Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Date: Wednesday, 31 May 2017

Time: 14:00

Venue: Committee Room 2,
Council Offices, Garshake Road, Dumbarton

Contact: Nuala Borthwick, Committee Officer
Tel: 01389 737594 Email: nuala.borthwick@west-dunbarton.gov.uk

Dear Member

Please attend a meeting of the **West Dunbartonshire Health & Social Care Partnership Board** as detailed above.

The business is shown on the attached agenda.

Yours faithfully

KEITH REDPATH

Chief Officer of the
Health & Social Care Partnership

Distribution:-

Voting Members

Marie McNair (Chair – nominated by WDC)
Denis Agnew
Heather Cameron
Gail Casey
Allan Macleod
Rona Sweeney

Non-Voting Members

Barbara Barnes
Kenneth Ferguson
Wilma Hepburn
Jackie Irvine
John Kerr
Neil Mackay
Diana McCrone
Anne MacDougall
Kim McNabb
Janice Miller
Peter O'Neill
Martin Perry
Keith Redpath
Selina Ross
Julie Slavin
Alison Wilding

Senior Management Team – Health & Social Care Partnership

Date of issue: 24 May 2017

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

WEDNESDAY, 31 MAY 2017

AGENDA

1 APOLOGIES

2 DECLARATIONS OF INTEREST

Members are invited to declare if they have an interest in any of the undernoted items of business on this agenda and, if so, state the reasons for such declarations.

3 MEMBERSHIP OF THE PARTNERSHIP BOARD **7 - 9**

Submit report by the Head of Strategy, Planning & Health Improvement requesting confirmation of the new Chair and new voting members of the Partnership Board from West Dunbartonshire Council following the local government elections on 4 May 2017.

4 MINUTES OF PREVIOUS MEETINGS **11 - 24**

Submit for approval as correct records:-

(a) Minutes of Meeting of the West Dunbartonshire Health & Social Care Partnership held on 1 March 2017; and

(b) Minutes of Special Meeting of the West Dunbartonshire Health & Social Care Partnership held on 22 March 2017.

5 HEALTH & SOCIAL CARE PARTNERSHIP BOARD AND BOARD MEMBER DEVELOPMENT **25 - 28**

Submit report by the Head of People & Change seeking approval of a proposed approach to providing relevant and timely development of the Board and its Members so that they are supported to fulfil the full range of their duties.

6/

6 JOINT INSPECTION OF SERVICES FOR CHILDREN AND YOUNG PEOPLE IN WEST DUNBARTONSHIRE - FEBRUARY 2017 **29 - 84**

Submit report by the Head of Children's Health, Care and Criminal Justice/Chief Social Work Officer providing an outline of the process and purpose of the Joint Children's Services Inspection and the outcome in terms of the Care Inspectorate's evaluation and final report.

7 UNISON'S ETHICAL CARE CHARTER **85 - 99**

Submit report by the Head of People and Change providing information on the principles of Unison's Ethical Care Charter.

8 COMPARATIVE AND RELATIVE USE OF PRESCRIPTION DRUGS IN THE PARTNERSHIP BOARD AREA **101 - 107**

Submit report by the Head of Community Health and Care Services advising on current expenditure, ongoing cost pressures and potential savings within West Dunbartonshire Health & Social Care Partnership's prescribing budget.

9 LOCAL CODE OF GOOD GOVERNANCE AND SOURCES OF ASSURANCE **109 - 125**

Submit report by the Chief Financial Officer seeking approval to establish a Local Code with sources of assurance for adoption by the Partnership Board to review and assess its governance arrangements.

10 2016/17 FINANCIAL PERFORMANCE AND 2017/18 ANNUAL REVENUE BUDGET UPDATES REPORT **127 - 139**

Submit report by the Chief Financial Officer:-

(a) providing an update on the financial performance of the West Dunbartonshire Health & Social Care Partnership for the period to 31 March 2017;

(b) providing an update on the level and utilisation of reserves based on this financial performance; and

(c) providing an update on the 2017/18 revenue budget position.

11 PUBLIC PERFORMANCE REPORT OCTOBER TO DECEMBER 2016 **141 - 164**

Submit report by the Head of Strategy, Planning & Health Improvement providing information on the Health & Social Care Partnership's Public Performance Report for the third quarter of 2016/17 (October to December 2016).

12 GLASGOW CITY HSCP-LED REVIEW OF SEXUAL HEALTH SERVICES ACROSS GREATER GLASGOW & CLYDE **165 - 173**

Submit report by the Head of Strategy, Planning & Health Improvement bringing to the Partnership Board's attention the Glasgow City HSCP-led Review of Sandyford Sexual Health Service across Greater Glasgow & Clyde.

13 MINUTES OF MEETINGS FOR NOTING **175 - 202**

Submit for information, the undernoted Minutes of Meetings:-

(a) Minutes of Meetings of the Argyll, Bute and Dunbartonshires' Criminal Justice Social Work Partnership Joint Committee held on 9 March 2016.

(b) Minutes of Meeting of the Clinical & Care Governance Group held on 29 March 2016.

(c) Minutes of Meeting of the Joint Staff Forum held on 18 April 2017.

(d) Minutes of Meeting of the Health & Social Care Partnership Locality Group for Alexandria & Dumbarton held on 27 January 2017.

(e) Minutes of Meeting of the Health & Social Care Partnership Locality Group for Clydebank held on 21 February 2017.

(f) Note of West Dunbartonshire Local Engagement Network Open Forum Discussion: Adult Carers held on 16 May 2017 in the Carers of West Dunbartonshire Centre, Clydebank.

(g) Note of West Dunbartonshire Local Engagement Network Open Forum Discussion: Young Carers held on 16 May 2017 in the Y-Sort-It offices, Clydebank.

14 EXCLUSION OF PRESS AND PUBLIC **203**

The Committee is asked to approve the undernoted Resolution:-

"In terms of Section 50 (A) of the Local Government (Scotland) Act, 1973 that the press and public be excluded from the remainder of the meeting as the following item of business involves the likely disclosure of exempt information as defined in Paragraphs 1 and 3 of Part 1 of Schedule 7A to the Act."

15 SOCIAL WORK COMPLAINTS REVIEW SUB-COMMITTEE - 24 FEBRUARY 2017 **205 - 208**

Submit report by the Strategic Lead – Regulatory advising of a complaint heard by the Social Work Complaints Review Sub-Committee on 24 February 2017.

16 DATE OF NEXT MEETING

Members are requested to note that the next meeting of the Partnership Board will be held on Wednesday, 23 August 2017 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31st May 2017

Subject: Membership of the Partnership Board

1. Purpose

1.1 To confirm the new Chair and two new voting members of the Partnership Board.

2. Recommendation

2.1 The voting members of the Partnership Board are asked to note that following its meeting of 17th May 2017, West Dunbartonshire Council identified:

- Councillor Marie McNair as the social work and health spokesperson for the new Administration, and thus its new lead councillor to this Partnership Board.
- Councillor Denis Agnew and Cllr Gail Casey to be new voting members on this Partnership Board.

2.2 The Partnership Board is asked to confirm Marie McNair as its new Chair.

3. Background

3.1 The constitution of the Health & Social Care Partnership Board is established through the Public Bodies (Joint Working) (Scotland) Act 2014.

3.2 At its 22nd March 2017 meeting, the Partnership Board was informed that given the impending local government elections that the three councillors who were voting members would consequently be stepping down from the Partnership Board, including the then Chair of the Partnership Board. It was confirmed then that a follow-up report would be brought to the Partnership Board at the May 2017 meeting confirming both the three councillors who would be voting members on the Partnership Board; and who the Council would nominate as the new Chair of the Partnership Board.

4. Main Issues

4.1 Following its meeting on 17th May 2017, West Dunbartonshire Council identified:

- Councillor Marie McNair as the social work and health spokesperson for the new SNP Administration, and thus its new lead councillor to this Partnership Board.
- Councillor Denis Agnew (Independent – in coalition with the SNP Administration) and Gail Casey to be new voting members on this Partnership Board.

4.2 In accordance with the Partnership Board's Standing Orders, the Chair of the Partnership Board will continue to be the social work and health spokesperson for the Administration of West Dunbartonshire Council Administration up until July 2018. Consequently the Partnership Board is asked to confirm Marie McNair as its new Chair.

5. People Implications

5.1 None.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 The Council and the Health Board are obliged to ensure that the constitution of the Partnership Board is as prescribed in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

10. Impact Assessments

10.1 Not applicable.

11. Consultation

11.1 Not applicable.

12. Strategic Assessment

12.1 Not applicable.

Author: Mr Soumen Sengupta – Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership.

Date: 31st May 2017

Person to Contact: Soumen Sengupta
Head of Strategy, Planning & Health Improvement

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Appendices: None

Background Papers: The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014

HSCP Board Standing Orders: http://wdhscp.org.uk/media/1216/standing-orders-final-version-080715.pdf

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

At a Meeting of the West Dunbartonshire Health & Social Care Partnership Board held in Committee Room 3, Council Offices, Garshake Road, Dumbarton on Wednesday, 1 March 2017 at 2.00 p.m.

Present: Gail Casey (Chair), Jonathan McColl and John Mooney (Proxy for Martin Rooney), West Dunbartonshire Council; and Allan Macleod, Rona Sweeney and Mark White (Proxy for Heather Cameron), NHS Greater Glasgow and Clyde Health Board.

Non-Voting Members Keith Redpath, Chief Officer; Julie Slavin, Chief Financial Officer; Barbara Barnes, Chair of the Local Engagement Network – Alexandria & Dumbarton; Kenneth Ferguson, Clinical Director for the Health & Social Care Partnership; Mari Brannagan; Partnership Nurse Director (substitute for Wilma Hepburn); Jamie Dockery, Strategic Housing Officer (substitute for John Kerr); Janice Miller, Lead Allied Health Professional; Diane McCrone, NHS Staff Side Co-Chair; Anne McDougall, Chair of Local Engagement Network – Clydebank; Neil McKay, Chair of Locality Group – Alexandria & Dumbarton; Peter O'Neill, WDC Staff Side Co-Chair of Joint Staff Forum; Dr Martin Perry, Acute Consultant; and Selina Ross, Chief Officer of West Dunbartonshire Council for Voluntary Services.

Attending: Joyce White, Chief Executive, West Dunbartonshire Council; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Chris McNeill, Head of Community Health & Care; Nigel Ettles, Principal Solicitor and Nuala Borthwick, Committee Officer.

Apologies: Apologies for absence were intimated on behalf of Martin Rooney, West Dunbartonshire Council; Heather Cameron, NHS Greater Glasgow and Clyde Health Board; Jackie Irvine, Chief Social Work Officer; John Kerr, Housing Strategy Manager; Kim McNab, Service Manager, Carers of West Dunbartonshire; Wilma Hepburn, Professional Nurse Advisor; Julie Lusk, Head of Mental Health, Learning Disability & Addictions and Serena Barnatt, Head of People and Change, West Dunbartonshire Health & Social Care Partnership.

Gail Casey in the Chair

CHAIR'S REMARKS

The Chair, Councillor Casey welcomed everyone present to the meeting of the Partnership Board. Before commencing with the business on the agenda, the Chair formally acknowledged the up and coming retirement of the Chief Officer, Keith Redpath, on 31 July 2017, adding that the recruitment process for a new Chief Officer was now under way.

The Chair highlighted the Council's forthcoming Employee Recognition Event to be held on 22 March 2017, and specifically the West Dunbartonshire Health & Social Care Partnership's services and staff who are finalists in the following categories:-

- Team Leader of the Year – Wendy Jack, Strategy and Planning Manager
- Team of the Year – Community Paediatric Speech and Language Therapy Team
- Community's Award – Karen McNab, Day Care Officer at Lancraigs

Councillor Casey also acknowledged the undernoted Partnership Teams who had recently been shortlisting as finalists for the Social Work Team of the Year award at the 2017 Scottish Association of Social Work Awards:-

- Looked After Children's Service – Service Manager is Carron O'Byrne
- Care at Home Service – Integrated Operation Manager is Lynne McKnight

Thereafter, the Committee joined the Chair, Councillor Casey, in congratulating all finalists for both their continued commitment and contribution to providing high quality services on behalf of the Partnership Board.

DECLARATIONS OF INTEREST

It was noted that there were no declarations of interest in any of the items of business on the agenda.

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the West Dunbartonshire Health & Social Care Partnership held on 16 November 2016 were submitted and approved as a correct record subject to the undernoted amendments:-

(1) that point 4 of the item entitled, 'Financial Report 2016/17 as at Period 6 (30 September 2016)', be amended to:-

That the proposed 2017/18 Social Care savings options, should be subject to public consultation and appropriate staff/patient group consultation.

(2) that an apology for absence from Janice Miller, Lead Allied Health Professional, be included in the Minutes; and

(3) that the instruction to write to the Scottish Government and the Chair of the Health Board seeking an explanation on requests from the Scottish Government to make cuts would be re-instated and drafted with immediate effect.

FINANCIAL REPORT 2016/17 AS AT PERIOD 9 (31 DECEMBER 2016)

A report was submitted by the Chief Financial Officer:-

(a) providing an update on the financial performance and capital work progress of the West Dunbartonshire Health & Social Care Partnership for the period to 31 December 2016 (period 9);

(b) advising of the projected outturn position of the 2016/17 revenue budget; and

(c) providing an update on budget challenges.

After discussion and having heard the Chief Officer and the Chief Financial Officer in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note that the revenue position is reporting an underspend of £2.774m (2.69%) for the period 1 April to 31 December 2016;

(2) to note that the underlying service underspend is £0.030m as at 31 December 2016;

(3) to note the flow through of the unallocated balance of the Social Care Fund contributing £2.744m to both the current reported underspend and the projected underspend of £2.867m (1.99%);

(4) to note that management action on reducing cost pressures and maximising income had resulted in a revised year end projection, for all other service expenditure, from break-even to an underspend of £0.123m (0.09%), subject to the impact of Winter planning;

(5) to note the intention to add the unallocated Social Care Fund balance to reserves to provide stability in 2017/18;

(6) to note the financial challenges in 2017/18 from partner funding allocations, the continuation of GP Prescribing risk sharing and the financial performance of the Acute Set Aside budget; and

(7) that an update on the financial risks associated with GP Prescribing for Partnerships in 2016/17 would be submitted to a future meeting.

2017/18 ANNUAL REVENUE BUDGET

A report was submitted by the Chief Financial Officer outlining the budget allocations to the Health & Social Care Partnership Board for 2017/18 from funding partners, NHS Greater Glasgow and Clyde Health Board and West Dunbartonshire Council.

After discussion and having heard the Chief Officer and the Chief Financial Officer in further explanation of the report and in answer to Members' questions, Gail Casey, seconded by Jonathan McColl, moved the undernoted motion:-

The Partnership Board agrees the recommendations of the report (namely):-

(1) to approve the 2017/18 Social Care Revenue Estimates figure of £62.673m required to deliver the strategic priorities of the HSCP;

(2) to note the Council's Social Care saving reduction of £0.866m in the context of the Scottish Government's financial settlement direction to the Council that it could reduce its allocation up to a maximum of £1.560m;

(3) to approve the 2017/18 West Dunbartonshire Council payment contribution to the HSCP of £60.673m and the application of £2.0m from the HSCP's ongoing available funding from the 2016/17 Social Care Fund budget;

(4) to note the required 2017/18 NHS Greater Glasgow and Clyde Health Board financial allocation of £80.676m to comply with the Scottish Government direction of maintaining contribution at 2016/17 cash levels;

(5) to approve the Chief Financial Officer's recommendation at paragraph 4.27 of the report, to reject the 2017/18 financial allocation offer by NHSGG&C on 23 February 2017, as detailed in Appendix 7 of the report;

(6) to approve the proposals set out in paragraphs 4.29 to 4.31 on addressing Health Care inflation and cost pressures;

(7) to note the indicative 2017/18 set aside budget, being maintained at 2016/17 cash levels;

(8) to note the indicative reserves position for consideration and application in 2017/18 to mitigate any budget volatility and failure to deliver on approved savings plans; and

(9) to note the financial risks around the possible change or cessation to existing risk sharing or hosting arrangements.

Thereafter, Rona Sweeney, seconded by Mark White, moved the undernoted amendment:-

> That contrary to paragraph 4.23 of the report, the Partnership Board accepts the offer made by NHS Greater Glasgow and Clyde to take its share of the £7.8 million legacy of unachieved CHCP savings from 2015/16.

On a vote being taken, 2 Members voted for the amendment and 4 for the motion which was accordingly declared carried.

Thereafter, having heard the Chair, it was noted that a Special Meeting of the Health & Social Care Partnership would be held on Wednesday, 22 March 2017 at 10.00 a.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton which would replace the scheduled meeting of the Partnership Board Audit Committee and that a further report updating on progress made with regard to the indicative funding allocation would be provided at that meeting.

PUBLIC PERFORMANCE REPORT JULY TO SEPTEMBER 2016

A report was submitted by the Head of Strategy, Planning & Health Improvement presenting the Partnership's Public Performance Report for the second quarter of 2016/17 (July to September 2016); and the Scottish Government's recently published Health & Social Care National Delivery Plan.

After discussion and having heard the Chief Officer, the Head of Strategy, Planning and Health Improvement and the Head of Community Health and Care Services in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to approve the Public Performance Report for July to September 2016 for publication.

ALCOHOL AND DRUG PARTNERSHIP VALIDATED SELF-ASSESSMENT AND IMPROVEMENT PLAN

A report was submitted by the Head of Mental Health, Addictions and Learning Disability seeking approval of the outcome of the recent Alcohol and Drug Partnership Validated Self-Assessment by the Care Inspectorate.

After discussion and having heard the Chief Officer and the Head of Strategy, Planning and Health Improvement in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to approve the Validated Self-Assessment Action Plan.

GOVERNANCE ARRANGEMENTS FOR COMMUNITY JUSTICE STRATEGIC PLANNING & CRIMINAL JUSTICE SERVICES

A report was submitted by the Head of Children's Health, Care and Criminal Justice providing an outline of both the changes to Community Justice Strategic Planning and the impending changes to the delivery and funding of Criminal Justice Services in West Dunbartonshire.

After discussion and having heard the Head of Strategy, Planning and Health Improvement in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the arrangements in place for the governance and structure of Community Justice;

(2) to note the progress to date in respect of the Community Justice Improvement Plan (as attached at Appendix 1 of the report) as recently reported to the Community Planning Management Group on 25 January 2017;

(3) to note the change to funding and delivery of the Criminal Justice Social Work service; and

(4) that the budget allocation for Criminal Justice Services in West Dunbartonshire would be highlighted at the start of the year and officers would report on how it is being achieved in budget updates to the Partnership Board.

COMPLAINTS HANDLING PROCEDURES

A report was submitted by the Head of Strategy, Planning & Health Improvement seeking approval of a suite of new Complaints Handling Procedures that cover the work of Partnership Board and the Health & Social Care Partnership.

