ERCHCP(M) 06/3
Minutes 25-34

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 16 August 2006 in
Eastwood House,
Eastwood Park, Giffnock

PRESENT

Councillor Daniel Collins (in the Chair)

Mr Forrest Alexander	Public Partnership Forum
Mr Gordon Anderson	Staff Partnership Forum Co-Chair (NHS)
Mr Stephen Devine	Staff Partnership Forum Co-Chair (East Renfrewshire 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
Mrs Anne Marie Kennedy	Public Partnership Forum
Doctor Alan Mitchell	Co-Clinical Director
Councillor George Napier	East Renfrewshire Council
Doctor 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
Erik Sutherland		Planning and Performance Manager

APOLOGIES

Mrs Safaa Baxter Chief Social Work Officer (Professional Executive Group); Jacqueline Reid (Public Partnership Forum); and Ms Melanie Small (Public Partnership Forum)

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ACTION BY

25. **INTRODUCTION AND WELCOME**

Councillor Collins welcomed to the meeting Forrest Alexander and Anne Marie Kennedy, who were attending their first meeting as designated Public Partnership Forum (PPF) representatives on the CHCPC.

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26. **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 21 June 2006.

27. **MATTERS ARISING**

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 on matters that had been raised at the previous meeting on 21 June 2006.

Discussion took place on various matters as follows:-

(i) Communications

Under reference to the Minute of previous meeting, (Item 17 refers), the Head of Planning and Health Improvement explained that the leaflets regarding the establishment of the CHCP had been distributed as inserts in free papers in the area, and by hand delivery in those areas where the free papers used were not in circulation. It was estimated that approximately 80% coverage had been achieved, but the Head of Communications, NHS Greater Glasgow and Clyde, who had carried out the exercise, had been asked to compile an audit report confirming the level of coverage achieved.

Councillor Fletcher suggested that if the object of the exercise was to reach every household in East Renfrewshire, then the use of free papers for circulating leaflets was questionable. Councillor Collins suggested that the way in which information was distributed throughout East Renfrewshire could be considered in further detail by the Communications Group as part of the development of a Communications Strategy for the CHCP.

(ii) Statistical Information

Under reference to the Minute of previous meeting (Item 22 refers), the Head of Planning and Health Improvement confirmed that the statistical information in the Development Plan related solely to East Renfrewshire.

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

Under reference to the Minute of previous meeting, (Item 17 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 information on the establishment of a Project Board that would lead the development process for the new Barrhead Health and Social Care Resource Centre, together with information on funding arrangements that had been agreed in relation to the NHS elements of the facility.

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The report explained that the first meeting of the Project Board had been held on 28 July, following which a Project Initiation document, which included the objectives of the Project Board, had been produced. A copy of the document, together with details of the Project Board membership accompanied the report.

The report highlighted the key elements of the project that had been discussed by the Project Board, explaining how these would be taken forward. In particular, the report explained that discussion on the timescales for the project would be discussed at the next Project Board meeting. Notwithstanding, indicative project timescales were given.

In addition, the report explained that NHS Greater Glasgow and Clyde had secured from the Scottish Executive an additional capital allocation of £15 million to support the building of both the Barrhead facility and a proposed development in Renfrew, with the Council confirming that once the full costs for the Barrhead project had been confirmed a pro-rata contribution would be made.

The Head of Health and Community Care explained that over the last two weeks much work had been carried out to refine the financial arrangements for the project. As part of this work, Tony Curran, Head of Capital Planning, NHS Greater Glasgow and Clyde, had agreed to lead a Finance Group, which would hold its first meeting on 8 September prior to the meeting of the Project Board the following week. Commenting on the question of public involvement in the project, he explained that he would be attending the meeting of the Public Partnership Forum (PPF) on 28 August to discuss questions of public involvement and engagement.

In terms of the design brief for the project, he explained that an advertisement would be placed in the European Journal seeking expressions of interest from suitably qualified architects. Setting out the process to be followed in appointing a design team, he explained that it was hoped to have the team in place within the next three months.

The Head of Health and Community Care then provided the Committee with a brief update in respect of arrangements for the repair of the roof of the existing Barrhead Health Centre.

Councillor Grant suggested that the representatives from both service deliverers and service users involved in the design of the new centre should be given clear instructions that once the design had been finalised it could not be changed, as this had the potential to lead to an increase in costs for the project.

