic and in the event of possible further changes to the Mental Health Regulations. He also highlighted the potential recruitment problems that would be faced, indicating that staff at Carstairs received an additional allowance and that discussions were ongoing about staff at Rowanbank Clinic also receiving this.

NOTED

29. VIOLENT OFFENDERS AND SEX OFFENDERS REGISTER (VISOR)

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 introduction and implementation of VISOR (Violent Offenders and Sex Offenders Register) within East Renfrewshire Criminal Justice Social Work Services.

The report explained that VISOR was an IT database currently used by every UK police force to facilitate multi-agency information sharing in relation to Registered Sex Offenders, Non-Registered Sex Offenders, Violent Offenders, Dangerous Offenders and Potentially Dangerous Offenders. It reported that VISOR had been identified as the national tool to support MAPPAs in Scotland and would provide agencies with a confidential communication tool through which they were able to exchange information in joint offender management.

The report further explained that only those with case management responsibility for sex offenders would be able to access VISOR with two Criminal Justice staff having recently completed a training course to allow them to train other staff within the authority on the use of VISOR. Staff would also be able to input data relative to clients, ensuring that the most up to date information was available to all agencies.

NOTED

30. PUBLIC PARTNERSHIP FORUM - UPDATE

Mrs Reid provided the Committee with an update of the work of the PPF over the past year. She explained that the PPF had met every month except December 2006, and that one of the key tasks had been the establishment of a sub-group to examine publicity arrangements for the Forum. She explained that a number of awareness raising events had been held throughout the year. Attendance at these had been disappointing, but those who had attended showed a real interest in the work of the Forum.

Mrs Reid reported that a number of those serving on the Interim Executive of the PPF were planning to stand for re-election, and that a public event was being held in June at which it was hoped to elect the Executive for the next two years, although work on the nomination process, particularly as it related to groups and individuals, was ongoing.

She emphasised that the commitment made by PPF members had helped both in the development of the PPF's identity and also in helping to make it as successful as it had been in the past year. Furthermore, she indicated that a copy of the PPF's annual report would be provided to members of the Committee for information.

Agreeing with Mrs Reid, Mr Hamilton paid tribute to the enthusiasm of the PPF and also to Gerry Tougher for his support of the Forum.

DECIDED:

- (a) that the update be noted; and
- (b) it be noted that a copy of the PPF annual report would be provided to Committee members for information in due course.

Principal
Committee
Services
Officer

31. STAFF PARTNERSHIP FORUM – UPDATE

Mr Anderson was heard on the work of the SPF. He highlighted a number of the challenges that had faced health staff in recent years such as the introduction of Joint Futures and subsequently the CHCP, the dissolution of NHS Argyll and Clyde, and management restructures. He explained that NHS Greater Glasgow were presently finalising their Staff Governance Action Plan which would be used as a basis for the establishment of a Staff Governance Committee, and referred to further work that was required in terms of a Communications Strategy which

would help to improve staff awareness of the CHCP and how their views could be fed into the organisation.

He commented that it was hoped that the period of stability now being enjoyed would lead to more meaningful engagement between staff and management with there being more staff-side involvement in working groups in future.

Mr Devine was then heard on the work of the SPF from a Council perspective. He referred to the steep learning curve associated with his position and that it had been interesting and challenging taking part in discussions with colleagues from health. He highlighted that whilst the PWC report referred to earlier commented highlighted the integrated nature of the SPF, Unison was the only trade union to become involved, with little interest being shown by either the T&G or the GMB. As a result, he was the sole staff contact.

In conclusion, he emphasised the positive nature of the first year, paid tribute to the assistance that he had received, and like Mr Anderson expressed the hope that there would be more staff-side involvement in future.

NOTED

32. PROFESSIONAL EXECUTIVE GROUP - UPDATE

Dr MacRitchie was heard on the work of the PEG in the previous year. He explained that the role of the PEG was to assist the Committee in professional matters, and reported that the PEG had met formally 4 times in the year, but that the majority of its work was carried out by working groups, an arrangement which appeared effective.

Having heard Dr MacRitchie explain that the main challenge for the PEG was in relation to prescribing, an area over which there was little real influence or control, and also question the benefit of the 4 full PEG meetings, Mr Millar suggested that in his view these meetings were helpful as they provided a useful networking opportunity. He also suggested that the mechanisms for cascading information down from the PEG required improvement.