After discussion and having heard the Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to approve the new Social Work Complaints Handling Procedure;

(2) to note the new NHS Greater Glasgow & Clyde Complaints Policy, presented to the meeting of its Health Board on 21February 2017;

(3) to approve the new Complaints Handling Procedure for the Partnership Board;

(4) to endorse the integrated summary complaints handling process document for use across the Health & Social Care Partnership;

(5) to confirm the dissolution of the local Social Work Complaints Review Sub-Committee, once any extant complaints from prior to the 1st April 2017 have been considered by them, and to express appreciation to the members of that group for their commitment and valuable contributions; and

(6) to write to the Scottish Government and the Ombudsman advising of the Partnership Board's concerns in relation to the use of the term 'customers' when referring to patients/service users.

MINUTES OF MEETINGS FOR NOTING

The undernoted draft Minutes of Meetings were submitted and noted:-

(1) Draft Minutes of Meeting of the Argyll, Bute and Dunbartonshires' Criminal Justice Social Work Partnership Joint Committee held on 8 December 2016.

(2) Draft Minutes of Meeting of the Health & Social Care Partnership Audit Committee held on 7 December 2016.

(3) Draft Minutes of Meeting of the Clinical & Care Governance Group held on 25 January 2017.

(4) Draft Minutes of Meeting of the Joint Staff Forum held on 17 January 2017.

(5) Draft Minutes of Meeting of the Health & Social Care Partnership Locality Group for Alexandria & Dumbarton held on 9 November 2016.

(6) Draft Minutes of Meeting of the Health & Social Care Partnership Locality Group for Clydebank held on 13 December 2016.

(7) Minutes of Meeting of the Joint Locality Engagement Network held on 9 November 2016.

In relation to the Draft Minutes of Meeting of the Joint Staff Forum held on 17 January 2017, the West Dunbartonshire Council Staff Side Co-Chair sought an update on discussions relating to adoption of the Ethical Care Charter. Following discussion, the Partnership Board agreed that the Chief Officer would provide a report on the Ethical Care Charter to the next meeting.

URGENT ITEM OF BUSINESS

In terms of Section 50B(4)(b) of the Local Government (Scotland) Act 1973, as inserted by the Local Government (Access to Information) Act 1985, the Chair was of the opinion that the undernoted item should be considered as a matter of urgency on the grounds that Members of the Partnership Board should be made aware of the content of the Joint Children's Services Inspection Report at the earliest possible date.

JOINT CHILDREN'S SERVICES INSPECTION REPORT

A report was submitted by the Head of Children's Health, Care and Criminal Justice Services/Chief Social Work Officer providing an outline of the process and purpose of the Joint Children's Services Inspection and the outcomes in terms of the Care Inspectorate's evaluation and final report as attached to the report.

After discussion and having heard the Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the content of the report and the Care Inspectorate Report as published on 28 February 2017; and

(2) to note that a further more detailed report and Improvement Action Plan would be submitted to the meeting of the Partnership Board scheduled to be held on 31 May 2017 once the Community Planning Management Group and the Care Inspectorate had approved the Action Plan.

FUTURE MEETINGS

Having heard the Chair, Gail Casey, it was noted that a Special Meeting of the Partnership Board would be held on Wednesday, 22 March 2017 at 10.00 a.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton.

It was noted that the next ordinary meeting of the Partnership Board would be held on Wednesday, 31 May 2017 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton.

Thereafter, Members agreed dates for future meetings as undernoted:-

Wednesday, 23 August 2017 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU.

Wednesday, 22 November 2017 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU.

The meeting closed at 3.55 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

At a Special Meeting of the West Dunbartonshire Health & Social Care Partnership Board held in Committee Room 3, Council Offices, Garshake Road, Dumbarton, on Wednesday, 22 March 2017 at 10.00 a.m.

Present: Gail Casey (Chair), Jonathan McColl and Martin Rooney, West Dunbartonshire Council; and Heather Cameron, Allan Macleod and Rona Sweeney, NHS Greater Glasgow & Clyde Health Board.

Non-Voting Members: Keith Redpath, Chief Officer; Julie Slavin, Chief Financial Officer; Kenneth Ferguson, Clinical Director for the Health & Social Care Partnership; Wilma Hepburn, Professional Nurse Advisor; Jackie Irvine, Chief Social Work Officer; John Kerr, Professional Advisor – Housing; Diane McCrone, NHS Staff Side Co-Chair; Anne McDougall, Chair of Local Engagement Network – Clydebank; Janice Miller, Lead Allied Health Professional and Selina Ross, Chief Officer of West Dunbartonshire Council for Voluntary Services.

Attending: Julie Lusk, Head of Mental Health, Learning Disability & Addictions; Chris McNeill, Head of Community Health & Care; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Serena Barnett, Head of People and Change; Colin McDougall, Chief Internal Auditor, Nigel Ettles, Principal Solicitor and Nuala Borthwick, Committee Officer.

Also attending: Fiona Mitchell-Knight, Assistant Director and Karen Cotterell, Senior Auditor, Audit Scotland.

Apologies: Apologies for absence were intimated on behalf of Barbara Barnes, Chair of the Local Engagement Network – Alexandria & Dumbarton; Neil McKay, Chair of Locality Group – Alexandria & Dumbarton; Kim McNabb, Representative of Carers of West Dunbartonshire; Peter O'Neill, WDC Staff Side Co-Chair of Joint Staff Forum and Dr Martin Perry, Acute Consultant.

Councillor Gail Casey in the Chair

CHAIR'S REMARKS

Councillor Casey, Chair, welcomed everyone present to the meeting of the Partnership Board. Before commencing with the business on the agenda, the Chair drew the Partnership Board's attention to the Care at Home Team's award success at the recent Scottish Association of Social Work Awards. The Partnership Board congratulated Lynne McKnight, Integrated Operations Manager and her team on their success in the category for best example of working in an integrated setting.

DECLARATIONS OF INTEREST

It was noted that there were no declarations of interest in any of the items of business on the agenda.

UNSCHEDULED CARE – COMMISSIONING INTENTIONS 2017 – 2020

A report was submitted by the Head of Strategy, Planning & Health Improvement seeking approval of the proposed commissioning intentions for unscheduled care.

A short presentation on Unscheduled Care Commissioning was provided by the Head of Strategy, Planning & Health Improvement and thereafter both the Chief Officer and the Head of Strategy, Planning & Health Improvement were heard in answer to Members' questions.

After discussion and having heard the Chief Officer and other officers in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to approve the proposed commissioning intentions for unscheduled care;

(2) to direct the Chief Officer to communicate the initial commissioning directions for acute services to the Chief Operating Officer of NHSGGC;

(3) that a report on tackling health inequalities in the context of national reviews for the wider realms of health would be submitted to a future meeting of the Partnership Board for consideration; and

(4) that officers would provide a report to a future meeting on planned actions being taken to improve communication and education to our communities on shifting the balance of care including educating the public on the alternatives to presenting at an Accident & Emergency Department for unplanned treatment or care.

2017/18 ANNUAL REVENUE BUDGET UPDATE

A report was submitted by the Chief Financial Officer providing an update on the progress made with regard to the indicative funding allocation for 2017/18 from the Board's funding partner, NHS Greater Glasgow and Clyde Health Board.

After discussion and having heard the Chief Officer and the Chief Financial Officer in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the content of the letter from the Chief Officer to the Chief Executive of NHS Greater Glasgow & Clyde communicating the decision of the Health & Social Care Partnership Board in respect of the Partnership Board's position on the allocation of historical savings;

(2) to approve an anticipated budget allocation from NHS Greater Glasgow & Clyde for 2017/18 of £80.676 million, based on the recurring budget as at 31 December 2016 (Period 9) as being compliant with the Scottish Government's direction to maintain funding at least at 2016/17 cash levels; and

(3) that a report on the comparative and relative use of prescription drugs in the Partnership Board area would be submitted to the next meeting of the Partnership Board to ensure a realistic budget allocation from NHS Greater Glasgow & Clyde reflected the population needs.

NHS GREATER GLASGOW & CLYDE-WIDE REVIEW OF OUT OF HOURS GP SERVICES – UPDATE

A report was submitted by the Head of Strategy, Planning & Health Improvement providing an update on the NHS Greater Glasgow & Clyde-wide Review of Out of Hours GP Services.

After discussion and having heard the Chief Officer, the Head of Community Health & Care and the Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Board agreed to approve the undernoted recommendations in the report:-

(1) to note the appended update report by the NHS Greater Glasgow & Clyde GP Out of Hours Review Group;

(2) that a further report would be brought back to the Partnership Board as the Review progresses; and

(3) that the Clinical Director and the Head of Community Health and Care Services would liaise with care homes and nursing homes in the Partnership Board area to ensure robust arrangements are in place for pronouncing life extinct.

The Partnership Board also agreed the undernoted motion by Councillor McColl:-

> The IJB agrees the recommendations and adds the following comments, to be taken into consideration during the review:
>
> The IJB notes that the current preferred option would see a serious reduction in out of hours GP services based at the Vale of Leven and Inverclyde Royal Hospitals.
>
> Given the geographical locations of these two facilities, the large numbers of service users (particularly at the Vale of Leven Hospital), and the wish of NHS Greater Glasgow & Clyde to reduce inappropriate presentations to A&E Services, we do not believe that the reduction of operating hours of these locality services would be appropriate.
>
> We are concerned about the reduced access to services that this decision would cause and are not convinced of the capacity of the patient transport service to be able to deal with the increased number of patient journeys to and from distant services. The impact of increasing health inequality across the NHSGGC is also a serious concern and we also believe that it would be a false economy, given the risk of increased footfall at A&E facilities.
>
> The IJB believes that out of hours GP services based at the Vale of Leven need to be planned and delivered in a better way, not cut, and we would add that the locations listed at 7.3 of the appendix cannot reasonably be described as 'accessible', especially out of hours, for those living in our communities or for those in Helensburgh who also rely on this service.

RECRUITMENT OF CHIEF OFFICER

A report was submitted by the Head of People and Change seeking approval of the process to recruit a new Chief Officer.

After discussion and having heard the Head of People and Change in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to approve the process set out in the report to recruit a new Chief Officer.

ADJOURNMENT

Having heard Councillor Casey, Chair, the Partnership Board agreed to adjourn for a short period.

The meeting resumed at 12 noon with all Members listed on the sederunt in attendance with the exception of John Kerr and Selina Ross.

AUDIT PLAN 2016/2017 PROGRESS REPORT AND AUDIT PLAN 2017/18

A report was submitted by the Chief Internal Auditor providing:-

(a) an update on the planned programme of audit work for the year 2016/17 in terms of the internal audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow and Clyde that may have an impact upon the West Dunbartonshire Health & Social Care Partnership;

(b) details of the planned programme of work for 2017/18; and

(c) findings of the completed audit of the Partnership Board's Governance, Performance and Financial Management Arrangements.

After discussion and having heard the Chief Financial Officer and the Chief Internal Auditor in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the progress made in relation to the Audit Plan for 2016/17;

(2) to approve the Audit Plan for 2017/18; and

(3) to approve the action plan within the completed Audit of the Partnership Board's Governance, Performance and Financial Management report.

AUDIT SCOTLAND: WEST DUNBARTONSHIRE INTEGRATED JOINT BOARD ANNUAL AUDIT PLAN 2016/17

A report was submitted by the Chief Financial Officer presenting the Audit Scotland Annual Audit Plan for the audit of the financial year 2016/17.

After discussion and having heard the Chief Financial Officer and both the Assistant Director and the Senior Auditor in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to note Audit Scotland's 2016/17 Audit Plan.

DATE OF NEXT MEETING OF HEALTH & SOCIAL CARE PARTNERSHIP AUDIT COMMITTEE

The Partnership Board agreed that the next meeting of the Health & Social Care Partnership Board Audit Committee would be held on Thursday, 22 June 2017 at 10.00 a.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU.

CHAIR'S CLOSING REMARKS

Councillor Casey, Chair, referred to it being the final meeting of the Partnership Board prior to the local government elections on 4 May 2017 and took the opportunity to extend her thanks to all members of the Partnership Board and the Senior Management Team, for the many collective achievements during this time. Specifically, Councillor Casey recognised the contributions of both Councillors McColl and Rooney, who like the Chair had been part of the Partnership Board from the start and prior to that, the Community Health & Care Partnership.

Mr Macleod, Vice Chair, endorsed Councillor Casey's comments and thanked her for her own contributions, adding that he was proud of the Partnership Board's strong focus on a 'person centred' approach to its decision making and wished all Members well for the future.

The meeting closed at 12.25 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31 May 2017

Subject: HSCP Board and Board Member Development

1. Purpose

To describe a proposed approach to providing relevant and timely development for our HSCP Board and its Members so that they are supported to fulfil the full range of their duties.

2. Recommendation

2.1 The Partnership Board is recommended to support this planned approach to HSCP Board and Board Member development.

3. Background

3.1 There is an ongoing commitment to HSCP Board Member development and support within the approved HSCP Workforce and Organisational Development Strategy.

In the first instance, this has been based on ensuring that covering reports for formal meetings are comprehensive, accessible and to a high quality. Initial induction material was prepared and presented during 2015 in accordance with and summarising the contents of the Scottish Government's guidance on the Roles, Responsibilities and Membership of Integration Joint Boards.

3.2 Through 2016-2017 HSCP Board Members also had an open invitation to Elected Member sessions led by the HSCP within West Dunbartonshire, alongside a number of formal presentations made at HSCP Board meetings and Audit Committee meetings on key issues (e.g. unscheduled care). This approach to-date has been informed by an appreciation of the imperatives to be efficient and pragmatic about the expectations that can reasonably be had on HSCP Board Members to attend additional meetings - over and above the HSCP Board and Audit meetings – given that the voting members do this on top of NHS Board and Council commitments (including development provided by both those organisations); that the NHS Board nominated voting members are not based within West Dunbartonshire and not physically present routinely within the Council; and that the non-officer non-voting members are neither remunerated for their participation and nor their time.

4. Main Issues

4.1 In light of new Board Members being appointed, it is timely to review how we develop our Board and its Members. It is proposed that a HSCP Board Development Programme be created which will provide opportunities for

training, development and support for individuals as well as for the HSCP Board itself. An initial Draft Programme is attached at Appendix 1.

5. People Implications

5.1 There are no people implications arising from this report.

6. Financial Implications

6.1 It is anticipated that the financial implications would be relatively low as much of the proposed Development Programme would be delivered in-house.

7. Professional Implications

7.1 For HSCP Boards, the Guidance - Roles, Responsibilities and Membership of the Integration Joint Board states that:

"The Integration Joint Board (IJB) is responsible for the strategic planning of the functions delegated to it and for ensuring the delivery of those functions through directions issued by it under section 25 of the Public Bodies (Joint Working) (Scotland) Act 2014. The IJB will also have an operational role as described in the locally agreed operational arrangements set out within their integration scheme.

To fulfil its remit the IJB will:

- *Adhere to the content of any future regulations or guidance issued by Scottish Ministers*
- *Ensure Stakeholder Engagement*
- *Take into consideration national developments in policy and practice"*

7.2 Although there are no direction implications for specific professions, Board Members must be supported to carry out their duties effectively so that the community served by the HSCP is positively impacted by its work.

8. Locality Implications

8.1 The impact of the outcomes of the work of the HSCP Board and its members will be felt across all of the HSCP community.

9. Risk Analysis

9.1 As indicated by point 7.2 above, Board Members must feel equipped to carry out their role in effectively.

10. Impact Assessments

10.1 None required for this report.

11. Consultation

11.1 None

12. Strategic Assessment

12.1 The Health & Social Care Partnership has a responsibility to ensure that its Board Members feel supported to carry out their duties effectively. This planned approach to development would provide the necessary support.

Author: Serena Barnatt – Head of People & Change
West Dunbartonshire Health & Social Care Partnership

Date: 31st May 2017

Person to Contact: Anne Marie Murdoch – Senior Organisational Development Advisor, Garshake Road, Dumbarton, G82 3PU Telephone: 01389 737536
e-mail: annemarie.murdoch@ggc.scot.nhs.uk

Appendices: Proposed Programme for West Dunbartonshire HSCP Board and Board Member Development

Background Papers: Facilitating the Journey of Integration A Guide for those supporting the formation of Integration Joint Boards *(December 2015, Scottish Government)*
http://www.gov.scot/Publications/2015/12/8010

Roles, Responsibilities and Membership of the Integration Joint Board Guidance and advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014
(September 2015, Scottish Government)

http://www.gov.scot/Publications/2015/09/8274/0

Wards Affected: All

Appendix 1

West Dunbartonshire HSCP Board and Board Member Development

DRAFT 1

ACTIVITY	FREQUECY	DURATION
Member Induction • About IJBs • Roles and Responsibilities • Individual skills / development needs • Board Governance • Current landscape & context • Health & Social Care Delivery Plan	As required	This could be covered in a half day for new members or as a Board Seminar for new and existing members.
Service Visits	Once per quarter with an annual planned schedule – members select area / service to be visited at start of financial year	1 hour per visit
Board Seminars - Reflection and Learning - Future Focus	Two per year to coincide with Planning and Performance timeframes	2 hours per seminar
90 Minutes Challenge E.G. Inspiring Innovation, National Health & Social Care Workforce Planning, Improving links between secondary, primary and community care	Topics identified by Board Members / SMT. 30 minute input from subject expert and 1 hour member discussion that results in 1agreed actions to be taken forward	90 minutes per topic
Board Development • Working as a Team • Exploring Collaborative and Partnership Working	As required or could from part of Induction above if all members are to participate	2 hours per session

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31st May 2017

Subject: Joint Inspection of Services for Children and Young People in West Dunbartonshire - February 2017

1. Purpose

1.1 The purpose of this report is to provide the Partnership Board with an outline of the process and purpose of the Joint Children's Services Inspection and the outcome in terms of the Care Inspectorate's evaluation and final report as attached at **Appendix 1**. In addition attached at **Appendix 2** is the Improvement Action Plan for the Community Planning Partnership as agreed by the Care Inspectorate and the Community Planning Partnership Management Group (CPPMG) on the 24th of May.

2. Recommendations

2.1 The Partnership Board is recommended to:

i) Note the content of this report, the attached Care Inspectorate Report as published on 28th February 2017 and the attached Improvement Action Plan;
ii) Note that further progress reports will be provided to the CPPMG.

3. Background

3.1 The joint inspection of services for children and young people in the West Dunbartonshire Community Planning area took place between 29 August and 14 October 2016. This inspection looked at the difference services are making to the lives of children, young people and families.

3.2 There were several phases to the inspection including some offsite scoping of key documents and evidence that had been submitted in advance of the inspection. The inspectors read 96 case records of the most vulnerable children and young people. They undertook 79 Focus Groups with staff and met with 103 children and young people and 39 parents and carers.