Referring to the proposed timescale for the production of the Outline Business Case (OBC) Mr Hamilton indicated that he understood that the OBC would incorporate the outcome of the community engagement activity, and that the timetable as set out did not leave much time for community engagement to occur. Acknowledging the tight timescale, the Head of Health and Community Care explained that it was necessary to strike a balance between moving forward with the project as quickly as possible and achieving adequate levels of public consultation as part of the OBC process. However, it may be possible to extend the OBC

timescale if it was considered that the level of public consultation had been inadequate.

Mr Hamilton then referred to the composition of the Project Board, suggesting that representation from health and social care professionals was comparatively low. In reply, the Head of Health and Community Care explained that the composition of the Project Board was driven by the nature of the project. He explained that a number of sub-groups would be established, for example, a Service Providers Group, that would look at the project detail, and provide advice to the Project Board on accommodation and all aspects of service provision. Notwithstanding, the composition of the Project Board could be revisited if it was considered appropriate.

Councillor Fletcher welcomed the confirmation of funding for the project, reminding members that under NHS Argyll and Clyde there had been real concerns that funding for the project may not have been delivered. He highlighted that the Council had significant gained significant experience in such large scale projects through participation in the construction of new schools in the area and the M77 extension and Glasgow Southern Orbital Route, and that this experience should not be discounted in taking the project forward.

Mrs Kennedy emphasised the need for there to be public involvement in the Project Board, and expressed concern that the timetable for the project may mean that the time available for public consultation may not be adequate.

Having heard Mr Anderson on the need to involve in the design of the building people that would be working there, Councillor Garscadden also expressed support for the need for community representation on the Board, which in his opinion appeared to contain an overrepresentation from the Council. He suggested that clinicians and social work practitioners needed to be reassured of an input into the project, and referring to the revenue funding for the project, enquired if this was based on current levels of service provision and whether it would influence the services to be made available in the new facility.

In reply, the Director acknowledged the high level of Council representation on the Project Board. However, he referred to a joint health/local authority project in West Lothian that had been dogged with legal and financial difficulties, explaining that the composition of the Board had been made up in part to help prevent similar difficulties with the new Health and Resource Centre.

Commenting on the timetable, Mr Devine suggested that with a build time for the project of 18-24 months, although the timetable indicated a 2009/2010 completion date, 2010/2011 was more likely. In reply, the Head of Health and Community Care explained that the timescales given were based on a minimum of information. The Project Board would need to reflect on the project timing and the design team, once appointed, would be able to provide more accurate information.

In conclusion, Councillor Collins again emphasised that this was an extremely positive story, expressing disappointment with the lack of

prominence of any press coverage given, which in his view strengthened the need for a Communications Strategy to be put in place as soon as possible.

The Committee noted the report.

29. **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 June 2006.

The report explained that the figures produced represented the first round of information produced by Health following the creation of Community Health Partnerships and took cognisance of the revised Clyde structures. Although a few anomalies remained it was anticipated that these would be resolved before the next monitoring report was presented to Committee.

The report highlighted that whilst there was a total underspend to date of £729,401 against a phased budget of £14,703,707 the majority of these underspends were due to timing differences caused by budget phasing not being in line with actual expenditure.

Having explained that regular budget monitoring reports would be presented to the Committee and that there were a number of areas where figures had not been finalised due to cost sharing arrangements not being concluded, the Director highlighted that whilst the budget was satisfactory in terms of budget management, there were a number of areas where the level of funds available resulted in low levels of service, particular reference being made to mental health services in Barrhead.

Agreeing with the Director, Councillor Garscadden indicated that it was important the Committee was made aware of these areas of low service in order for it to take a view on how these service areas could be developed, with the production of appropriate strategies and action plans. In reply, the Director explained that he and the Head of Planning and Health Improvement were attending a financial planning meeting the following day involving the acute sector, one of the aims of the meeting being for CHCPs to identify areas of pressure. A report on the meeting would be submitted to the next meeting of the Committee.

Whilst welcoming this, Councillor Garscadden highlighted the importance of the Committee being made aware of service planning and development across all service areas in order for it to obtain a holistic view of service provision. The Director suggested that this could be further developed at the CHCP seminars being arranged. Furthermore, the Head of Planning and Health Improvement, supported by Mr Hamilton, suggested that many of the issues around levels of service would be reported to the Committee through the proposed Performance Management Framework.

Councillor Grant sought details of the voluntary organisations being funded by the Council through Changing Children's Services. In reply, the Finance Manager explained that a number of organisations received

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funding and that he could produce a report with the information for the next meeting of the Committee.