Further comment having been made on the need for lessons to be learned from the comments of those involved in the process, Dr Mitchell indicated that the next major piece of work for the PEG was regarding the role and structure of the PEG and how members could contribute to work on secondary care service redesign. In this regard, Councillor Garscadden sought clarification of whether there would be a PEG representative on any groups set up to consider service redesign and whether this person would have authority to agree to proposals on behalf of the PEG.

In reply, it was explained that this process had yet to be clarified, it being highlighted that one of the difficulties that had faced primary care services in the past was the lack of opportunity to have an input into secondary care service redesign. In particular, it was explained how local primary care services had no negotiations with either the Victoria Infirmary or the

ACTION BY

Southern General Hospital over service redesign, and that one of the main challenges was to develop the relationships between GPs and local hospitals.

In addition, the Head of Planning and Health Improvement explained that the interface between primary and secondary care services had always been challenging and confirmed that there was an acute services representative on the PEG.

NOTED

33. VALEDICTORY REMARKS

Mr Hamilton referred to the forthcoming local government elections on 3 May at which two of the Council's representatives on the Committee, Councillors Collins and Garscadden, were not seeking re-election. He explained that he known Councillor Collins for 7 years, firstly through the Greater Glasgow Health Council and latterly as a colleague on the Board. He had always found Councillor Collins to be very constructive in his comments at meetings, a fact that had also been highlighted by Professor Arbuthnott, the Chairman of the Board, at the Board meeting the previous day.

On behalf of the Committee he thanked both councillors for their contributions to the work of the Committee over the last 12 months, particular thanks being given to Councillor Collins for the effective manner in which he had chaired meetings of the Committee. In conclusion he also offered best wishes to Councillors Fletcher, Grant and Napier, who were seeking re-election.

Thanking Mr Hamilton for his kind words, Councillor Collins paid tribute to all the members of the Committee and the various sub-groups that had been set up for their efforts over the last year. He also thanked the officers involved for their support for the work of the CHCP, and those members of the public that had taken an interest in the work of CHCP, either through the PPF or by attending meetings of the Committee itself.

**GREATER GLASGOW AND CLYDE NHS BOARD
EAST RENFREWSHIRE COUNCIL**

**Minute of meeting of the
East Renfrewshire Community Health and Care Partnership
Care Governance Sub-Committee
held at 10.00am on 12 March 2007 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
Mary Gallagher	Operations Manager, Children and Families
Wilma Hepburn	Senior Nurse, Adults
Ellen McGarrigle	Lead Nurse
Fiona Middler	Clinical Effectiveness Facilitator
Candy Millard	Commissioning, Performance and Planning Manager
Mr Peter Hamilton	NHS Greater Glasgow and Clyde Board
Dr Alan Mitchell	Clinical Director
Cindy Wallis	Mental Health and Partnerships Manager

IN ATTENDANCE

Eamonn Daly	Principal Committee Services Officer
Angus Hunter	Administration Manager
Erik Sutherland	Planning and Performance Manager

ACTION BY

1. MINUTE OF PREVIOUS MEETING

There was submitted the Minute of meeting of 27 November 2006, a copy of which had been issued previously to each member.

Under reference to Item 5 (Proposed Care Governance Arrangements), Mr Sutherland reported that a number of meetings had taken place to discuss supporting arrangements, the Care Governance Network had been established, and work was ongoing

to establish the Practice Forums, in respect of which a workshop session had been arranged to further discuss mechanisms for their establishment.

In response to a question from Mrs Dean on the composition of the Practice Forums, it was confirmed that so far, membership had not been

extended to the Staff Partnership Forum, but that the Forum would be invited to nominate representatives in due course.

DECIDED

- (a) that the Minute be approved; and
- (b) that the additional information be noted.

2. ROLE AND FUNCTION OF THE CLINICAL GOVERNANCE SUPPORT UNIT

Councillor Collins invited Fiona Middler, Clinical Effectiveness Facilitator, to make a presentation to the sub-committee on the Role and Function of the Clinical Governance Support Unit.

By way of background, Ms Middler explained that prior to the recent establishment of CH(C)Ps, the Clinical Governance Department of the Board dealt solely with primary care matters. However, since the changes, the Department also covered both acute services and the new Partnerships. She reported that the Unit covered 4 main areas; the provision of advice to clinicians and managers in the development of policies; the provision of clarification of Scottish Executive policies for implementation at local level; the development of risk systems; and development of a programme of care governance training in areas, for example, such as audit and clinical effectiveness.

Reference was then made to the contact details within the Unit for both the Partnerships and acute services, details of which had been issued previously, it being highlighted that this was the position as at the end of February and that any updates would be circulated as staff changes occurred.