3.3 West Dunbartonshire area is one of the last few CPP areas to be inspected and this cycle of inspection will conclude in 2017. Thereafter it is anticipated that the Care Inspectorate will move to thematic inspections on Child Protection and Corporate Parenting.

4. Main Issues and Outcome

4.1 The result of the inspection was extremely positive for West Dunbartonshire and for this we should acknowledge the commitment and efforts of all staff across the children's services partnership, both in terms of their dedication to children, young people and families and in relation to the time and enthusiasm they committed to the inspection process. The inspectors commented at various points about the commitment, enthusiasm and positive contribution made by staff and all partners.

4.2 The inspection team covered a wide range of areas and issues in respect of achieving positive outcomes for children and their families, we were awarded grades in respect of specific Quality Indicators. These are as follows:

How well are the lives of children and young people improving?	
Improvements in the wellbeing of children and young people	**Good**
Impact on children and young people	**Very Good**
Impact on families	**Good**
How well are partners working together to improve the lives of children, young people and families?	
Providing help and support at an early stage	**Very Good**
Assessing and responding to risks and needs	**Adequate**
Planning for individual children	**Adequate**
Planning and improving services	**Good**
Participation of children, young people, families and other stakeholders	**Very Good**
How good is the leadership and direction of services for children and young people?	
Leadership of improvement and change	**Good**

4.3 The inspectors identified a number of particular strengths which were making a positive difference to the lives of children and young people:

- *The strength of strategic approaches to targeting key universal health services had achieved some real gains within a very challenging context of high deprivation;*
- *Highly committed staff groups across the partnership demonstrated clear ownership of the strategic vision for children, young people and families and felt clearly connected to improvement planning;*
- *Young people, including the most vulnerable, were meaningfully involved in influencing policy and service development;*
- *There was an evident commitment to early intervention and prevention with very effective help and support processes;*

- *A coherent shared vision was in place and modelled by a mature partnership.*

4.4 In respect of areas for improvement, the inspection team concluded that;

Partners had demonstrated a commitment to continuous improvement and reflective practice and we are confident that partners are well placed to incorporate the opportunities for further improvement highlighted during this inspection within their ongoing activities. In doing so, the community planning partnership should take action to:

- *Demonstrate the difference investments in early intervention and prevention are making for all children and young people through measurement of robust data and progress across strategic plans.*

- *Strengthen strategic plans in recognition of national policy directives on prevention of domestic abuse and local trends in use of kinship care.*

- *Achieve greater consistency in quality of assessments of risk and need and the formulation of plans to meet identified factors by ensuring that approaches to day-to-day quality assurance of operational practice are robust, systematic and deliver intended improvements.*

4.5 The inspection team also identified 3 examples of Good Practice;

- Effective change management –Seasons for Growth
- Leadership by young people for young people – Y Sort It
- Commitment to equality and inclusion – Highly Dependent Learners

Improvement Action Plan

4.6 Following the publication of the report all Community Planning Partnerships are required to submit an Improvement Action Plan to set out how the CPP will address the key recommendations of the report as outline at 4.4 above. The Improvement Action Plan attached at **Appendix 2** has been approved by our link inspector Rosie Laurence and agreed at the Community Planning Management Group on 24th of May.

4.7 The CPP Joint Children's Services Inspection Improvement Plan represents a number of improvement actions and milestones which will in effect be developed and implemented across the various CPP strategic planning fora. This plan is therefore a collection of the actions that will be taken to address the learning arising from the Joint inspection of children's services carried out in 2016 by the Care Inspectorate.

4.8 Whilst the overall strategic Responsibility lies with the Children and Families Delivery and Improvement Group (DIG) there are aspects of the actions assigned to either additional Community Planning Strategic Groups or Key Officers who do not sit on the Children and Families DIG. The expectation is therefore that the actions assigned to both the officers and strategic groups

will be reported directly into the Children and Families DIG at regular intervals, most likely quarterly. From there progress made will be reported to the CPPMG and any challenges to progressing actions will be passed to the CPPMG for remedial action if necessary.

5. People Implications

5.1 None.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 None.

10. Impact Assessments

10.1 Not applicable.

11. Consultation

11.1 All partners will be consulted in the development and approval of the Action Plan to be submitted to the Care Inspectorate.

12. Strategic Assessment

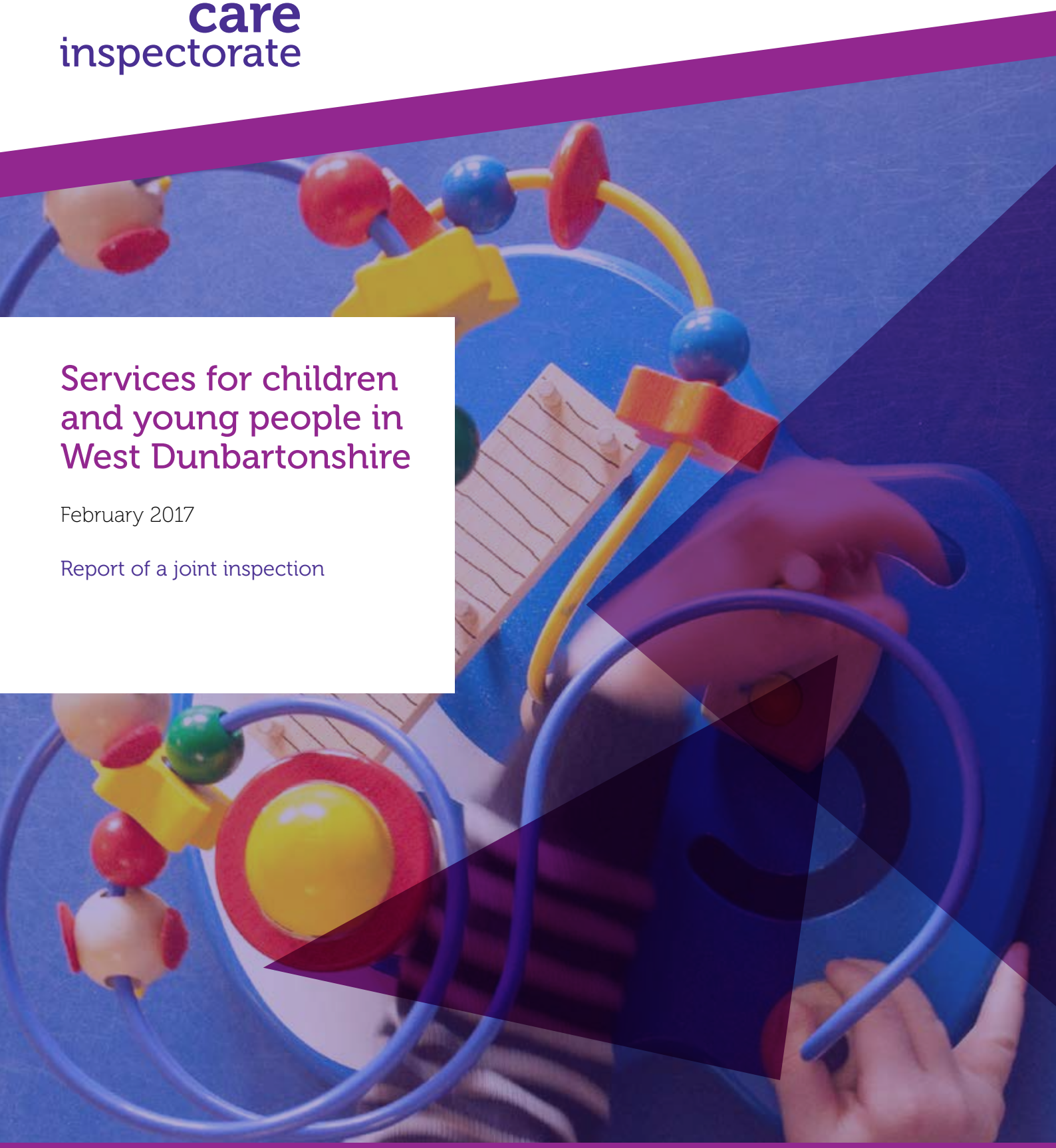
12.1 This reflects our key strategic priorities and outcomes for children, young people and families as set out in the HSCP Strategic Plan.

Author: **Jackie Irvine**

Date: **31st May 2017**

Person to Contact:	Jackie Irvine, Head of Children's Health, care and Criminal Justice and Chief Social Work Officer
Appendices:	Appendix 1: Care Inspectorate Report February 2017 Appendix 2: CPP Improvement Action Plan
Background Papers:	None
Wards Affected:	All

care inspectorate



Services for children and young people in West Dunbartonshire

February 2017

Report of a joint inspection

Contents

1. Introduction

At the request of Scottish Ministers, the Care Inspectorate is leading joint inspections of services for children and young people across Scotland. When we say 'children and young people' in this report we mean people under the age of 18 years or up to 21 years and beyond if they have been looked after.

These inspections look at the difference services are making to the lives of children, young people and families. They take account of the full range of work with children, young people and families within a community planning partnership area. When we say 'partners' in this report we mean leaders of services who contribute to community planning, including representatives from West Dunbartonshire Council, NHS Greater Glasgow and Clyde, Police Scotland, the Scottish Fire and Rescue Service.

When we say 'staff' in this report we mean any combination of people employed to work with children, young people and families, including health visitors, school nurses, doctors, teachers, social workers, police officers, and the voluntary sector. Where we make a comment which refers to particular groups of staff, we mention them specifically, for example health visitors or social workers.

Our inspection teams are made up of inspectors from the Care Inspectorate, Education Scotland, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary for Scotland. Teams include young inspection volunteers, who are young people with direct experience of care and child protection services who receive training and support to contribute their knowledge and experience to help us evaluate the quality and impact of partners' work. Associate assessors are also included on inspection teams. These are staff and managers from services in another community planning partnership area.

In September 2014, the Care Inspectorate published How well are we improving the lives of children, young people and families? A guide to evaluating services for children and young people using quality indicators. This framework is used by inspection teams to reach an independent evaluation of the quality and effectiveness of services. While inspectors keep in mind all of the indicators in the framework, we evaluate nine of the quality indicators in each inspection, using the six-point scale as set out in Appendix 2. These nine indicators are chosen for evaluation because they cover the experiences of children, young people and families and the difference services are making to their lives; the outcomes partners collectively are making in improving outcomes for children across the area; and key processes which we consider to be of critical importance to achieving positive outcomes for children and young people. These are leading change and improvement; planning and improving services and involving children and families in doing so; and assessment and planning for children who are particularly vulnerable, including children and young people who are looked after or in need of protection.

2. How we conducted the inspection

The joint inspection of services for children and young people in the **West Dunbartonshire Community Planning area** took place between 29 August and 14 October 2016. It covered the range of partners in the area that have a role in providing services for children, young people and families.

We reviewed a wide range of documents and analysed inspection findings of care services for children and young people. We spoke to staff with leadership and management responsibilities. We carried out a survey of named persons and lead professionals. We talked to large numbers of staff who work directly with children, young people and families and observed some meetings. We reviewed practice through reading records held by services for a sample of 96 of the most vulnerable children and young people. We met with 103 children and young people and 39 parents and carers in order to hear from them about their experiences of services. We are very grateful to everyone who talked to us as part of this inspection.

The Care Inspectorate regulates and routinely inspects registered care services provided or commissioned by West Dunbartonshire Council. For the purposes of this inspection, we took into account findings from inspections of all relevant services for children and young people undertaken over the last two years. We also referred to a report of a joint inspection of services to protect children in the West Dunbartonshire Council area published by Her Majesty's Inspectorate of Education in 2012 to consider what progress had been made in the areas for improvement outlined in that report. This report can be found at www.educationscotland.gov.uk

As the findings in this joint inspection are based on a sample of children and young people, we cannot assure the quality of service received by every single child in the area.

3. The community planning partnership and context for the delivery of services to children, young people and families

With a population of 90,340, West Dunbartonshire is one of Scotland's smallest local authorities. It is an area of geographical contrasts and diverse communities; from remote rural villages to the densely populated former industrial areas on the River Clyde. Almost half of the population live in Clydebank. The town of Dumbarton serves as the civic headquarters for the local authority and the Vale of Leven area attracts visitors to the Loch Lomond and Trossachs National Park. There is a strong sense of pride in the area's shipping heritage and tourist industry. The Scottish Index of Multiple Deprivation is the Scottish Government's official tool for identifying communities suffering from deprivation. The index divides Scotland into small areas, called data zones, each containing around 350 households. The most recent 2016 index identified 48 data zones as among the most deprived 20%, highlighting West Dunbartonshire as one of the most deprived areas in Scotland. As at 2011, approximately 1.6% of the West Dunbartonshire population belonged to an ethnic minority, which was less than the Scottish figure of 4%.

The population of children aged 0-15 is 15,913 equating to 17.5% of the population. Young people aged 16-19 years, at 4,494 make up 5% of the population. Many communities have experienced lower employment rates than the rest of Scotland for an extended period, with 7.2% of the population being described as unemployed compared to the national figure of 5.6%. West Dunbartonshire has 9.8% lone parent households, which exceeds the national average of 7.2%. The percentage of the population living in low-income families at 25% is also above the national average of 18%.

During 2013-14 the community planning partnership implemented a new framework for community planning. A single **community planning partnership management group** titled **Community Planning West Dunbartonshire** replaced previous structures with a view to strengthening partnerships and ensuring effective participation. The community planning partnership management group is chaired by the leader of West Dunbartonshire Council. The membership of the group includes elected members, chief officers from key public agencies such as Police Scotland, Scottish Fire and Rescue Service and the Health and Social Care Partnership as well as important third sector partners and other stakeholders. The management group is responsible for agreeing joint priorities and delivery of resources. It also acts as the final approval and scrutiny body for the partnership.

The Single Outcome Agreement 2014-17 expresses four priorities for children, young people and families with specific intentions of improving attainment, increasing positive destinations and ensuring families are confident and equipped. These priorities are delivered through groups aligned to the community planning management group: the public protection chief officers group; **the child protection committee**; **delivery and implementation groups**; and **review and improvement** subgroups. All of these groups report on progress through a performance framework. Commitments to community engagement and empowerment are being taken forward by the Your Community and Youth Alliance initiatives.

4. How well are the lives of children and young people improving?

Improvements in the wellbeing of children and young people

This section considers improvements in outcomes community planning partners have achieved in relation to three themes. These are: improving trends through prevention and early intervention; improvements in outcomes for children and young people and improvements in the lives of vulnerable children and young people.

Performance in improving outcomes for children and young people was good. We recognised the clear challenges partners faced in advancing the life chances of children given the high levels of enduring poverty and inequality across communities. Partners had a strong commitment to early intervention and had invested in approaches and services to prevent problems escalating. While there were improving trends in a number of health measures, others remained stubbornly difficult to shift, in spite of the concerted efforts of staff across services. This led us to conclude that current joint approaches to give children the best start in life were unlikely to significantly narrow outcome gaps unless partners are supported in taking a more radical approach. Importantly, partners had achieved strong and improving trends in early literacy, raising attainment and narrowing the attainment gap. Increasing numbers of vulnerable young people were able to remain within their families. Care leavers were being well supported into education, employment and training. The most recent performance report helpfully combined progress reporting on the single outcome agreement and integrated children's services plan. However, several areas of strategic importance lacked identified measures of success. Consequently, this limited the ability of partners to demonstrate the extent to which investments in early intervention and prevention and the commitment to corporate parenting were delivering improvements in the lives of children and young people, particularly the most vulnerable.

How well are trends improving through prevention and early intervention?

There were positive improvements in a number of health measures such as childhood immunisations, the numbers of women attending for antenatal care by the twelfth week of pregnancy and health screening for newborn babies. In 2015-16, uptake of 27-30 month developmental assessments was above the national average. Positively, 77% of children assessed were found to be meeting their developmental milestones compared to the national figure of 71.6%.

In spite of concerted efforts, achieving improvements in other key early-years indicators continued to prove challenging. Smoking in pregnancy was higher than the national average. Although the numbers of women involved were very small, a successful **Early Years Collaborative** approach to smoking cessation was beginning to show positive results. This approach has been upscaled across NHS Greater Glasgow and Clyde.

In 2015-16, the percentage of babies who were exclusively breastfed at 6-8 weeks and mixed-fed on breast milk and formula were lower than national rates (17.4% and 24.7% compared to 28.2% and 38.9% respectively). Although partners were proactive in addressing this issue, progress was slow.

West Dunbartonshire had a higher rate of hospital admissions due to unintentional injuries than any other area of the NHS Greater Glasgow and Clyde Board. However, specific initiatives had helped reduce the number of incidents of children ingesting medication prescribed to parents from 18 in 2013 to one in 2015.

Self-reporting by secondary school pupils within the 2010-2013 Scottish Schools Adolescent Lifestyle and Substance Use Surveys showed significant improvements in smoking, alcohol consumption and drug use. This change in behaviour was reflected within a reducing trend in alcohol-related admissions to hospital among 15-19 year old young people.

Extensive activity was taking place to alleviate the adverse consequences of deprivation, including community-led approaches. School breakfast clubs were provided and clothing grants had been enhanced. There were successes in maximising income and reducing debt. However, available data did not identify those who had benefitted, such as households with children or young people living independently. As a result, opportunities to demonstrate the difference strategies to tackle child poverty and inequality had made to the lives of children and young people were missed.

Rates of reported domestic abuse were the second highest in Scotland. Prevalence was markedly worse in the most deprived areas, with 49% of reported incidents from Clydebank. Numbers rose from 768 incidents in 2014-15 to 975 in 2015-16. Partners had been unsuccessful in their bid to secure government funding which would have enabled them to deliver the accredited **Caledonian** programme. As a result, they were attempting to co-design and deliver an integrated approach from within available resources. Partners had purposefully analysed data and identified the number and age of children present during domestic abuse incidents. The number of children and young people involved rose from 1578 in 2014-15 to 2008 in 2015-16. Given there were families with repeat incidents, the numbers of children reflect some duplication. Overall, the numbers indicate an increase of 27% in both incidents and children. Work had also been undertaken to change operational practice and raise awareness among staff. However, a lack of mutually agreed outcome measures hindered partners' ability to evaluate the effectiveness and impact of early intervention and prevention approaches.

Investments in all strands of the **Whole System Approach** had resulted in the delivery of a wide range of early intervention approaches. As a result, children and young people at risk of offending were being appropriately diverted from formal systems. Between May 2015 and April 2016, the children's reporter received 37 referrals on offence grounds, only three of which needed to proceed to a children's hearing.

The Lord Advocate's guidelines direct the police as to when children and young people over the age of 12 are reported to both the procurator fiscal and to the children's reporter. Of the young people who were "jointly reported", the majority avoided prosecution due to the use of diversion and restorative approaches.

In 2014-15, there were 445 homeless applications by young people. This represented 23.6 per 1,000 of the population under 18 years compared to 15.3 nationally. Although the trend in homeless applications by young people was decreasing, we found performance was worse than other local authority areas, including cities. Partners recognised the need to achieve sustained improvements through more effective approaches to youth homelessness and a new strategy was in the final stages of development at the time of inspection.