The Committee:-

(a) noted the report and that regular budget monitoring reports would be presented to the Committee; — Finance Manager

(b) agreed that a report be submitted to the next meeting of the Committee on the outcome of the discussions at the financial planning meeting to discuss service areas under pressure; and — CHCP Director

(c) agreed that a report be submitted to the next meeting of the Committee providing details of those voluntary organisations receiving funding from the CHCP. — Finance Manager

30. **PERFORMANCE MANAGEMENT FRAMEWORK**

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 the implementation of a Performance Management Framework for the CHCP which met the performance reporting and management requirements of partner agencies.

Having reminded members that the development of a Performance Management Framework was a key action point in the 2006/07 CHCP Development Plan, the report explained that as well as meeting key priorities in the Development Plan, the CHCP also had local responsibility for delivering on a range of national and local objectives and targets set by, amongst others, the Scottish Executive and Audit Scotland. In order to synchronise these national and local requirements and to monitor outcomes, an integrated Performance Management Framework had been developed, organised around 9 strategic objectives, details of which were listed.

The report proposed that performance reporting would be divided into a quantitative report that would provide information on measurable areas of performance, and a qualitative report on the more descriptive performance areas. Details of the proposed reporting periods and differing reporting styles were outlined, with it being explained that in those instances where performance appeared to have fallen below accepted tolerance levels, exception reports would be produced which explored the issues in detail and set out proposed corrective action.

The report also explained that the proposed reporting timetable for the first year, details of which were given, would align with the reporting, review, and budget setting timescales for the Council and the Board, and would also form the basis of bi-lateral accountability meetings between the Chief Executives of the Council and NHS Greater Glasgow and Clyde, and the CHCP Director.

Having heard the Head of Planning and Health Improvement in further explanation of the report, Dr Mitchell referred to the inclusion in the

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proposed performance report of measurement of A&E waiting times. He suggested that this was an issue over which the CHCP had no control, and that such issues should not be included in the report.

In reply, the Director explained that the time a patient way have to wait at A&E often depended on the service they were able to obtain locally through primary care and general practitioner services, and it was important for the CHCP to consider these relationships.

Dr Quin acknowledged the need to understand the links between the various services and that the seminars being arranged would provide an excellent opportunity for this.

The Committee approved the proposed Performance Management Framework and reporting timetable and agreed that arrangements now be made for its introduction. CHCP Director

31. **CARE GOVERNANCE PROPOSAL**

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 proposals to establish a Care Governance Sub-Committee to strategically oversee the development of care governance across the CHCP.

The report explained that Clinical Governance having emerged in the late 1990s in the NHS as a new way of approaching existing health care activity with a view to improving the quality and safety of clinical practice, Care Governance was a more recent term developed to reflect a partnership approach to the continuous improvement of professional practice and the delivery of care or support in the context of joint management.

Having explained that Care Governance was the framework by which the CHCP was accountable for continuously improving the quality of services, safeguarding standards of care and fostering an environment where excellence could grow, the report highlighted the need to develop a Care Governance approach to support arrangements reflecting the shared responsibility for service delivery.

The report highlighted that there were 7 core components of Care Governance, each relating to a wider and challenging range of activity and organisational development, and proposed the establishment of a Care Governance Sub-Committee to promote the development of Care Governance within the CHCP and to ensure that arrangements were in place to promote improvement in the quality of care services. The report set out the proposed terms of reference of the new sub-committee together with details of the proposed membership and support arrangements. Furthermore, the report explained that the sub-committee would require all decisions to be ratified by the CHCP, and that as a formal sub-committee of the CHCP, the Standing Orders of the CHCP would apply, with the exception of the number of members required to form a quorum, which would be three.

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The Director reported that the paper had been tabled at the last meeting of the Staff Partnership Forum (SPF) and that whilst the SPF was satisfied with the content, some concerns had been expressed over process, in that the paper had not been submitted to the SPF in the first instance and that there was no SPF representative on the proposed sub-committee. The Director explained that there was no difficulty if the Committee wished to alter the sub-committee composition to include a SPF representative. Furthermore, he explained that in terms of process it had to be borne in mind that as CHCPs were new there was no guidance available. However, issues would be considered as and when they arose.

Dr Mitchell then explained the background to the establishment of Care Governance. He reminded the Committee that Clinical Governance had been well established in the health service since the mid 1990s, and that prior to the introduction of CHCPs social work departments had been responsible for quality assurance in social care services. The establishment of integrated CHCPs provided an excellent opportunity to develop a single approach to quality care.

Dr Mitchell reported that one of the key tasks of the sub-committee, if established, would be to consider how to quality assure services and to satisfy the requirements of both the Council and the Board.