Ms Middler then made comment on the liaison roles set up by the Board. Details of the reasoning behind the establishment of the roles, what the designated liaisons were required to do, together with a list of the various Directorates and Partnerships and the contacts within these bodies, together with their respective liaisons in the Unit, had been issued previously.

Ms Middler highlighted that the role of the Liaison Officer was not to carry out for the Partnership any of the development work required, but to provide advice and guidance to allow the Partnership to carry out this work itself.

Mr Hamilton referred to a recent seminar at which the question of clinical risk had been discussed. He explained that there had been support at the seminar for the view that it was unlikely that the main issues relating to clinical risk in one area would differ greatly from those in another. In view of this, there had been support for the development of a Clinical Risk Register that could be used across different Partnerships. It had been indicated at the seminar that Andy Crawford, Head of Clinical Governance, would investigate whether this could be taken forward, and Mr Hamilton enquired if any progress had been made in this regard.

NOT YET ENDORSED AS A CORRECT RECORD

ACTION BY

In reply, Dr Mitchell clarified that Mr Crawford had taken forward work on risk registers, it being explained that each CH(C)P had been asked to identify their “top 5” risks, which would be collated and form the basis of a CH(C)P wide register.

In addition, commenting on the seminar referred to by Mr Hamilton, Dr Mitchell indicated that the general feeling was that there was no clear strategy on how to develop a proactive plan for the delivery of risk registers for the Partnerships. He suggested that the Unit as described by Ms Middler was too reactive in nature, and expressed disappointment that rather than simply offer advice and guidance to Partnerships, the Unit should be more proactively involved in the development of clinical/care governance work plans. He indicated that he would discuss this with Mr Crawford.

Councillor Collins reminded the sub-committee that Partnerships were at different stages of development and it was important that the pace of issues such as the development of risk registers was not held back by those Partnerships that were least advanced in their development. He suggested that there was a real danger that the work in question would drift if timescales were not attached, in view of which it was suggested that the sub-committee agree that Dr Mitchell discuss the question of timescales with Mr Crawford.

Dr Mitchell then explained that one of the positive issues that had emerged from the seminar had been the development of a common reporting template. This was being developed by the Head of Clinical Governance in consultation with the Clinical Directors and would give a better indication of where resources should be focussed and/or practices altered to achieve service improvements.

On behalf of the sub-committee, Councillor Collins thanked Ms Middler for her presentation.

DECIDED

- (a) that the sub-committee support the proposals that Dr Mitchell make approaches to Mr Crawford on the need for the Clinical Governance Support Unit to have a more proactive role in the development of clinical and care governance work plans; and **Clinical Director**
- (b) that Mr Crawford be asked to provide timescales for the provision of the CH(C)P risk register **Clinical Director**

3. **RISK REGISTERS**

Under reference to the Minute of previous meeting (Item 3 refers), further discussion took place on the development of risk registers.

Mr Hunter explained the processes used to date in the development of the registers, it being noted that as part of the process the main risks would be established and used as a starting point for further development.

NOT YET ENDORSED AS A CORRECT RECORD

ACTION BY

Referring to the incidents reported on the health side over the previous 6 months, he explained that there was under-reporting in terms of incidents involving abusive language towards staff and violence to staff. He suggested that it was important to go back to staff and encourage them to complete an IR1 form in these instances as this would help to determine the level of seriousness attached to such incidents in the risk register.

In response to Councillor Collins, Mr Hunter explained that in the event staff were subjected to abuse/violence by a particular individual, this information was made available across health services, to ensure that they were aware of the possibility of such incidents when dealing with the individuals in question.

Commenting on the relatively small number of completed IR1 forms, Mrs Dean suggested that a patient's medical condition could affect their behaviour and staff often took this into account when deciding whether to submit a form. Whilst acknowledging this, Councillor Collins suggested that it was important that all incidents were reported as this could help to identify a pattern of behaviour and allow appropriate steps to be taken.

In support of the need for all incidents to be reported, Dr Mitchell emphasised that accurate reporting of incidents helped to protect both patients and staff. He emphasised the importance of managers being made aware of any actions against staff by patients in order for them to determine how best to deal with similar incidents in the

future. In respect of incidents against patients, he explained how these tended to be as a result of system failure, and it was important for there to be an environment in which staff were supported in these cases rather than the focus being on identifying the "guilty party".

Mrs Baxter reported that Social Work staff tended to report only major incidents and further work was required to encourage staff to report all incidents.