How well are outcomes improving for children and young people?

Health and education services made a significant contribution through partnership working to improving the wellbeing of all children and young people. As part of the national Childsmile programme, supervised, daily tooth brushing was taking place in all nurseries and almost all primary schools. Similar to other areas, the percentage of fluoride varnishing treatments had yet to reach the expected national target. In 2015/16, the percentage of children in Primary 1 with no obvious signs of tooth decay was 66.3% compared to 69.4% nationally. Over the past decade, childhood obesity rates have been similar to the child population for Scotland as a whole. The latest data for body mass index of children in Primary 1 showed that 82.1% of children achieved a healthy weight compared to 84.8% nationally. Although still above the national figure, teenage pregnancy rates were reducing.

A whole-child approach to nurture within schools had utilised Scottish Index of Multiple Deprivation data to target approaches aimed at improving the emotional wellbeing of children and young people and combat the impact of domestic abuse. Nurture groups, the widespread delivery of the **Seasons for Growth** programme and external evaluation of the **Roots of Empathy** initiative reported improvements in the emotional wellbeing of children. These findings were complemented by Young People in Mind and the Life Link Youth school counselling service using "before and after" self-reporting. Child and adolescent mental health services had successfully reduced waiting times over the previous three years to an average of five to six weeks, well below the national target of 18 weeks.

The council's 2014-15 Standards and Quality Report demonstrated improving performance in early literacy, raising attainment and closing the attainment gap. Attendance in primary schools was in line with the national average, and in secondary schools sat just below the national figure (89.6% compared to 91.8%). Attendance at schools for children with additional support needs was higher than the national average. Partners were tracking attendance at early years and childcare centres and nurseries with specific areas for improvement being taken forward by the Early Years Collaborative**.** Although the percentage of primary and secondary school exclusions were less favourable when compared to national figures, rates were reducing.

The proportion of children excluded from primary school was slightly above the national figure and in secondary school sat at 57 per 1,000 pupils compared to 49.5 per 1000 nationally. The proportion of children and young people excluded from schools for children with additional support needs was well below the national figure (62.5 compared to 126.4 per 1000 pupils.)

A high percentage of children and young people were living in the most deprived areas. Despite this, some secondary schools performed better than others in comparator areas. Levels of attainment in reading, writing and mathematics for primary-aged learners had been increasing, most notably in schools that served areas of deprivation. Although attainment for older young people at levels 5 and 6 was less positive than comparators, in 2013/14 there were improvements by the end of S4, S5 and S6 on almost all measures, particularly at SCQF Level 2. There was evidence that partners were beginning to close the outcome gap. Significantly, the percentage of pupils from deprived areas gaining five or more awards at SCQF Level 5 was higher than the national average and the majority of comparators. Following a period of above average performance, in 2014-15, the percentage of young people who entered a positive destination fell below comparators and the national rate, now standing at 90% compared to 93% nationally.

A snap shot at September 2015 of children affected by homelessness identified 28 families in temporary accommodation, all of whom were appropriately placed, with none in bed and breakfast establishments or hostels.

How well are the life chances of vulnerable children and young people improving?

The partnership was able to demonstrate improvements in the life chances of vulnerable children. However, an absence of outcome focused indicators within the existing performance framework meant that measures tended to relate to volume and frequency of activities.

Partners were committed to reducing the use of out-of-area placements. This approach was supported by the Alternative to Care service which had proved highly successful in sustaining young people within their families and local communities. The use of independent foster care placements had increased and a highly visible campaign was aimed at recruiting local carers. The proportion of children who needed to be looked after was, at 31 July 2015, equivalent to 2.2% of the child population compared to 1.5% nationally. The balance of care at 85% community-based and 14% in residential accommodation was below the national rates of 88% and 12% respectively. While there were significantly more children placed with kinship carers than nationally (38% compared to 27%), measures of improved wellbeing for this particular group had yet to feature within performance frameworks.

Over time, there have been consistently fewer children on the child protection register than the national average (currently 1 compared to 3 per 1,000).

With high levels of deprivation and domestic abuse, leaders sought assurance that decision making in response to child protection concerns and removing children's names from the register was effective by routinely analysing quantitative and qualitative data and requesting additional information as required.

Although there had been a decreasing trend in the number of school exclusions of looked after children, other data was limited. Education services planned to include analysis on the attendance, attainment and achievements of looked after children in the next standards and quality report.

Of the children and young people eligible for aftercare support in 2014-15, 89% were in contact with services, which significantly exceeded the national figure of 69%. Within this group, 41% was in employment, education or training compared to the national figure of 28%. However, there was more work to be done in terms of increasing the proportion of looked after young people remaining in care placements over the age of 16, which in 2015 was 7% compared to the national average of 12%. As corporate parents, partners had very few ways of measuring the extent to which the actions they were taking resulted in improvements in the wellbeing and life chances of looked after children and care leavers. Measures of trends among care leavers that reflect success in moving towards independence were not being tracked, for example sustaining suitable accommodation, increased employability, keeping active and being included.

Impact on children and young people

This section is about the extent to which children and young people are able to get the best start in life and the impact of services on their wellbeing. It is about how well children and young people are helped to be safe, healthy, achieving, nurtured, active, respected, responsible and included.

The impact of services on the wellbeing of children and young people was very good. Children benefitted from positive and respectful relationships with highly committed and motivated staff. A wide range of innovative programmes raised awareness of risk and enabled children and young people to make informed decisions to ensure their personal safety at home, online and in the community. Children and young people were important, effective contributors within their communities via a range of volunteering and mentoring opportunities. Access to universal and specialist health provision promoted the physical and emotional wellbeing of children and young people. For some of the most vulnerable children and young people, there had been insufficient attention paid to identifying and recording strengths and deficits in wellbeing within their individual plans.

How well are children and young people helped to keep safe?

A wide range of projects and diversionary activities were raising awareness about personal safety among large numbers of children and young people, promoting opportunities to make informed decisions and choices. Experiential learning programmes alerted primary pupils to dangers such as carrying knives and fire-raising. Secondary school pupils attending the Safe Drive Stay Alive programme were better able to understand the importance of driving safely.

Children and young people previously at risk of serious harm and abuse had been helped to be safe as a result of effective multi-agency interventions and close monitoring of their progress. Some children were ultimately protected by appropriately removing them from parental care. Children looked after away from home benefitted from the security offered within their respective care placements. Care experienced young people were making safe transitions towards independence as a result of the highly effective support they received. There were clear processes in place to identify, manage and mitigate risks in respect of young people who had potential to cause harm to themselves or others.

Children were clearly safer when their parents received the support they needed to address issues related to substance misuse, domestic abuse and parental mental health. In a small number of instances, we found that children's safety was less assured because staff held an overly optimistic view of the improvements made by parents over relatively short timescales. On a very few occasions, actions taken met children's needs in the short term only, with insufficient consideration of what contingency arrangements were needed.

How well are children and young people helped to be healthy?

The health of babies was promoted through increased attendance at antenatal appointments and uptake of specific supports offered by the Special Needs in Pregnancy Service (SNIPs) and Family Nurse Partnership. Within early years children's centres, nurseries and primary schools young children benefitted from health promotion activities and provision such as breakfast clubs, healthy eating and supervised tooth brushing. Early identification of need within 27-30 months assessments had enabled young children and their parents to access specific supports at an early stage.

An extensive range of early intervention, universal and specialist services contributed to improvements in the emotional wellbeing of children and young people, often helping them to come to terms with significant loss and trauma. Sexual health was promoted through specialist after-school drop-in and advice services, with vulnerable young people benefitting from a priority, same day service. Structured services, delivered by third sector partners alongside crisis intervention through GPs, enabled young people with substance misuse issues to access comprehensive support.

Children looked after away from home benefitted from comprehensive health assessments. The majority of children and young people looked after at home had their physical and emotional needs met. In some instances, greater direction and challenge from professionals was required to ensure parents prioritised the health needs of their children.

How well are children and young people helped to achieve?

Caring staff within stimulating nursery and early years childcare centres helped young children to reach their developmental goals. There had been sustained improvements in literacy within primary education.

Redirection of savings made by elected members enabled provision of an internet enabled laptop for every primary 7 pupil, enhancing digital learning and improving connections between school and home.

Children were being supported to manage the transition from primary to secondary school as a result of effective supports provided by pupil and family support teams and a highly visible educational psychology service.

Improvements in literacy and numeracy helped children gain more from education. Increasing numbers of young people achieved awards and qualifications, with results showing marked progress in attainment by young people from the most deprived communities. Young people at risk of not entering a positive destination were increasingly benefitting from earlier identification and specialist support. Funding of educational maintenance allowance awards payments exceeded what is required nationally, which supported increasing numbers of young people in post school destinations.

Children who were looked after away from home enjoyed improved outcomes related to attendance, behaviour and presentation. The same was not always true for children and young people looked after at home as a number continued to experience poor attendance and limited progress in school.

How well are children and young people helped to experience nurturing care?

Effective work with families at home, in early years centres and schools was strengthening attachments between vulnerable children and their parents and enhancing experiences of being nurtured. Young people who were not yet in a position to secure a positive destination spoke of an increased sense of belonging as a result of their attendance at an activity agreement nurture group.

From our review of case records it was clear that support from Seasons for Growth, **CEDAR** (Children Experiencing Domestic Abuse Recovery) and **CARA** (Challenging and Responding to Abuse) programmes enabled vulnerable children and young people to come to terms with difficult life experiences. However, we also found instances of children who may have benefitted from similar support but there was no evidence of a service having been offered to them.

In a few instances, earlier recognition of the cumulative impact of the factors that affect parents' emotional availability might have enhanced children's wellbeing and improved their sense of stability and security.

For many children, their lives were clearly transformed when they became permanently settled within alternative families. However, for a few children, delays in planning contributed to uncertainty over their longer-term futures.

Care leavers felt valued and talked positively of the supports offered by throughcare staff. A growing number of young people were taking the opportunity to either remain within their care placements for longer or maintain links to their former children's house.

How well are children and young people helped to be active?

Partners delivered a range of sport and leisure opportunities to children and young people of all abilities. Initiatives also promoted opportunities for families. For example, the Set 4 Sport programme enabled parents living in properties with little or no garden to creatively engage their children in physical activities in any location. Children and young people with a disability benefitted from the disability sport programme which offered coaching and support to access a range of well used activities. The programme was viewed positively by children, young people and their parents. Free access to leisure activities for young people who were looked after away from home and subsidised Pulse vouchers for other groups of young people helped them to access community resources. With Loch Lomond on their doorstep, youth groups were assisted to attain a range of awards through services delivering outdoor education and conservation programmes.

The School Games initiative enabled 4,900 students from P2 to S6 to participate in competitions and fixtures incorporating a range of different sports. A successful summer programme supported over 300 young people to access physical activities on a weekly basis during the school holidays.

Our review of records found that the majority of children and young people participated in some form of activity that they enjoyed. However, for a significant number of the most vulnerable children and young people, lack of attention to this wellbeing indicator within plans resulted in lost opportunities to recognise, support and encourage meaningful activity.

How well are children and young people respected?

Staff across services treated children and young people with respect, to their considerable benefit. Young people we met felt listened to and involved. During the Dare to Care event organised by care experienced young people, corporate parents had clearly heard and were acting on the messages they received from young people about making changes that would reduce stigma and promote respect.

Examples related to rounding up the amount of weekly allowance to avoid the counting out of coins, which was viewed as demeaning by young people, and discontinuing the practice of requiring receipts for all money spent, including for personal hygiene products.

Children and young people looked after away from home within children's houses viewed their Youth Forum as not only enabling them to raise concerns, issues and ideas, but to have them acted on. Who Cares? Scotland actively supported the Youth Forum and offered an individual support and advocacy service. However, from our review of cases records and discussions we identified many young people who had yet to benefit from independent advocacy. The views of looked after children were not always routinely recorded or gathered using the tools available. This activity is particularly significant when children and young people do not have access to an independent person to represent their views.

How well are children and young people helped to become responsible citizens?

School-based programmes enabled children and young people to improve their awareness of safe choices and to make informed, responsible decisions. For younger children, use of the ClassDojo app creatively encouraged pupils to behave well.

Youth work initiatives enabled potentially vulnerable young people to demonstrate their ability to be responsible citizens through a range of positive activities in the evening and across weekends. This was contributing to a reported reduction in antisocial behaviour by young people. Restorative approaches and diversion from prosecution enabled young people to explore the issues that contributed to offending behaviour and make reparation where appropriate. The contribution made by the **Y Sort It** group, which is led by young people, has been recognised as an example of good practice and is discussed in further detail at the end of the report.

Children who were looked after away from home were encouraged and supported to be responsible. It was clear that residential care staff helped young people to exercise age-appropriate decision making skills.

How well are children and young people helped to feel included?

A range of volunteering and mentoring opportunities promoted children and young people's sense of belonging and enabled them to make important contributions to their communities. For example, the Scottish Government's accredited award scheme for 12-25 year old volunteers enabled young people to complete over 1,500 Saltire Awards.

There was a strong, embedded approach to mentoring which 'matched' children and young people to pro-social volunteers who acted as important sources of flexible support for as long as needed.

Examples included the award winning Youth Mentoring Project and the Buddy Up initiative, which enabled formerly looked after young adults to act as mentors to care experienced young people.

Young carers benefitted from in-school champions and a range of flexible supports that contributed to them feeling more resilient, included and supported.

The Lesbian Gay Bisexual Transgender and Intersex (LGBTI+) committee was an example of an important pupil-led initiative which promoted inclusivity and positive outcomes for often marginalised young people. There were many examples of cross-generational initiatives whereby children and young people developed mutually beneficial relationships with older people. In one school, the parent council had bought hens and children sold the eggs to fund afternoon tea dances for older people.

Foster families involved children and young people in family life while contact arrangements enabled children and young people to maintain important relationships where appropriate. However, some children who were looked after at home were socially isolated with reduced opportunities to form friendships. These issues were exacerbated when school attendance was poor.

Impact on families

This section is about the extent to which family wellbeing is being strengthened and families are supported to become resilient and meet their own needs. It also considers parental confidence and the extent to which earlier help and support has a positive effect on family life.

The impact on families was good. The provision of parenting supports across all ages, but particularly in early years, was a key strength. Families were signposted to supports by a range of online and written information. A broad range of universal supports and specialist interventions were evaluated positively by parents. Effective partnership working was having a positive impact on families, including families caring for a child with a disability, as well as parents experiencing mental health and substance misuse issues. The shared language of Getting it Right for Every Child enhanced communication across services and offered greater consistency of understanding for parents and carers. The experience of some families was diminished by their needs not being effectively recognised within plans, or delays in getting help when it was most needed. While there was helpful guidance available to staff working with reluctant families, in a few instances lack of parental engagement was tolerated for too long, which impacted on outcomes for parents and children.

Many parents grew in confidence as a result of participating in a range of available parenting programmes such as Triple P, Incredible Years, Mellow Parenting and Handling Teenage Behaviour.

Evaluations of parenting programmes demonstrated positive impact on parental resilience and confidence. An extensive programme of family learning opportunities delivered in partnership across services had a significantly positive impact on families who participated. When parents lacked confidence to attend group provision, there were opportunities for individual supports to be provided by trained outreach and family support workers.

Early education and childcare centres offered opportunities for parents to become involved and engaged with other parents. This impacted positively on their sense of inclusion, for example the well-attended daily 'tea, toast and talk' groups. Families and Schools Together (FAST) provided a successful, evidence-based programme of interactive family activities. Increased parental involvement enhanced the child's engagement and experiences in school, at home and in the wider community.

Vulnerable women and their partners benefitted from the flexible and effective support given by the Special Needs in Pregnancy Service (SNIPs). As a result, there were improvements in parenting skills, confidence and parents' ability to address their own wellbeing needs. Young Family Support Workers and the Family Nurse Partnership worked collaboratively with increasing numbers of vulnerable young women, offering early help, practical and educational support to promote antenatal care and promote the wellbeing of very young children. Pregnant women were asked about smoking throughout their pregnancy with help available to reduce or cease smoking.

Parents of children with complex health needs were often more resilient as a result of the services, advice and guidance they received. The uptake and creative use of self-directed support was helping some families to address their needs flexibly. Overnight and daytime respite provision for children and young people with a disability and their families was higher than the national average. Early identification of children with low-level communication difficulties was helping to ensure that most families requiring speech and language therapy were getting the timely help that they needed.

Overall, partner agencies worked well together to support families and carers to access help and support at an early stage. Parents involved with the CEDAR project demonstrated improved communication with children. The Action for Children family support project used local volunteers to befriend and mentor parents, resulting in improvements in parenting capacity for all who attended. Support had been extended to offer kinship carers greater insight into the impact of domestic abuse. Kinship carers and foster carers had benefitted from training on child sexual exploitation and online safety to promote the safety of their households.

Good communication and co-ordinated supports across adult services helped parents to address mental health, substance misuse issues and offending behaviour. Parents facing difficulties in managing the sometimes complex and challenging behaviour of their teenage children welcomed the flexible, often intensive supports available.

Working in partnership with skilled and experienced staff enabled parents to resolve and manage conflict, ultimately resulting in young people remaining at home. Parents viewed the 24-hour helpline offered by the Alternative to Care service as particularly helpful.

Kinship carers we spoke to expressed a variety of views, more negative than positive, regarding the practical, emotional and financial supports they had received over time. However, a comprehensive review of financial arrangements and the introduction of a new, more robust kinship carer assessment were welcome initiatives. With increasing numbers of children in kinship care, leaders recognised the need to work collaboratively and build trusting relationships with carers.

A clear parenting strategy was in place and demand for support services was monitored. However, our review of case records indicated that many more families could have benefitted from available interventions if their needs had been better identified and reflected within plans. For example, some families affected by domestic abuse could have benefitted from support at an earlier stage to understand better the impact of domestic abuse on children.

Although staff worked in partnership with parents to increase resilience, in a few instances there was over optimism about a family's ability to meet their own needs or sustain necessary change in the longer term. We say more about this later in the report.

5. How well are partners working together to improve the lives of children, young people and families?

Providing help and support at an early stage

This section considers how well staff recognise that something may be getting in the way of a child or young person's wellbeing, share relevant information and intervene early to stop difficulties arising or getting worse.

The extent to which services provide help and support at an early stage was very good. Staff across services were confidently recognising when children and young people needed help or support to prevent difficulties arising or escalating. A very high percentage of staff who responded to our survey viewed Getting it Right for Every Child principles as having made it easier to access assistance at an early stage. There was a well-embedded, common understanding of the wellbeing indicators and the national practice model, supported by a strong culture of collaborative working. Helpful and effective processes were in place to support staff to share information appropriately. Most children and young people received the right support from the right service at the right time. Partners had yet to make full use of feedback and data to gauge the effectiveness of early support and to consider all available opportunities to address jointly emerging difficulties for families.