Responding to a suggestion by Mrs Kennedy that there should be public representation on the sub-committee, the Director explained that this was inappropriate as the sub-committee was a development of the Professional Executive Group (PEG). However he acknowledged that the public would welcome the opportunity to comment on safe practices, and explained that any proposals made by the sub-committee would require to be approved by the CHCPC on which there were PPF representatives. Furthermore, the Head of Planning and Health Improvement explained that a number of sub-groups below the sub-committee would be established and there would be an opportunity for PPF representatives to become involved in these.

Having heard a number of members in support of the proposal to establish the sub-committee, reference being made to much of the excellent work in clinical governance in the past by the Primary Care Trusts, Mr Devine referred to the challenges to be faced in terms of re-educating both health and social care staff in the use of a new single scheme.

Councillor Garscadden sought clarification of how the work of the sub-committee would link to that of the Care Commission. In reply, the Director explained that there were two aspects to this. Firstly, in terms of service planning, any registerable services proposed by the CHCP would require to be negotiated with the Care Commission. Secondly, Care Commission inspections could result in the need to carry out certain actions that were compulsory, arising from requirements of the Commission, and other non-compulsory matters arising from recommendations made by the Commission. In the case of Commission recommendations, there would be a role for the sub-committee in determining whether to follow the Commission's advice.

ACTION BY

The Committee:-

(a) approved the establishment of a Care Governance Sub-Committee of the CHCP, to strategically oversee the development of Care Governance across the CHCP; with

membership and terms of reference as set out in the report, subject to the inclusion of a SPF representative on the sub-committee; and

(b) agreed that Councillor Collins be appointed Chair of the sub-committee

32. **COMMUNICATION ISSUES**

Councillor Collins reported that there had been 2 meetings of the Communications Group since the last meeting of the CHCPC. Referring to a paper on the role and remit of the Group, a copy of which was tabled, Councillor Collins explained that work was under way to develop a Communications Strategy for the CHCP, as well as developing the CHCP website, in respect of which a presentation would be made at a future meeting of the Committee.

Councillor Collins also reported on 2 local projects that had won bronze awards at the recent COSLA Awards. The first of these was the Health Information Project, a collaboration between the Council's Culture and Sport Division and Health Connect, addressing the poor health and wellbeing of residents within East Renfrewshire's priority regeneration areas. This was achieved through the provision of one to one advice and information and also group sessions, either in Barrhead Library or outreach venues, the development of programmes of activity including complementary therapies, and free internet access to health-related websites as well as other resources such as leaflets and DVDs.

The second project, a collaborative project between Renfrewshire, East Renfrewshire and Inverclyde Councils, related to the development of a training programme for existing council staff to train as social workers on a part-time basis.

Welcoming the development of a Communications Strategy, Councillor Fletcher highlighted that in terms of the Council, much of the work undertaken by public relations staff was to act quickly to deal with any unforeseen events or problems that arise. He suggested that it was important to establish whether the Council's public relations staff or those of the Board would respond to questions in such circumstances.

Councillor Collins referred to the cryptosporidium outbreak in Eastwood Swimming Pool, which although dealt with by the Council was a health-related matter. He emphasised that any protocols put in place needed to cut across all Council departments to ensure that the CHCP had an input into any information being released about this or other health-related incidents.

ACTION BY

Having heard the Head of Planning and Health Improvement explain that protocols between the Council's and the Board's public relations staff were already in place, the Director suggested that the Communications Group revisit these to ensure that they covered such circumstances as those referred to by Councillors Collins and Fletcher. In addition in response to comments from Councillor Garscadden on the composition of the Group, the Head of Planning and Health Improvement confirmed that the Council's Education Department would be invited to nominate a representative to serve on the Group.

The Committee noted the information.

33. **PUBLIC PARTNERSHIP FORUM**

Mrs Kennedy gave an update on the activities of the PPF since the last CHCPC meeting. She explained that a small sub-group had been set up to examine ways in which information on the PPF could be made available to the public. A series of public meetings were to be held across East

Renfrewshire over September/October to give the public an opportunity to find out more about the work of the PPF and its relationship with the CHCP. This would be complemented by the production of leaflets and posters.

Concern was expressed that only a small amount of funding had been made available to the PPF and there was still uncertainty over whether this would continue. In reply, Mr Hamilton was able to confirm that with the Head of Planning and Health Improvement he had been able to negotiate £20,000 per annum from NHS Greater Glasgow and Clyde for PPF activities, in addition to the initial £5,000 start-up funding provided by the Scottish Health Council.

The Committee noted the information and welcomed the commitment of funding for the PPF.

34. **DATE OF NEXT MEETING**

The Committee noted that the next meeting would be held on Wednesday 11 October 2006 at 10.00 am, venue to be decided.