Mrs Hepburn highlighted that some CH(C)Ps operated a system of two incidents books, one specifically for clinical incidents, and suggested that the introduction of such a system in the East Renfrewshire CHCP may prove helpful.

Further discussion then took place on how some issues could cut across different departments and geographical areas. Mrs Wallis highlighted that there was still a lack of clarity about incident reporting. By way of example, she explained that staff employed by the South East CHP, East Renfrewshire CHCP and Renfrewshire CHP worked in other areas from time to time and there was uncertainty over whether an incident in which they were involved, if it occurred not in their own area, should be reported to their employer or the area in which the incident occurred. Mrs Baxter explained that this was compounded by the fact that staff often dealt with more than one CH(C)P, and that further work was required across the CH(C)Ps to lessen the confusion amongst staff.

Dr Mitchell suggested that a small sub-group of the sub-committee be convened over the next few weeks to take forward the question of incident

NOT YET ENDORSED AS A CORRECT RECORD

ACTION BY

reporting including the issues that had been raised in the course of discussion. The outcome of the discussions and any developments taken forward could be reported back to the next meeting of the sub-committee.

DECIDED

- (a) that a small sub-group of the sub-committee be convened over the next few weeks to take forward the question of incident reporting including the issues that had been raised in the course of discussion; and **Planning and Performance Manager**
- (b) that it be noted that the outcome of the discussions and any developments arising therefore would be reported to the next meeting of the sub-committee.

4. **POLICY FOR ADDRESSING CLINICAL GOVERNANCE RELATED GUIDANCE**

The sub-committee took up consideration of a draft policy for addressing clinical governance related issues, a copy of which had been issued previously to each member.

Referring to the policy, Ms Middler explained it had been produced to set out clearly the approach taken by NHS Greater Glasgow and Clyde to addressing clinical governance related guidance, information on the type of documents that the policy did and did not cover, being given. She highlighted that it was in draft form at present and comments would be welcomed.

Dr Mitchell expressed concern that in the event decisions to implement guidance were taken at CH(C)P level, this could lead to inconsistency across the Board area, and suggested that whilst it was appropriate for CH(C)Ps to have an input into the Board's decision-making process, it was important that the final decision on whether to implement guidance was taken at Board level and implemented by all CH(C)Ps thereafter.

Mrs Baxter suggested that the sub-group looking at incident reporting could also prepare comments and Councillor Collins proposed that in view of the lengthy consultation period, any proposed comments on the draft policy be submitted to the next meeting of the sub-committee.

DECIDED

- (a) that the sub-group set up to consider incident reporting mechanisms also consider further the draft policy on addressing clinical governance related guidance; and
- (b) that the views of the sub-group be submitted to the next meeting of the sub-committee prior to being sent to the Clinical Governance Support Unit. **Planning and Performance Manager**

5. INCIDENT REPORTS

The sub-committee took up consideration of all IR1 and ACC1 forms in respect of incidents between October 2006 and early March 2007, copies of the forms being tabled.

The Planning and Performance Manager explained that analysis of the forms had allowed the 5 most common types of incidents to be identified, details of these being given. It was also confirmed, in response to Mr Hamilton, that the information covered the Levern Valley area in respect of Social Work services, but not health services.

It having been confirmed that in future it would be possible for the forms to be accompanied by a summary sheet categorising the various types of incident, discussion took place on the different approaches used by health and social work staff to determine whether home visits should be undertaken by lone members of staff. It was noted that in many cases this was a judgement call that needed to be made and an individual may have different thresholds depending on the services involved.

Discussion also took place on the lack of a common system for health and social work staff which would allow better information sharing on patients and clients to ensure that staff were better protected and service were quickly advised of situations when patients and clients required assistance.

Ms Wallis highlighted that different incident reporting systems were in place for voluntary sector community services, and sought clarification of how this arrangement would be reflected through the health and social work systems. In reply, Mrs Baxter explained that there was an expectation that the Practice Forums would be the vehicle by which such issues would be resolved, and that how this was being dealt with by the Forums would be reported back to the sub-committee.

Comment was also made on the need to encourage GPs to share information with the CHCP, it being suggested that this was a matter that needed to be discussed by the Professional Executive Group as it applied not only to GPs but to all independent contractors.

Commenting on the issue of information sharing, Mrs Dean highlighted that district nurses were supposed to be advised of any safety concerns relating to GPs' patients when visiting them. However, this did not always happen, it being suggested that in many cases GPs were overly cautious about the issue of patient confidentiality.

NOTED