Staff in universal services were clear about the responsibilities of the named person. A helpful set of frequently asked questions had been produced which reduced anxiety over the role and enhanced staff knowledge and confidence. From our review of case records, we found information was being shared appropriately. Managers were confident that practice complied with the recent Supreme Court ruling.[1]

There was a particular focus on promoting speech and language development in early years services. Link workers within early education and childcare centres had greatly improved joint working and helped respond to issues at an early stage. Staff in schools deployed a range of tools to help them in identifying children and young people who may be in need of additional support at an early stage. Children's attainment was monitored and tracked, which was helping to alert staff to emerging difficulties. Partnership working with Skills Development Scotland helped in identifying as early as S1 those older young people who were at risk of not reaching a positive destination. The **Joint Assessment Team** arrangements were being used as an effective multi-agency forum to share information, review needs and respond to the issues identified. Funding of additional educational maintenance allowance payments incentivised and supported young people to engage and enabled services to track attendance as part of the senior phase pathway.

[1] **In July 2016 the Supreme Court delayed implementation of the Children and Young People (Scotland) Act 2014. The Scottish Government is now required to provide greater clarity on how those in a named person role share information.**

The Special Needs in Pregnancy multi-agency group was considering all women at all stages of pregnancy. Specialist midwives, mental health and addictions staff within the service provided valuable support to women and their partners. Staff involved with the Family Nurse Partnership programme were recognising the needs of vulnerable young women through use of the universal pathway.

Helpful arrangements were in place for promoting smooth transitions into early years services and for children moving on to primary school. There was a clear focus on identifying children who may need some additional support with helpful involvement of parents. Future planning for young people affected by disability started at age 14, using the wellbeing indicators as a tool to provide early preparation and identification of supports that may be needed in adult services. A dedicated support group for children with a sibling who had a disability was highly valued by participants.

Staff working with adults had well developed relationships with colleagues in services for children. They were alert to the needs of children within complex families and proactively shared child protection concerns in accordance with local guidance. The **EMIS** (electronic management information system) had had a significant positive impact on recording and sharing of information. Staff recognised the benefits of real time access to information about children recorded by colleagues across health disciplines.

Impressively, a scheme to improve information sharing between GPs and other children's service staff had achieved a considerable impact in terms of supporting early and effective intervention. It was improving understanding of respective roles and responsibilities and contributing to trusting relationships between GPs, named persons and lead professionals. This was evidenced by a growing willingness to share relevant information across services, provided consent had been obtained. In turn, this supported improved outcomes for children and young people. There was a better shared understanding of **Getting it Right for Every Child** wellbeing indicators and the importance of sharing information, particularly where potential adverse impact on wellbeing could be anticipated.

Clear pathways for communication had been embedded. For example, the request for assistance process enabled named persons to make referrals to services such as the child and adolescent mental health service, in partnership with GPs. The achievements of the initiative were being increasingly recognised at a national level.

The multi-agency domestic abuse coordinator (MADAC) post had enhanced the earlier identification of children affected by domestic abuse. Staff confidence and awareness had increased and information was being shared appropriately and quickly between services. Notifications regarding incidents of domestic abuse affecting children and young people were being sent routinely to named persons. However, little was being done to intervene with domestic abuse perpetrators at an early, non-statutory stage that could enhance prevention and promote positive role models.

There was strong commitment to early and effective intervention and delivering a whole-system approach to young people at risk of offending. Multi-agency forums were convened when young people aged between 14 and 21 were identified as vulnerable, to consider how best to address issues such as offending behaviour, substance misuse, mental health and wellbeing. Staff viewed the request for assistance process as making it more straightforward to access support and that this was having a positive impact in helping families get the support they needed earlier.

Assessing and responding to risks and needs

This section examines the quality of assessment of risks and needs in relation to three themes. These are: the initial response when there are concerns about the safety or wellbeing of children; the effectiveness of chronologies to identify significant events in a child's life and the quality of assessments.

Assessment of risks and needs was adequate. Responses to concerns regarding immediate risk of harm, abuse or neglect were prompt and resulted in the child's immediate safety being assured. In general, appropriate alternative accommodation was secured for children who needed it. Beyond the immediate emergency, a small number of children and young people remained in accommodation that did not provide the best living environment. Implementation of an initial referral discussion process was still at a relatively early stage and routine involvement of all key partners in decision making had yet to be fully established. While most vulnerable children and young people's records had a chronology of significant events, the content was not effectively informing assessment, planning or identification of risk. There was evidence of a shared language of Getting it Right for Every Child within practice, alongside a growing confidence in the use of assessment to inform decisions. Notwithstanding these positive developments, the quality and consistency of assessments of risk and need were variable.

Initial responses to concerns about safety and wellbeing

The systems, processes and checks to ensure that children at risk were identified and assessed, were working effectively. Alerts from services prompted the out-of-hours social work service to support families in crisis. Police Scotland was developing standard operating procedures in relation to the initial referral discussion process and their out-of-hours response to enable more effective planning.

Police checked the child protection register following reported incidents of domestic abuse. Thereafter, the **ASSIST** team would visit victims of domestic abuse to establish the level of risk to the victim and offer support. The Domestic Abuse Disclosure Scheme shared information about perpetrators of domestic abuse with persons at risk of being harmed. Such information is shared to help the person at risk make informed decisions about their situation.

In the majority of records we reviewed, agencies responded promptly to concerns that a child or young person faced immediate risk of harm, abuse or neglect. Staff were generally alert to signs of significant harm and recognising accumulated risks associated with parental substance misuse. In a small number of cases, the welfare of children and young people would have been more assured had there been better recognition of the complexities and cumulative impact of domestic abuse.

When it was not safe for children or young people to remain at home, their immediate safety was assured by securing alternative accommodation, most commonly with relatives or friends. Routine checks were carried out to ensure the appropriateness of proposed addresses and carers. Beyond the immediate emergency, a small number of children and young people remained in accommodation that did not provide the best living environment. Some children and young people remained at home with parents who lacked capacity. In a few instances, consideration of the potential risks posed by parents with a history of domestic abuse who were no longer living at home had not been adequately identified within initial risk assessments.

Information was disseminated appropriately by individual agencies. Within initial case conferences relevant details were used to identify the nature of the risk, inform decision making and enhance the ability of services to protect children and young people from the likelihood of further harm.

The recent introduction of the multi-agency domestic abuse co-ordinator role had sharpened focus on domestic abuse issues. Routine sampling of police concern reports received by the hub ensured the effectiveness and efficiency of responses, with children being proactively identified for intervention.

Staff were clear about thresholds and, because of accessible and direct lines of communication, they had become more confident and enabled to escalate child protection concerns. A clearly defined and inclusive approach to initial referral discussions had been introduced, supported by refreshed guidance, comprehensive training and quality assurance processes. Implementation, in the form of telephone calls as opposed to round-table discussion, was at a relatively early stage and managers were continuing to review and refine the process.

Notable improvements had been achieved in the form of securing GP attendance at initial case conferences and inclusion of the named person from the outset. Nevertheless, a number of initial referral discussions did not feature the expected level of multi-agency discussion or decision making. In spite of the training provided, some staff lacked clarity regarding the purpose of initial referral discussions and respective roles and responsibilities within the process.

While local guidance outlined expectations of recording, it was not always possible to track multi-agency discussions or decision-making rationale within our review of children's records. In general, managerial oversight and quality assurance activities were not well recorded within entries.

Gathering information through the child protection unit was improving the picture of risk and need within initial referral discussions. When a comprehensive medical examination is required, the health board's central child protection unit (CPU) in Glasgow is noted as the single point of contact. The NHS Greater Glasgow and Clyde rota for paediatricians, operated through the CPU, considers all requests for medicals from West Dunbartonshire. Any comprehensive medical examinations are arranged by the CPU to take place locally at the Acorn Centre with a local paediatrician. This enabled West Dunbartonshire to use a local, on-site resource, which was viewed by practitioners as offering swift access and additionality as it ensured the child was seen by the local dental service on the same day.

The quality and use of chronologies

Staff told us they recognised the value of chronologies and considered their production as an area of practice that was improving. They welcomed what they viewed as good quality training that covered issues of consent as well as the purpose and value of chronologies within operational practice and professional supervision. Nonetheless, our review of case records found that while the majority of records contained a chronology of the significant events in the child or young person's life, the content was highly variable.

In 60% of records, chronologies did not effectively inform assessment, planning or consistently identify risk. There were different interpretations of what constituted a significant event and entries had varying detail or omitted key information. As a result, decisions were not always supported by an appreciation of the full picture. In a few instances, cumulative risk had not been given the appropriate weighting within assessments, for example about domestic abuse, owing to the lack of a detailed record of events within the chronology.

The quality of assessments

The quality of assessments was variable with a high percentage of adequate performance. When considering assessment of risk, 55% were considered good or above, while 10% were weak.

Almost all children had a needs assessment, with 57% rated as good or above and 10% as weak. The quality of assessments were diminished by inconsistent recording across the wellbeing indicators. In a small number of cases, there was failure to recognise or give appropriate weight to specific risks or needs.

The shared language of Getting it Right for Every Child was embedded within assessments. There was evidence of growing confidence in the use of assessment to inform practice and decisions. The National Practice Model was assisting universal services to contribute meaningfully to shared assessments and enabling parents and partners to be clear about risks and resilience factors. Increasingly, specialist assessments were undertaken as required.

Children's reporters generally viewed assessments as being of a good quality, with some examples of additional information being received, which was seen as helpful to children's hearings. A few services were beginning to see assessments accompanying referrals such as child and adolescent mental health services and within the request for assistance process. Adult services were adapting their assessments to include impact on children and young people. Although planned, a comprehensive multi-agency assessment was not yet in use and the single shared assessment was most often the product of multi-agency discussion.

Planning for individual children and young people

This section considers the quality of children's plans and the effectiveness of arrangements to review them.

Planning for individual children and young people was adequate. Comprehensive guidance, tools and briefings were in place to support and direct staff in delivering positive outcomes for children, young people and families. Training on assessment and planning had taken place and was positively received, on the whole. However, while virtually all children and young people had a plan, there was significant variation in quality. Plans were not sufficiently detailed, outcome focused or SMART (specific, measurable, achievable, relevant and time bound) which impacted upon monitoring of progress. Arrangements for chairing children's reviews were inconsistent across services. There was insufficient independent challenge within current reviewing arrangements to hold services to account and drive improvement. Encouragingly, improvements in permanency planning and partnership working were contributing to better outcomes for vulnerable children and young people.

The quality of children and young people's individual plans

While almost all children and young people had a plan to manage risk and need there was considerable variation in the quality of plans across all groups of children and young people. Just over a third of plans to manage risk were rated as good or above. Almost half (42%) were evaluated as adequate with 20% considered weak.

In a small number of child protection cases the actions taken to protect children were short-term in nature with insufficient attention to long-term safety issues.

Similarly, plans to meet the needs of children and young people were rated as adequate in 37% of cases. A quarter of plans were weak. It was clear that staff often had all the relevant information available to them but this had not been meaningfully translated within well formulated, purposeful, outcome focused plans.

In a few instances, there was undue optimism in the face of short-term improvement by parents. A lack of further incident was sometimes taken to indicate an absence

of risk. As a result, a small number of children were deemed to be at no risk of further harm too early.

There were clear strengths in the quality of plans for children and young people looked after away from home. There were notable strengths in transition planning for care leavers and young people with mental health difficulties. Plans for children and young people looked after at home or in kinship care often lacked specific detail or longer-term goals. Overall, a significant proportion of plans were not sufficiently SMART. Strengths or intended outcomes were not recorded consistently across the wellbeing indicators.

For those families choosing to take up self-directed support, we saw that creative use was enhancing the lives of young people with complex needs.

Staff had received training on how to prepare a child's individual plan. This was supported by comprehensive policy, practice guidance and briefings that offered clarity around stages and timescales for assessment, support and review. Within our survey of staff, 88% of respondents believed they had the necessary tools and guidance to prepare a child's individual plan. Getting it Right for Every Child had enhanced communication and promoted understanding for parents and carers in terms of meeting the needs of children and young people.

The quality and effectiveness of planning and reviewing

In a high percentage of the records we reviewed, agencies were working collaboratively to implement plans, including specialist services such as child and adolescent mental health services. On occasion, representation across all key agencies could have been more consistent. As noted earlier, a good range of provision, low waiting times and capacity within services resulted in minimal delay in children and young people being assessed for, and receiving, services to meet identified needs.

The inclusion of parents, carers or family members in planning for children was evaluated as good or above in 75% of the cases we reviewed. The majority of parents and carers we spoke to were aware of the child's plan and had contributed to the process. For a few, this was not the case and they would have welcomed further opportunities to better understand the role of services, to be listened to and included.

The majority of child's plans were reviewed regularly and appropriately to meet the child and young person's needs. While 45% of reviews were rated good or above, the majority were adequate or weak. Arrangements for chairing reviews were inconsistent across different groups of children and young people. Where there was a lead professional, reviews were chaired by first line managers.

This process was viewed as beneficial by staff and managers as it meant they knew the circumstances of children, young people and families. However, chairs lacked sufficient distance from operational case management to offer objectivity. In

contrast, across residential care services, reviews of practice were undertaken by managers from a different children's house or team. These alternative arrangements were increasingly seen by residential staff as affording opportunities for effective and constructive challenge within review meetings. Overall, we concluded that there was insufficient independent challenge within current reviewing arrangements to drive improvements in performance.

There were helpful processes in place for senior managers to audit and monitor the quality of plans and progress of interventions. Most recently, a local management review (LMR) process had been introduced and was beginning to identify areas for improvement for specific categories of children and young people. The process has already highlighted the need for routine benchmarking of decision making and monitoring of changes to recording systems. While promising, it was too early to comment upon the effectiveness of this process as a systematic approach to quality assurance and achieving consistency in practice.

Securing stable and nurturing environments

The effectiveness of plans in securing caring and stable environments for children and young people was good or above in just over half of the records we reviewed. The principles of Staying Put were firmly embedded in practice.

A child-centred approach had refocused and reasserted the positive value for some young people remaining longer in foster and residential care. In 2016, adoption and fostering services operated by West Dunbartonshire Council were evaluated by the Care Inspectorate and found to be offering a very good quality of support and a range of positive and nurturing environments. Leaders were actively seeking to recruit foster carers in a bid to further extend the range of provision for looked after and accommodated children and young people. Inspections of registered care services found that children and young people looked after away from home within local children's houses were involved in reviewing their own plans and were working towards mutually agreed goals. Consultation with young people and their families was embedded in everyday practice and young people were found to be achieving positive outcomes. The most recent inspection of the adult placement service noted the significant throughcare supports being offered to young people as they moved towards independent living, with every aspect of the service rated as excellent.

Growing numbers of children and young people were being supported within their own communities through use of kinship care and specialist, often intensive, support services. Plans were generally progressing well for the majority of children and young people requiring permanent substitute care. Following evaluation of practice, timescales for permanence had improved and decisions were being taken at an appropriately early stage. Managers had identified scope for further improvement in this regard, for example for children and young people in kinship care placements.

Planning and improving services

This section considers the rigour of integrated children's services planning and strategic planning and the extent to which it can be demonstrated to support improvement in the wellbeing of children and young people. It includes a focus on how well partners identify and manage risks to vulnerable groups of children and young people.

Joint planning to improve services was good. Local priorities and national expectations were well balanced within the single outcome agreement and threaded through a range of coherent, inter-related strategic plans. A dynamic strategic governance structure promoted strong leadership and effective communication. There had been a transformational shift towards empowering and engaging staff within improvement plans and structures. Although not entirely evident from the most recent integrated children's services plan, the system was working well, with progress towards achieving outcomes better evidenced within the plan's subsequent review report. While key groups in need of additional support had been identified by partners, the process by which the needs of these groups had been identified was less explicit. An absence of mutually agreed performance indicators at the outset meant that partners were unable to measure improving outcomes for these important groups across the wellbeing indicators. The voice of the child and detail as to how the views and expectations of children and young people had been used to inform planning decisions was absent. The language and principles of Getting it Right for Every Child had strengthened partnership working and enhanced communication across services. The child protection committee was functioning well with clear direction from the public protection chief officers group. Partners were appropriately risk aware and risk management approaches were well embedded and integrated within a mature partnership.

Integrated children's services planning

Strategic planning arrangements were robust with clear connections between structures and processes. The Integrated Children's Services Plan 2015-18 was an outline of intention for a wide audience that reflected the single outcome agreement priorities. It took appropriate account of existing statutory requirements and soon-to-be-enacted legislative duties, including implementation of Getting it Right for Every Child. A comprehensive review reported on the progress made against key actions and refreshed priorities for 2016-17.

Strategic planning was progressed within the multi-agency children and families delivery and implementation group, below which sat six multi-agency review and improvement sub-groups. These groups had reduced duplication and were making purposeful progress towards meeting the demands of improvement plans deriving from the integrated children's services plan.

These were dynamic forums and staff across services showed very high awareness and ownership of these planning processes. Reporting on the delivery and implementation groups was fairly SMART, with some helpful performance information and trend data, but limited detail in terms of outcomes.

Partners worked effectively together to identify cross-cutting themes and agree a manageable number of priorities. Rather than utilising a specific, joint strategic needs assessment, partners used a process of analysis, single agency review, audit and consultations with stakeholders to identify the needs of children, young people and families. This quantitative and qualitative data was then refined by partners within annual, multi-agency development sessions to identify and agree future priorities. A strong third-sector interface, facilitated by an engagement dashboard system, contributed to cost-benefit analysis, enabling partners to commission, review and realign services according to identified priorities and stakeholder's desired level of involvement.

Progress in implementing the integrated children's services plan was reported in 2015-16. Measures tended to report on volume and frequency of activity and improvements in joint processes. A lack of jointly agreed local outcome indicators at the outset limited partners' ability to measure achievements and improving wellbeing, particularly for vulnerable groups.

Child protection committee business planning

The child protection committee was accountable to the public protection chief officers' group. The group's work plan had helped crystallise the business of the committee and increased understanding of the committee's role and function.

The committee was an ambitious group, determined to plan, monitor and improve child protection services. It was working effectively to a comprehensive strategic improvement action plan that linked well to the priorities within the single outcome agreement and integrated children's services plan. Membership of the committee had been reviewed to ensure representatives had an appropriate level of seniority to fully participate with delegated authority. Previously identified issues regarding attendance had been resolved and attendance overall was now good. Long-standing subcommittees had been disbanded and replaced with purposeful, short-life working groups. These arrangements had contributed to improved connectivity, efficiency and accountability.

Performance was monitored through the performance and reporting framework, which provided a snapshot of particular areas of performance. While useful, it did not offer a more comprehensive picture of child protection performance or outcome measures. The frameworks for each strategic group were shared across public protection chief officer group areas of responsibility, with a view to ensuring consistency.

A range of regular single- and multi-agency joint self-evaluation activities had taken place. The committee was keen to learn from good practice elsewhere, using

findings from significant case reviews and joint inspection of services for children in other areas to inform practice. Self-evaluation was making a clear contribution to continuous improvement. A multi-agency audit of 50 police child concerns due to domestic abuse found that the response could have been more robust and that sufficient account was not always taken of a pattern of previous domestic abuse incidents.

Arrangements were in place whereby GPs received weekly lists of children in their practice who were currently on, or had been removed from, the child protection register. Meetings about vulnerable children were held within practices to ensure an overview and monitoring of the potential for risk to present again in respect of these families. The local management review (LMR) process had focused on children on the child protection register and tracked sustainment of progress for those children who had recently been removed from the child protection register. Partners had used the Social Care Institute of Excellence model to consider learning from issues which had arisen in practice.

A programme of joint staff training and development opportunities was in place across the health and social care partnership and education service. Integration and new strategic structures had improved child protection processes and enhanced partnership working. A multi-agency strategy group provided effective oversight and governance of local plans in relation to child sexual exploitation, which was clearly and appropriately seen as a child protection issue. The strategy included partnership working, staff training and engaging children and young people in a range of initiatives to promote personal, online and community safety. An action plan to further support the implementation of the strategy was in development.

Identifying and responding to emerging risks

Robust risk management processes and strategies were in place within single agencies. There was evidence of ownership of risk across business structures and services, with clear expectations as to how risk was to be addressed. Helpfully, there was a system to escalate risks from an operational to strategic level. A joint risk register was appropriately maintained by the community planning partnership's management group.

The child protection committee actively monitored monthly trend information, reporting to the public protection chief officers' group through quarterly reports as well as identifying any pertinent issues as they arose. Fluctuations in the number of children on the child protection register were analysed in terms of impact on specific groups. As a result, leaders were well informed about potential or emerging risks to vulnerable children and young people. They demonstrated confidence in their ability to jointly identify, manage and mitigate risks. Learning from serious events in recent years, including the deaths of young people who were known to services, had further deepened and strengthened working relationships and informed a shared understanding of risk assessment and management.

The Safe, Strong and Included development and implementation group had improved connectivity between the Violence Against Women Partnership, the **EEIDA** (Early and Effective Intervention Domestic Abuse) strategy group and the child protection committee. Leaders had identified areas of duplication between the EEIDA strategy group and the **MARAC** meeting which was now in abeyance as ASSIST had decided that they could no longer manage this process. The potential impact upon risk management and planning in respect of victims had yet to be explored fully by partners.

Participation of children, young people, families and other stakeholders

This section examines the extent to which children, young people, families and other stakeholders are involved in policy, planning and service development.

The extent of participation by children, young people, families and other stakeholders was very good. There was an embedded culture of involving young people. This was matched by a strong commitment from leaders and staff at all levels to ensure that children and young people were enabled to play an integral role in shaping service design, policy and practice. A helpful three-year participation and engagement strategy directed consultation undertaken by key partners such as the Youth Alliance and Y Sort It. The extent of this consultation and the views of children, young people and families had yet to be meaningfully reflected within the integrated children's services plan or corporate parenting strategy. The educational services parental involvement strategy group facilitated strategic involvement and consultation activities with parents. Staff across services acted as advocates on behalf of children, young people and families. However, Who Cares? Scotland's ability to promote the rights of children and young people was underused, as the service was not sufficiently promoted by professionals.

Strategic planning structures supported children and young people's involvement in a considered, regular and user-friendly way. A range of stakeholders were engaged within the previously described delivery and implementation groups, and review and improvement subgroups. Stakeholders were positive about their involvement within these groups, viewing them as accessible and successful in driving forward improvements for children, young people and families.

Engaging children and young people within service planning was a central priority within the integrated children's service plan review. A three-year plan had been agreed with the **Youth Alliance** who were responsible for directing and providing oversight of engagement and participation processes. Children and young people, along with their parents, were positive about the flexible supports provided to help young people become active citizens within their communities. Staff were fully committed to listening to children, young people and their families, and took very seriously the need to engage service users in planning and improvement activities. Some third-sector providers were successfully engaging with seldom heard young

people and were striving to ensure that the needs of these groups of young people continued to be recognised.

Corporate parenting was a key priority for partners. A range of co-produced events had involved enthusiastic, care experienced young people in raising awareness among elected members and other staff across services. Care experienced young people welcomed the opportunity to share their views about what was needed to support young people to make successful transitions to adulthood. Effectively engaging and representing the views of children and young people looked after at home was an ongoing challenge.

Young people on the autism spectrum had been supported to make a DVD which enabled them to explain their difficulties and how best to overcome these to their teachers as well as raising awareness among staff in other schools. Young people who had participated benefitted from an opportunity to shape service delivery and felt listened to and empowered by their experience. They were rightly very proud of their achievements, as were their parents. Young carers were developing a similar project to share their experiences.

Consultation activities were well planned and on occasion led by young people themselves in partnership with senior managers. Such activities effectively contributed to the flow of information between the partnership and young people. Engaged young people and their families had a sense of ownership about the priorities and changes which were made as the result of consultations. These included practical changes that significantly affected the lives of children and young people who were looked after and accommodated, as well as assisting partners in setting priorities for services.

Likewise, there were active parent councils in all schools that influenced approaches on how support to families was delivered. However, not all parents felt involved or consulted on all pertinent issues.

Leaders were committed to meaningful community engagement and empowerment. Under the auspices of the Your Community approach, local charrettes (intensive public consultations that engage local people in the design of their community) and events were engaging communities in driving transformation across the area. Increasingly, the Community Fund initiative was making money available to community groups to deliver locally agreed improvements. A calendar of consultation events was in place with clear connections across the Youth Alliance, Your Community and corporate parenting activities. Partners worked diligently to avoid duplication by coordinating activities and approaches.

Partners actively sought feedback from service users and communities, with the information received demonstrating high levels of confidence in the services being provided to children, young people and families.

A number of successful consultation events had taken place, exceeding the target numbers of young people that partners had hoped to involve over the last two years.

An annual Youth Alliance consultation event was successfully seeking the views of young people in order to inform youth-led service development and delivery. Most recently, over 300 young people identified three clear priorities related to health and substance misuse, which were being taken forward by the review and improvement subgroups.

Partners were committed to supporting the United Nations Convention on the Rights of the Child, ensuring children and young people were fairly treated and had their needs met. They had implemented the **Rights Respecting Schools** award initiative across a number of schools.

All staff, across services, particularly the third-sector, viewed themselves as advocates for children and young people. While this is not an unusual view for staff to hold, in this instance the children and young people we met agreed with the sentiment. They described staff as advocating on their behalf to ensure that their rights were supported and that they received help when needed.

As previously mentioned, the Youth Forum acted as an important mechanism for children and young people looked after away from home to air their views and affect change. Who Cares? Scotland effectively supported children and young people who were currently looked after within children's houses. The service had capacity to support more eligible young people but had not received referrals from relevant services. From our activities, we identified a general absence of independent advocacy available to other groups of children, young people or their families. A number of young people we met believed they would have benefitted from additional support to express their views and wishes during difficult events and meetings.

6. How good is the leadership and direction of services for children and young people?

This section is about the extent to which collaborative leadership is improving outcomes for children, young people and families. It comments on the effectiveness of the shared vision, values and aims, leadership and direction, and leadership of people. It also examines how well leaders are driving forward improvement and change.

Leadership of improvement and change was good. The collective leadership of the community planning partnership knew its area well and presented as ambitious and committed to delivering improved outcomes for children and young people. Leaders were highly visible and known to their staff. At all levels, across all services, staff not only understood and articulated the shared vision for services, but demonstrated ownership of strategic plans and planning structures. Working across an area of multiple deprivation in a climate of diminishing resources had resulted in partners striving to do more with less. There were clear successes in terms of reducing some outcome gaps, particularly across education services where attainment by children and young people from all communities had improved. In several interconnected areas of strategic importance such as domestic abuse, child poverty and corporate parenting, the lack of shared outcome measures limited the ability of leaders to demonstrate how the lives of children and young people had improved as a result of strategic approaches and investments. A relatively new senior management team had been implementing changes with a view to strengthening performance. However, our review of case records found that the quality of assessment and planning for individual children remained variable, highlighting the need for ongoing robust quality assurance and a systematic approach to addressing operational weaknesses.

The broad community planning partnership vision for "a prosperous West Dunbartonshire recognised as a dynamic area within a successful Scotland" was articulated well across strategic plans. Within the integrated children's services plan this over-arching vision was aligned to Getting it Right for Every Child principles and legislation with a stated aim "to improve the life chances of children and young people".

Refreshed and streamlined strategic governance arrangements supported strong leadership and effective communication. Elected members, the chief executive and senior managers across services were highly visible and known to staff. All were fully engaged in the Back to the Floor initiative which involved them in a regular programme of engagement activities across services. These activities, combined with newsletters, blogs and creative use of social media, enabled leaders to sustain the vision and report on progress in achieving key priorities.

Elected members, central to the delivery of effective leadership, had benefitted from a programme of well received awareness-raising training to help them fulfil their responsibilities in respect of Getting it Right for Every Child, child sexual exploitation, domestic abuse and corporate parenting.

The culture and principles of Getting it Right for Every Child were being embedded within practice. The shared language was promoting communication and staff were confident about their respective responsibilities. Nevertheless, there remained a need for strong leadership going forward in order to deliver on practice developments such as a single child's plan, multi-agency comprehensive assessments and integrated chronologies.

Strategic governance structures supported and encouraged collaborative working. Staff at all levels across services told us they were empowered to make decisions, which enabled them to act autonomously and in partnership with others. Third-sector representatives played an important role in securing and directing resources to best meet need and were keen to become even more involved in strategic planning.

Partners were working hard to achieve cultural change in areas that had traditionally proved difficult to shift, such as health outcomes and domestic abuse. There was clear evidence of resources being shifted to support the commitment to early intervention and prevention. Workers across agencies spoke positively of the restructuring of services, viewing change as sometimes challenging but well handled. Multi-agency leadership groups had removed silo working and contributed to a culture of integration, shared ownership, genuine partnership and an open, listening culture. Staff presented as informed, included and motivated to deliver high quality services. Within our staff survey, 100% of respondents agreed there were positive examples of joint working and shared approaches to service delivery.

There was evidence that services were making use of a range of methodologies, approaches and tools to support continuous improvement and reflective practice. Chief officers viewed the performance and assurance framework as enabling them to question performance and hold one another to account. However, much of the data we scrutinised related to quantitative data and process measures, as opposed to outcomes that could demonstrate improvements in the lives of children, young people and families and contribute to strategic decision making.

Community planning partners estimated that one in 10 children were adversely affected by domestic abuse. Such experiences were often exacerbated by associated parental substance misuse and poor mental health. Reducing the number of children and families affected by domestic abuse was recognised as a key, cross-cutting priority. Concerted efforts had gone into raising awareness, training staff, developing and reviewing practice. Leaders had sought to benchmark against comparators but recognised the scale of domestic abuse in West Dunbartonshire overshadowed many other areas.

Partners had made a positive start in terms of gathering statistical information. Leaders had yet to make full use of the range of analytical data available to them in order to inform strategic planning, quality assurance and self-evaluation plans. The appointment of an equalities officer had advanced many of the connections across governance groups. However, there were opportunities for strategic, tactical and operational activities to be better co-ordinated across the pillars of the **Equally Safe Approach** within a performance framework that is capable of assessing impact across the various work streams.

Corporate parenting was also a key, cross-cutting priority. Although the final format of a champions' board was not yet in place, partners had demonstrated real success in raising awareness and engaging stakeholders. This included involving care experienced young people in the co-production and delivery of a range of annual events. It was clear that leaders were in the process of achieving transformational change in this area of practice. However, as previously commented upon, there was an absence of mutually agreed measures that would demonstrate successful outcomes for care experienced young people.

Investments in the wholesale modernisation of the school estate were commendable. Elected members were committed to raising attainment and had successfully secured increasing amounts of funding to support local efforts. School attainment had improved, including positive exam results for young people from the most deprived communities. Leaders recognised that more needed to be done to improve outcomes for children who were looked after at home and accommodated away from home.

Significant progress has been made since the 2012 joint inspection report in terms of strengthening leadership and embedding a culture of self-evaluation. However, the findings from our review of case records were variable, with clear weaknesses in the quality of assessments and plans for individual children and young people. While leaders had taken steps to improve practice, recent activities such as new staff appointments and actions derived from local management reviews (LMR) were not yet in a position to demonstrate comprehensive impact.

7. Conclusion, areas of particular strength and areas for improvement

During the course of this joint inspection, partners evidenced a clear commitment to integration and collaborative working. Strong leaders were delivering a clear vision within a dynamic and responsive system of strategic governance.

Highly committed staff groups across the partnership demonstrated ownership of the strategic vision for children, young people and families and felt connected to improvement planning. There was an obvious culture of self-evaluation and continuous improvement.

These elements, considered alongside the feedback received from service users, led us to confidently conclude that through their collective efforts and commitment of staff, partners were delivering a range of services which were impacting positively on the lives of children, young people and families.

Children in need of protection were safer as a result of prompt responses and the supports they received. Staff across services took their responsibilities to keep children safe very seriously. Some children were ultimately protected by appropriately removing them from parental care. For a small number of children and young people, while they had been protected from immediate harm, they remained within environments that did not offer the optimum level of care or long-term safety.

Children and young people who were looked after away from home told us they felt loved and cared for within nurturing environments. As corporate parents, partners were ambitious to achieve positive outcomes for care experienced young people. However, the quality of plans and arrangements for reviewing the progress and wellbeing of children and young people were too variable.

Getting it Right for Every Child was enhancing communication and information sharing across services. The approach promoted understanding of children's needs for their parents and carers. Elements of the approach, such as integrated chronologies and plans, required continued attention by leaders to improve quality and consistency.

An extensive range of support services was being delivered by partners and stakeholders to support children, young people and families across communities. These initiatives were offering support to parents from pre-birth through teenage years and beyond. Intensive supports were helping to avoid family breakdown and youth homelessness. Young people at risk of offending were being diverted from formal measures as a result of receiving the right service, from the right people at the right time. Staff demonstrated strong persistence in terms of working alongside rarely-heard or reluctant-to-engage children, young people and families in order to facilitate improved outcomes in circumstances and life chances.

In the course of our inspection, we identified a number of particular strengths which were making a positive difference for children and young people in the community planning West Dunbartonshire area.

- The strength of strategic approaches to targeting key universal health services had achieved some real gains within a very challenging context of high deprivation.

- Highly committed staff groups across the partnership demonstrated clear ownership of the strategic vision for children, young people and families and felt clearly connected to improvement planning.

- Young people, including the most vulnerable, were meaningfully involved in influencing policy and service development.

- There was an evident commitment to early intervention and prevention with very effective early help and support processes.

- A coherent shared vision was in place and modelled by a mature partnership.

Partners had demonstrated a commitment to continuous improvement and reflective practice and we are confident that partners are well placed to incorporate the opportunities for further improvement highlighted during this inspection within their ongoing activities. In doing so, the community planning partnership should take action to:

- demonstrate the difference investments in early intervention and prevention are making for all children and young people through the measurement of robust data and progress across strategic plans
- strengthen strategic plans in recognition of national policy directives on prevention of domestic abuse and local trends in use of kinship care
- achieve greater consistency in quality of assessments of risk and need and the formulation of plans to meet identified factors by ensuring that approaches to day-to-day quality assurance of operational practice are robust, systematic and deliver intended improvements.

8. What happens next?

The Care Inspectorate will request that a joint action plan is provided that clearly details how the community planning partnership in West Dunbartonshire will make improvements in the key areas identified by inspectors. The Care Inspectorate and other bodies taking part in this inspection will continue to offer support for improvement through their linking arrangements. They will also monitor progress in taking forward the partnership's joint action plan.

February 2017

Appendix 1: Good practice examples

In each inspection, we ask partners to nominate some examples of good practice which can be shown to have a positive impact on the lives of children, young people and families. During the inspection, we assess these examples to identify those that we consider would be useful to community planning partnerships across Scotland. We commend the following examples.

Effective change management – Seasons for Growth

While many schools across Scotland run Seasons for Growth groups, the programme in West Dunbartonshire is led strategically, well embedded in primary and secondary schools and is delivered in other settings. The inspection team viewed it as a model of outstanding and sustainable practice.

In 2005, staff recognised that the long-term, negative impact of unresolved issues arising from changes such as bereavement, separation and divorce might be mitigated by using the Seasons for Growth programme. Seasons is a peer education group work programme facilitated by two trained 'companions'. Initial attempts to introduce the programme were ineffective. Although initially dozens of companions were trained, only one group was actually delivered. As a result, a multi-agency action group was established to develop a sustainable development plan to make Seasons available to all children and young people.

Choose Life committed funding for training, materials and employment of a senior educational psychologist one day a week to chair the multi-agency action group and coordinate the programme. Continued support from strategic leaders (through the mental health and wellbeing strategy group) has been key to success. Partners analysed barriers that had prevented the programme being used. A model of sustainable development was put in place, including two trained companions in each school supplemented by a large pool of multi-agency 'floating companions', which included health and social work professionals and staff from the third sector. The programme was successfully rolled out one learning community at a time, over a two-year period. The programme has been delivered in children's houses and many looked after children attend groups in their own schools. A first adapted programme for Syrian refugees is due to start in January 2017. Every group is evaluated and positive feedback has been received from staff, children, young people and families. Further, the action group has identified a relationship between a well-embedded Seasons for Growth programme and raising attainment. We believe this merits further research as part of the Scottish Attainment Challenge.

Leadership by young people for young people - Y Sort It

Led by a management board of young people, Y Sort It is an influential project delivering high quality, innovative and inclusive youth work opportunities to children, young people and families. With a proven track record in strategic and operational partnership working over a fifteen-year period, the project has successfully supported young people to achieve positive outcomes.

There is a clear vision of enhancing life opportunities by young people, for young people with staff and mentors acting as strong advocates; influencing decision making and achieving transformation in services.

A strong collaborative partner, the project plays a key role in holding partners to account and ensuring the views and needs of young people are central to strategic decision making, service design and delivery. By accessing important sources of revenue and attracting matched funding, the project supports partners in delivering a range of sustainable, early intervention provision and opportunities for young people.

The project recognises that young people living in an area of multiple deprivation often experience, or are at risk of experiencing, social and economic exclusion. It promotes equality and diversity by helping young people achieve their ambitions. The project has achieved success in engaging and supporting a range of seldom-heard or difficult-to-reach young people, such as young people with caring responsibilities, young people from the lesbian, gay, bi-sexual, transgender and intersex (LGBTI+) community and young people involved in offending behaviour and substance misuse.

A youth centre in Clydebank offers a young person-friendly space, free internet access, a range of youth groups, activities and opportunities. These include: open youth work; volunteering; an arts hub; mentoring for looked after young people by care experienced young adults; support for young parents and self-directing groups for the community of young LGBTI young people. In addition, the Y Sort It bus, known as the **MISC** (Mobile Information Cyber Station) enables youth work activities to be accessed by young people in more rural communities. By understanding new technology and digital media, the project engages, supports and consults young people through social media and social networking.

Y Sort It has led the first specific service for young carers aged 12-18 and has evidenced engagement with young people which has increased year on year since 2010. Y Sort It currently offers support to over 350 young carers. The HomeReach aspect of the project has reached out to young carers who were most reluctant to engage. Support to young people aged 12-21 through the widely respected, Wrecked & Wasted initiative has been helping young people to change attitudes and behaviours related to alcohol and drug use through harm reduction and peer-led youth work approaches.

Commitment to equality and inclusion - Highly Dependent Learners

The Highly Dependent Learners approach, facilitated by a strategic steering group, demonstrated a strong multidisciplinary approach to supporting children and young people with complex physical, medical and learning needs within mainstream education provision. It clearly demonstrates partners' commitment to equality and inclusion. Staff work collaboratively within the spirit and principles of Getting it Right for Every Child to meet legislative requirements and promote positive outcomes for children with additional support needs.

Families have indicated that they feel engaged, listened to and believe that services are responsive to meeting the changing needs of their children at every stage of development. Multi-agency protocols facilitated partnership working, which in turn contributed to positive outcomes for vulnerable young babies. There is very early recognition by neonatal health staff of issues related to prematurity or other additional needs. Excellent communication between neonatal units, primary care and nurseries enables staff to identify and anticipate the longer-term developmental needs of children. One-to-one training sessions between health professionals and education staff have been put in place to build confidence in providing services to this particular group of children and young people.

A centralised store of equipment and dedicated time from an occupational therapist enables staff to have easy access to specialist equipment as required. Centralised processes for requesting, controlling and maintaining equipment have not only resulted in ease of access, but also proved cost effective. Staff within schools work hard to ensure they use similar equipment to that available at home, which results in parents being more confident that their children's needs will be met within mainstream schools and nurseries. The approach has been underpinned by a comprehensive strategic protocol, clear pathways and referral processes which ensure that requests for additional services or equipment can be accessed quickly. Joint assessment and advice clinics ensure assessments and responses are timely and efficient in meeting the needs of children and young people. Access to specialist gym equipment and physiotherapy support enables children and young people with disabilities to expand their physical capabilities within a safe but appropriately challenging environment.

The Highly Dependent Learners steering group has demonstrated clear success in the effective planning for children and young people with a disability, meeting all transitions in line with agreed targets. Highlighting transitions two years before a move taking place is ensuring that necessary adaptations to meet the needs of children and young people are made in good time. This promotes inclusion, demonstrating how much the children and young people are valued as members of the school community, and avoids unnecessary disruption and stress for all parties. A post-review process has ensured that learning is used to inform future activities and to ensure progress for the young person is sustained.

Appendix 2: Evaluated Indicators of quality

Quality indicators help services and inspectors to judge what is good and what needs to be improved. In this inspection we used a draft framework of quality indicators that was published by the Care Inspectorate in October 2012: How well are we improving the lives of children, young people and families? A guide to evaluating services for children and young people using quality indicators. This document is available on the Care Inspectorate website.

Here are the evaluations for nine of the quality indicators.

How well are the lives of children and young people improving?	
Improvements in the wellbeing of children and young people	**Good**
Impact on children and young people	**Very Good**
Impact on families	**Good**
How well are partners working together to improve the lives of children, young people and families?	
Providing help and support at an early stage	**Very Good**
Assessing and responding to risks and needs	**Adequate**
Planning for individual children and young people	**Adequate**
Planning and improving services	**Good**
Participation of children, young people, families and other stakeholders	**Very Good**
How good is the leadership and direction of services for children and young people?	
Leadership of improvement and change	**Good**

This report uses the following word scale to make clear the judgements made by inspectors.

Excellent	outstanding, sector leading
Very good	major strengths
Good	important strengths with some areas for improvement
Adequate	strengths just outweigh weaknesses
Weak	important weaknesses
Unsatisfactory	major weaknesses

Appendix 3: The terms we use in this report

ASSIST (Advocacy; Support; Safety; Information; Services Together) is a team that aims to offer a high quality, early intervention and proactive service to victims, children and young people to meet individual needs while focusing on reducing risk and promoting safety.

The Caledonian Programme is one part of the Caledonian system, which is an integrated approach to address men's domestic abuse and to improve the lives of women, children and men.

Community Planning West Dunbartonshire is the local community planning partnership for the West Dunbartonshire Council area.

The community planning partnership management group meets quarterly and is chaired by the leader of West Dunbartonshire Council.

The child protection committee brings together all the organisations involved in protecting children in the area. Its purpose is to make sure local services work together to protect children from abuse and keep them safe.

The delivery and implementation group sits under the CPPMG as part of the community planning structure.

Early Years Collaborative was launched by the Scottish Government in October 2012 with the support of NHS Scotland, the Coalition of Scottish Local Authorities (COSLA) and Police Scotland. It is a multi-agency, local, quality improvement programme delivered on a national scale, focusing on the national outcome "Our children have the best start in life and are ready to succeed".

EEIDA stands for Early and Effective Intervention Domestic Abuse group.

EMIS stands for electronic management information system.

Equally Safe Approach is Scotland's strategy for preventing and eradicating violence against women and girls.

Getting it Right for Every Child is the Scottish Government's approach to making sure that all children and young people get the help they need when they need it. There are eight wellbeing indicators, which are safe, healthy, achieving, nurtured, active, respected, responsible and included. These provide an agreed way of measuring what a child needs to reach their potential.
www.scotland.gov.uk/gettingitright

Integrated children's services plan is for services that work with children and young people. It sets out the priorities for achieving the vision for all children and young people and what services need to do together to achieve them.

LMR stands for local management review.

MADAC stands for multi-agency domestic abuse co-ordinator and is the post within the health and social care partnership that assists with the arrangement of the MARAC and EEI meeting.

MARAC stands for multi-agency risk assessment conference (primarily for adult victims of domestic abuse who may or may not have children).

MISC stands for mobile information cyber station and is the name for the bus used by the Y Sort It project.

PPCOG stands for public protection chief officers' group

The review and improvement group sits under the delivery and implementation group to drive operational practice issues.

Rights Respecting Schools is an award initiative that recognises success in putting the United Nations Convention on the Rights of the Child at the heart of a school.

Roots of Empathy is an evidence-based classroom programme shown to reduce aggression and promote social competence and empathy among children.

Seasons for Growth is a programme which provides a safe and nurturing way to explore feelings, memories and experience of loss and grief through peer led groups.

Self-directed support is the support a person purchases or arranges to meet agreed health and social care outcomes. It allows people to choose how their support is provided and gives them as much control as they want of their individual budget.

Single outcome agreement is an agreement between the Scottish Government and community planning partnerships, which sets out how they will work towards improving outcomes for Scotland's people in a way that reflects local circumstances and priorities.

Youth Alliance is made up of influential community planning partners and key stakeholders, including young people, who work together to plan activities and maximise resource

Whole System Approach is the Scottish Government's approach for addressing the needs of young people involved in offending. It aims to divert young people who offend from statutory measures, prosecution and custody through early intervention and robust community initiatives.

Appendix 4: The Quality Indicator Framework

<table>
<tr><th>What key outcomes have we achieved?</th><th>How well do we meet the needs of our stakeholders?</th><th>How good is our delivery of services for children, young people and families</th><th>How good is our operational management?</th><th>How good is our leadership?</th></tr>
<tr><td>1. Key performance outcomes</td><td>2. Impact on children, young people and families</td><td>5. Delivery of key processes</td><td>6. Policy, service development and planning</td><td>9. Leadership and direction</td></tr>
<tr><td rowspan="6">1.1 Improving the wellbeing of children and young people</td><td>2.1 Impact on children and young people
2.2 Impact on families</td><td rowspan="6">5.1 Providing help and support at an early stage
5.2 Assessing and responding to risks and needs
5.3 Planning for individual children and young people
5.4 Involving individual children, young people and families</td><td>6.1 Policies, procedures and legal measures
6.2 Planning and improving services
6.3 Participation of children, young people, families and other stakeholders
6.4 Performance management and quality assurance</td><td rowspan="6">9.1 Visions, values and aims
9.2 Leadership of strategy and direction
9.3 Leadership of people
9.4 Leadership of improvement and change</td></tr>
<tr><td>3. Impact on Staff</td><td>7. Management and support to staff</td></tr>
<tr><td>3.1 Impact on staff</td><td>7.1 Recruitment, deployment and joint working
7.2 Staff training, development and support</td></tr>
<tr><td>4. Impact on the community</td><td>8. Partnership and resources</td></tr>
<tr><td>4.1 Impact on communities</td><td>8.1 Management of resources
8.2 Commissioning arrangements
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CPP Joint Children's Services Inspection Improvement Action Plan 2017

Appendix 2

1. Key Improvements/Recommendations

Care Inspectorate CPP Areas for Improvement	Actions	Milestones	Progress	Strategic Responsibility	Assigned to	Completed Date
1. Demonstrate the difference investments in early intervention and prevention are making for all children and young people through the measurement of robust data and progress across strategic plans.						
	Create robust measurement processes for data analysis to support effective monitoring of progress, delivery of desired outcomes and to assist in the efficient targeting of resources.	Review activities / actions and outcomes from Integrated Children Services Plan Annual Report 2016.		C&F DIG	Head of Children's Health, Care & Criminal Justice (HSCP)	31-August-2017
		Develop new Children Services Plan 2018 - 2021 in line with C&YP Act 2014.		C&F DIG	Head of Children's Health, Care & Criminal Justice (HSCP)	31-August-2017
		Development Strategic Needs Assessment (SNA) as part of development of Children Services Plan.		C&F DIG	Head of Strategy, Planning & Health Improvement (HSCP)	31-October-2017
	Review current Strategic Plans across CPP partners to ensure they are fit for purpose and are improving the wellbeing of children and young people	Review CPP Integrated Performance Report including analyses and reporting on findings.		C&F DIG	Head of Strategy, Planning & Health Improvement (HSCP)	30-September-2017
		Evaluate performance across CPP on annual basis alongside trend analysis data.		C&F DIG	Head of Strategy, Planning & Health Improvement (HSCP)	31-March -2018

Care Inspectorate CPP Areas for Improvement	Actions	Milestones	Progress	Strategic Responsibility	Assigned to	Completed Date
2. Strengthen strategic plans in recognition of national policy directives on prevention of domestic abuse and local trends in use of Kinship Care.						
i) Domestic Abuse	Continue to address issues relating to Domestic Abuse across CPP in accordance with the Scottish Government Equally Safe Strategy in order to deliver an effective multi-agency response across strategically connected planning groups	Establish West Dunbartonshire Violence Against Women Partnership (VAWP) with Argyll and Bute in line with Police Scotland Divisional boundaries.		Safe and Strong DIG	Head of Children's Health, Care & Criminal Justice (HSCP)	In place
		Identify and share learning, training and development across new wider partnership in order to support partnership working and a share understanding of the nature and impact of domestic abuse.		VAWP	Head of Children's Health, Care & Criminal Justice (HSCP) & Police Scotland Lead	31-March-2018
		Explore opportunities for delivering Safer Together programme across the new wider partnership. Intention to deliver 2 programmes and then analyse impact.		Domestic Abuse Strategy Group	Fieldwork Manager and Criminal Justice Manager (HSCP)	30- June - 2018
		Deliver integrated and appropriate housing approach to meet the needs of those affected by domestic abuse, including *No Home for Violence.*		CPP	Strategic Lead Housing & Employability	31-March-2018
		Reinforce Domestic Abuse as a key priority of the CPP through development of new Local Outcome Improvement Plan (LOIP).		CPP	Communication, Culture & Community Manager (WDC)	31-May-2017
		Explore the use of preventative strategies locally; • SACRO development to be explored; • Violence Reduction Unit Street Arrow		Domestic Abuse Strategy Group & SS DIG	Fieldwork Manager and Criminal Justice Manager (HSCP)	30-June -2018

Care Inspectorate CPP Areas for Improvement	Actions	Milestones	Progress	Strategic Responsibility	Assigned to	Completed Date
		• Food Truck development; • Preventative Group work with young people from backgrounds of DA. And identify actions and outcomes as a result of these ventures.				
ii) Kinship Care	Continue to address issues relating to Kinship Care by ensuring our commitments and desired outcomes are reflected within strategic plans	Improve liaison with local Kinship Care Network to ensure their involvement of strategic planning. Evaluate impact via audit following full year basis.		HSCP	Fieldwork Manager (HSCP)	30-June-2018
		Develop opportunities for alternative supports for kinship carers in order to meet identified needs.		C & F DIG	Fieldwork Manager (HSCP)	31-March-2017
		Revise Kinship Care Policy in order to demonstrate our strategic commitments and intended outcomes.		HSCP & Legal Services	Fieldwork Manager (HSCP)	30-June-2017
3. Achieve greater consistency in quality of assessments of risk and need and the formulation of plans to meet identified factors by ensuring that approaches to day-to-day quality assurance of operational practice are robust, systematic and deliver intended improvements.						
	Enhance Joint Quality assurance processes to reduce variability and demonstrate improved quality and consistency of assessments and individual child's plans	Agree process for integrated chronologies and provide single and multi-agency training and development opportunities to staff across CPP.	In place	C&F DIG	GIRFEC RIG	In place
		Introduce new comprehensive assessment and ensure consistent application and quality through supervision of front line staff.	In place	C&F DIG	Fieldwork Manager (HSCP)	In place
		Create clear and robust performance	Agreed.	C&F DIG	GIRFEC RIG	31-Oct-2017

Care Inspectorate CPP Areas for Improvement	Actions	Milestones	Progress	Strategic Responsibility	Assigned to	Completed Date
		measures for assessment and care planning.				
		Develop and deliver training materials which support and encourage robust assessment and care planning.	Single agency training designed & taking place prior to end of June 2017	C&F DIG	GIRFEC RIG	31-Oct-2017
		Further develop single and multi-agency case file audits to measure improvements and maintain quality.	To take place following completion of training.	C&F DIG	GIRFEC RIG	30-Nov-2017
	Improve outcomes for children and young people Looked after at home	Deliver Raising Attainment programme focused on looked after at home children and young people.		C&F DIG	Strategic Lead Education, Learning & Attainment	31-March-2018
		Deliver raised aspirations for looked after at home children in terms of educational outcomes. Develop performance data, outcome measures to enable reporting which will demonstrate outcome measures from the work undertaken.		C&F DIG	Strategic Lead Education, Learning & Attainment	31-March-2018
		Develop clear joint working across Community Alliance, Youth Alliance, HSCP, and Education quality clusters and Housing Services. Engagement in priorities of next 3 year Children's Plan and in annual reviews thereafter. Vies to be captured in annualised progress reporting.		C&F DIG	Strategic Lead Education, Learning & Attainment AND Communication, Culture & Community Manager (WDC	30-June-2018

Note:

- This CPP Joint Children's Services Inspection Improvement Plan represents a number of improvement actions and milestones which will in effect be developed and implemented across the various CPP strategic planning fora. This template is therefore a collection of the actions that will be taken to address the learning arising from the Joint inspection of children's services carried out in 2016 by the Care Inspectorate.

- The CPP Management Group will receive a progress report on a quarterly basis regarding actions and key milestones.
- In respect of the progress of priorities and actions over the course of each year – these will be reviewed, analysed and reported on at the end of each year. The report on progress will be presented to the CPP Management Group. For Strategic Responsibilities that are out with the Children and Families DIG – the responsible group or service area will report progress directly to the Children and Families DIG.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31st May 2017

Subject: Unison's Ethical Care Charter

1. Purpose

1.1 The purpose of this report is to inform West Dunbartonshire Health and Social Care Partnership Board of the principles of Unison's Ethical Care Charter.

2. Recommendations

2.1 The Board are asked to note update on Unison Ethical Care Charter.

3. Background

3.1 In October 2012 UNISON launched its Ethical Care Charter, and invited all Public Sector Commissioners for Care at Home to sign up to the Charter across the United Kingdom. The Ethical Care Charter was created in response to the findings of a UNISON survey of homecare workers in summer of 2012. The overriding objective behind the Ethical Care Charter for the commissioning of homecare services is to establish a minimum baseline for safety, quality and dignity of care by ensuring employment conditions that encourage recruitment and retention through more sustainable terms and conditions and training levels.

3.2 The charter stipulates that in general 15-minute visits will not be used as they undermine the dignity of the clients, that zero hour contracts will not be used in place of permanent contracts, and that all homecare workers will be regularly trained to the necessary standard to provide a good service

4. Main Issues

4.1 The over-riding aim of the Charter is to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which:

a) Do not routinely short –change clients and

b) Ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels.

4.2 The Ethical Care Charter is a national document which outlines a number of phased expectations in 3 stages. The Charter principles align with the aims and objectives for the Health and Social Care Partnership to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire. The core values are protection;

improvement; efficiency; transparency; fairness; collaboration; respect; and compassion. While we are largely in agreement with the principles of the Charter, there are some areas which require further consideration specific to West Dunbartonshire and where the Charter seems to acknowledge a need for flexibility, 15 minute visits being one such example. Short visits may on occasion be appropriate, for example for medicine prompts, evening check visits and meal delivery. Where appropriate and as required visits are extended.

4.3 The HSCP commissions services from a variety of providers and has recently established a Practice and Development Group which aims to include providers in the delivery of a stable sector with improvements in quality of care, sustainability of the sector and standards for the workforce.

4.4 It is recommended that this group reviews the implications of the charter for local providers and works towards meeting its principles.

4.5 A further report will be provided to the Joint Staff Forum and Health and Social Care Partnership Board on its work. It is proposed that the Health and Social Care Partnership endorses the principles set out in the Charter but does not seek to formally approve the charter until this work is completed.

5. People Implications

5.1 The impact on staff would be assessed as part of the work of the Practice and Development Group proposed in this paper.

6. Financial Implications

6.1 The Health & Social Care Partnership delivers 90% of Care at Home Services through direct management and commissions 10% of its Care at Home Services externally from the Independent Sector.

6.2 The HSCP has already committed to the Living Wage Charter element of the Scottish Government policy, and as previously reported by the Chief Finance Officer, in the budget reports to the Health and Social Care Partnership Board, this will form a core part of our contracting with providers

7. Professional Implications

7.1 The HSCP commissions services from a variety of providers and has recently established a Practice and Development Group which aims to include providers in the delivery of a stable sector with improvements in quality of care, sustainability of the sector and standards for the workforce.

7.2 It is recommended that this group reviews the implications of the charter for local providers and assesses any professional implications as part of this work.

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 A risk assessment will be undertaken as part of this work.

10. Impact Assessments

10.1 Supporting the principles of the Ethical Care Charter would contribute towards a positive approach to fair work practices but further work with providers is required to ensure the stability of the local market

11. Consultation

12.1 Draft paper discussed at Joint Staff Forum.

13. Strategic Assessment

13.1 The principles of the Ethical Care Charter are in accordance with the Strategic Plan for the Health and Social Care Partnership.

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Date: **31st May 2017**

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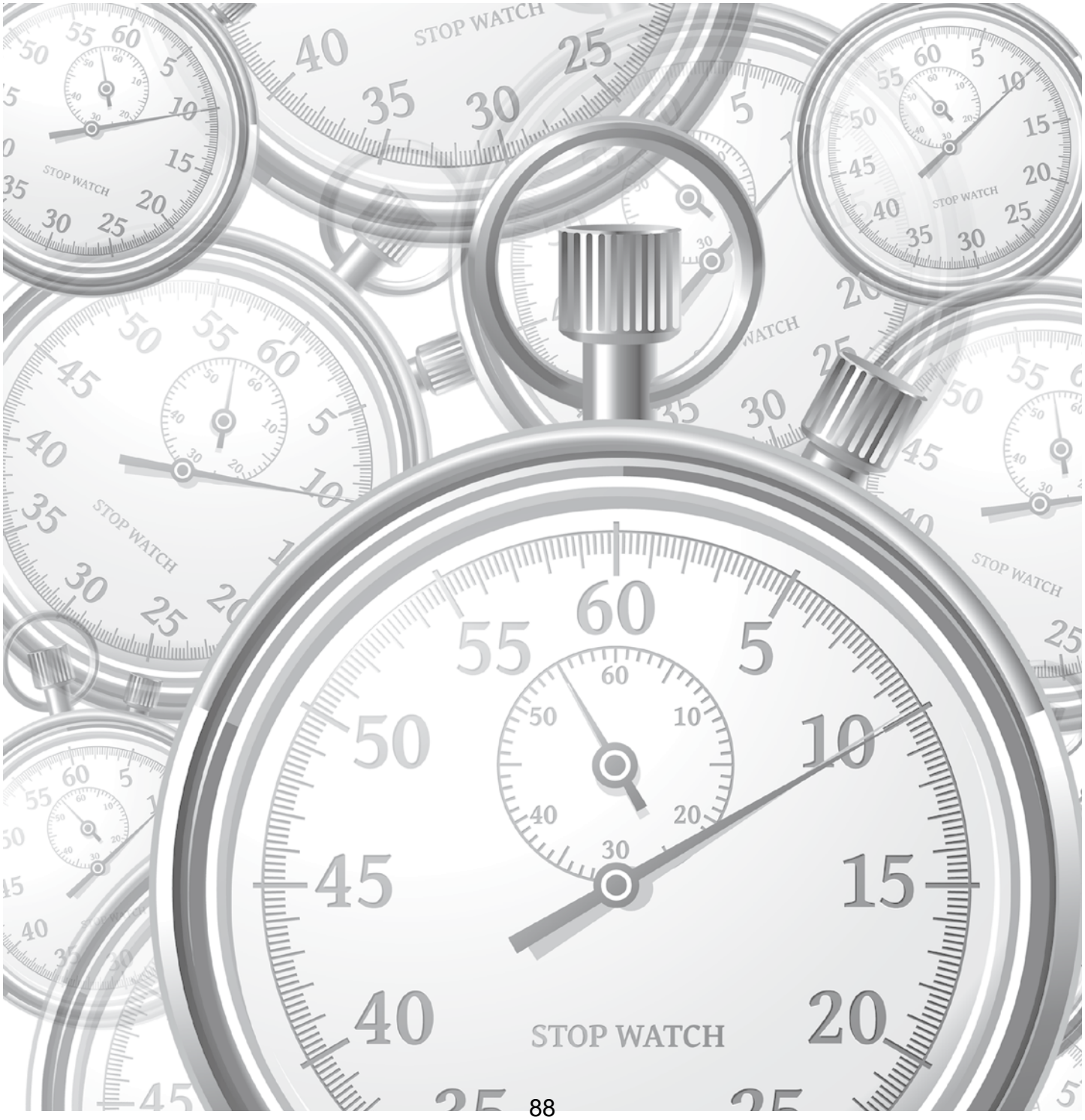
Appendix: Unison's Ethical Care Charter

Background Papers: None

Wards Affected: All

UNISON
the public service union

UNISON's ethical care charter



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Introduction

A number of reports from client organisations, consumer groups, and homecare providers have recently been produced which have been highly critical of the state of homecare services in the UK. Little consideration however has been given to the views of homecare workers themselves as to why there are so many problems in this sector.

UNISON, the largest public service union, conducted a survey of homecare workers entitled “Time to Care” to help address this imbalance and to illustrate the reality of homecare work. The online survey which was open to homecare workers who were either UNISON members or non-members attracted 431 responses between June and July of 2012.

The responses showed a committed but poorly paid and treated workforce which is doing its best to maintain good levels of quality care in a system that is in crisis. The report highlights how poor terms and conditions for workers can help contribute towards lower standards of care for people in receipt of homecare services.

Key findings

- 79.1% of respondents reported that their work schedule is arranged in such a way that they either have to rush their work or leave a client early to get to their next visit on time. This practice of 'call cramming', where homecare workers are routinely given too many visits too close together, means clients can find themselves not getting the service they are entitled to. Homecare workers are often forced to rush their work or leave early. Those workers who refuse to leave early and stay to provide the level of care they believe is necessary, also lose out as it means they end up working for free in their own time.
- 56% of respondents received between the national minimum wage of £6.08 an hour at the time of the survey and £8 an hour. The majority of respondents did not receive set wages making it hard to plan and budget. Very low pay means a high level of staff turnover as workers cannot afford to stay in the sector. Clients therefore have to suffer a succession of new care staff.
- 57.8% of respondents were not paid for their travelling time between visits. As well as being potentially a breach of the minimum wage law, this practice eats away at homecare workers' already low pay.
- Over half the respondents reported that their terms and conditions had worsened over the last year, providing further evidence of the race to the bottom mentality in the provision of homecare services.

  56.1% – had their pay made worse
  59.7% – had their hours adversely changed
  52.1% – had been given more duties
- 36.7% of respondents reported that they were often allocated different clients affecting care continuity and the ability of clients to form relationships with their care workers. This is crucial, especially for people with such conditions as dementia.
- Whilst the vast majority of respondents had a clearly defined way of reporting concerns about their clients' wellbeing, 52.3% reported that these concerns were only sometimes acted on, highlighting a major potential safeguarding problem.
- Only 43.7% of respondents see fellow homecare workers on a daily basis at work. This isolation is not good for morale and impacts on the ability to learn and develop in the role.
- 41.1% are not given specialist training to deal with their clients specific medical needs, such as dementia and stroke related conditions.

The written responses to our survey paint a disturbing picture of a system in which the ability to provide some companionship and conversation to often lonely and isolated clients is being stripped away. Some recounted the shame of providing rushed and insufficient levels of care because of the terms and conditions of their job, whilst many detailed insufficient levels of training that they had been given to carry out the role. Others made the point that rushed visits are a false economy leading to a greater likelihood of falls, medication errors and deterioration through loneliness.

However the survey also showed the selflessness and bravery of homecare workers who, to their own personal cost, refused to accept the imposition of outrageously short visits and worked in their own time to ensure that their clients received good levels of care. Some homecare workers were doing tasks and errands for their clients in their spare time, despite the seemingly best efforts of the current care model to strip away any sense of personal warmth or humanity.

Homecare workers are personally propping up a deteriorating system of adult social care, but they are being pushed to breaking point. That they are still willing to deliver good levels of care in spite of the system is nothing short of heroic. For the system to work it needs to be underpinned by adequate funding and a workforce whose terms and conditions reflect the respect and value they deserve. Crucially they must be given the time to care.

“ I never seem to have enough time for the human contact and care that these people deserve. ”

“ A lot of the people I care for, are old and lonely, they are not only in need of physical support, but they are also in need of company and someone to talk to. The times given to these people are the bare minimum to get the job done, no time for a chat, just in and out. ”

“ People are being failed by a system which does not recognise importance of person centred care. ”

“ We are poorly paid and undervalued except by the people we care for! ”

“ I have worked as homecare worker for 15 years. Things have to change but not at the expensive of clients. It’s appalling the care they receive now. ”

Ethical care councils

In light of UNISON's findings, we are calling for councils to commit to becoming Ethical Care Councils by commissioning homecare services which adhere our Ethical Care Charter.

The over-riding objective behind the Charter is to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which a) do not routinely short-change clients and b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels. Rather than councils seeking to achieve savings by driving down the pay and conditions that have been the norm for council – employed staff, they should be using these as a benchmark against which to level up.

Councils will be asked to sign up to the Charter and UNISON will regularly publish the names of councils who do.

Ethical care charter for the commissioning of homecare services

Stage 1

- The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients
- The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients
- Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones
- Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time
- Those homecare workers who are eligible must be paid statutory sick pay

Stage 2

- Clients will be allocated the same homecare worker(s) wherever possible
- Zero hour contracts will not be used in place of permanent contracts
- Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing
- All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)
- Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation

Stage 3

- All homecare workers will be paid at least the Living Wage (As of September 2012 it is currently £7.20 an hour for the whole of the UK apart from London. For London it is £8.30 an hour. The Living Wage will be calculated again in November 2012 and in each subsequent November). If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract
- All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients.

Guidance for councils and other providers on adopting the charter

Seeking agreements with existing providers

1. Convene a review group with representation from providers, local NHS and UNISON reps to work on a plan for adopting the charter – with an immediate commitment to stage 1 and a plan for adopting stages 2 & 3

2. Start by securing agreement for a review of all visits which are under 30 minutes. The review will include getting views of the homecare workers and client (and/or their family) on how long the client actually needs for a visit and what their care package should be

Looking for savings

3. Are providers' rostering efficiently – for example are there cases of workers travelling long distances to clients when there are more local workers who could take over these calls?

4. How much is staff turnover costing providers in recruitment and training costs?

5. How much are falls and hospital admissions amongst homecare clients costing the NHS and could some of these be prevented by longer calls and higher quality care?

6. Are there opportunities for economies of scale by providers collaborating around the delivery of training and networking/mentoring for workers?

7. Are there opportunities for collaboration between providers to achieve savings on procurement of mobile phones, uniforms and equipment for workers?

The commissioning process

1. UNISON's evidence, along with that of other bodies such as the UKHCA, shows that working conditions are intrinsically bound up with the quality of care.

2. When councils are conducting service reviews and drawing up service improvement plans, the Charter will provide a helpful benchmark for ensuring service quality – whether for an improved in-house service or in relation to externally commissioned services.

3. Where a decision has been taken to commission homecare externally, identify how the elements of the charter will be included as service delivery processes, contract conditions or corporate objectives in the invitation to tender documents. It must explain how these are material to the quality of the service and achieving best value.

Service monitoring

1. Work with providers and trade unions to agree how service quality will be monitored and compliance with the Charter assured

2. Build regular surveys of homecare workers into this process to gain their views and consider establishing a homecare workers panel from across local providers who can provide feedback and ideas on care delivery

The provisions of this charter constitute minimum and not maximum standards. This charter should not be used to prevent providers of homecare services from exceeding these standards.

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31 May 2017

Subject: Comparative and Relative Use of Prescription Drugs in the Partnership Board Area

1. Purpose

1.1 The purpose of this report is to advise on current expenditure, ongoing cost pressures and potential savings within West Dunbartonshire Health and Social Care Partnership's prescribing budget.

2. Recommendations

2.1 The Integration Joint Board is recommended to note:

- The planned savings activities to be undertaken by the prescribing team in conjunction with GP practices; and
- The potential implications for the HSCP as a result of the in year funding gap of £8.5m across NHS Greater Glasgow and Clyde (GGC).

3. Background

3.1 Prescribing and medicines management that is safe, clinically effective, cost efficient and patient-centred is essential for health and social care organisations. Medicines are the most frequent and effective intervention to support the health and wellbeing of patients with long term conditions keeping them within the community and out of hospital.

From a financial perspective, prescribing is a complex and unpredictable activity. Development and implementation of initiatives to address current challenges in prescribing and medicines management, support cost efficiency on the prescribing budget, while continuing to prioritise safe use of medicines and patient-centred care is already undertaken within the HSCP.

4. Main Issues

4.1 As at February 2017 West Dunbartonshire HSCP is reporting a £10,500 (0.06%) overspend against a full year prescribing allocation £19.3million. It is anticipated that financial balance will be achieved by end of the financial year. NHS GGC is reporting an overall under spend of £1.5m (0.7%)

4.2 The anticipated spend on NHS GGC primary care prescribing for 2017-2018 is up to £8.5m in excess of the funding available despite the £10m efficiency plan for prescribing.

4.3 Discussions around the allocation of additional savings to Partnership areas are ongoing but for West Dunbartonshire this could be in the region of an additional £656k. This is in addition to the expected savings from the current savings plan of approximately £825k. (see 4.2)

4.4 Prescribing in West Dunbartonshire

In common with other areas of Scotland the population of West Dunbartonshire is ageing; the 2015 population estimates show a decline in the number of residents aged 16 and under with an increase in residents aged 60 and over[1]. With old age comes the increasing likelihood of morbidity with around 59% of over 75s likely to have two or more long term conditions[2]. In addition, health generally worsens as deprivation levels increase[3]. Within West Dunbartonshire 9 out of the 17 GP practices have more than one third of their patients living in the most deprived datazones.[4]

Table 1 below demonstrates that a greater proportion of our population compared to Scotland as a whole, suffer from these long term conditions and consequently are subject to polypharmacy, (taking more than 5 medicines) with its associated increased risks and costs[6].

Table 1
Raw Prevalence per 100 patients[5]

Condition	West Dunbartonshire	Scotland
COPD	2.81	2.29
Diabetes	5.41	4.97
Asthma	6.03	6.39
Heart Failure	1.09	0.85
Heart Disease	4.61	4.10
Hypertension	14.70	13.93
Stroke & TIA	2.48	2.20
Depression	7.12	6.80

The top 5 areas of prescribing, which represents 71.7% of the overall spend in the current year, reflect the health of our population and are noted in Table 2 below.

Table 2

Total Cost by BNF Approved Name	Prescribing cost to February 2017
04 Central Nervous System	£4,033,814
06 Endocrine System	£2,444,429
03 Respiratory System	£2,263,578
02 Cardiovascular System	£2,184,372
01 Gastro-intestinal System	£1,162,051
Total Schedule 4 Prescribing (GIC)	£17,592,176

4.4.1 Central Nervous System

This area includes medicines for a wide variety of conditions including anxiety, depression, insomnia and pain. The main cost pressures relate to the use of pregabalin (neuropathic pain) and co-codamol. The second patent for Lyrica (pregabalin) relating to pain is due to expire in mid July with costs reducing likely by August, however these anticipated savings have already been accounted for in this year's saving plan.

4.4.2 Endocrine System

This is an area of increasing costs due to the prescribing for patients with diabetes. In 2016/17 every GP practice in West Dunbartonshire participated in the prescribing initiative scheme indicator which encouraged a switch of blood glucose testing strips to the preferred list versions. This was well supported by the prescribing team and as a result 94% of practices have exceeded the target of a 25% switch. Consequently costs for these strips have reduced. For 2017/18 a further prescribing initiative has been offered to increase this percentage to 50%. The expected savings however are already accounted for in the current savings plan.

4.4.3 Respiratory System

Costs are driven by the use of inhalers for patients with asthma and Chronic Obstructive Pulmonary Disease (COPD). Recent work has concentrated on reducing the inappropriate prescribing of high dose steroid inhalers. The prescribing savings plan for 2017/18 already includes anticipated savings in this area by the switching of patients from one inhaler device to another more cost-effective device.

4.4.4 Cardiovascular System

This includes medicines for high blood pressure (hypertension), lowering cholesterol, for the treatment of angina or following a heart attack. The increased costs are primarily as a result of the continued increase in the use of New Oral Anticoagulants (NOAC's) which is in line with current guidance. The HSCP has 1004 patients on a Direct Oral Anticoagulant (DOAC**)** with 938 on Warfarin. Across all HSCPs Warfarin use has not significantly decreased.

4.4.5 Gastrointestinal System

These are drugs used to reduce the symptoms of reflux, to prevent or treat stomach ulcers and laxatives.

4.4.6 Table 4 below shows the spend to February 2017 on the top 10 individual medicines.

Table 4

West Dunbartonshire Health and Social Care Partnership		
March 2016 - February 2017		
Approved Drug Name	**Main Use**	**Total Gross Ingredient Cost for Drug (£)**
Pregabalin	Neuropathic pain	768,376
Tiotropium	COPD	622,471
Enteral Nutrition	Enteral Nutrition	545,488
Salmeterol with Fluticasone Propionate	Asthma/COPD	468,182
Apixaban	Anti-coagulant	403,916
Budesonide with Formoterol Fumarate	Asthma/COPD	384,823
Co-codamol	Pain	373,096
Blood Glucose Testing Strips	Blood Glucose Testing	276,000
Omeprazole	Reflux, Gastroprotection	232,082
Catheters - Urethral	Catheters - Urethral	223,450

Current additional cost pressures include a lack of availability of some commonly prescribed drugs leading to price increases. Non medicine prescribing increases on items such as oral nutritional supplements, catheters and stoma appliances are also a factor.

4.5 Within prescribing there are standard performance indicators which allow for comparison.

4.5.1 Examples of these measures include:

- The Annual Cost per weighted[a] GP list size - the figures for West Dunbartonshire show that overall spend on our population compares well with the rest of NHSGGC.
- Formulary Compliance - high formulary compliance, where GPs prescribe from an agreed list, indicates both good quality and cost effective prescribing. The current target for preferred list formulary prescribing is 78% which 16 out of our 17 GP practices are currently achieving. Overall West Dunbartonshire is one of the most formulary compliant areas.

4.5.2 Newer initiatives are measured using treated patients and include any patient within a practice who has received a prescription within a specified time period. This is more indicative of practice workload. Across West Dunbartonshire 77% of patients had received at least one prescription between Jan to Dec 2016.

4.6 Local Action

4.6.1 All practices have been offered the opportunity to participate in specific prescribing initiatives/indicators which will generate savings with a return on investment of 2 to 1.

4.6.2 We are providing training on safe and efficient medicines management and we provide support to minimise waste in all local Care Homes.

4.6.3 Referrals to our Community Prescribing Service (CAPS) to help patient and carers take the right medication continues, and social care medicines management is supported by a clear Medication Policy and training. A new e-learning module has been developed for Care at Home and Care Home staff.

4.6.4 Targeted Polypharmacy Reviews

Pharmacists look at all the medicines being taken by a patient and ensure that that they are all appropriate, safe and cost-effective. Currently these are being done for patients who have had a recent fall, frail elderly and nursing home patients.

4.6.5 Pharmacist Led Pain Clinics

These have been set up across the HSCP to allow for a more in depth review of patients with chronic pain (taking painkillers for > 3 months). Pilot work within West Dunbartonshire has shown that not only does it improve patients' quality of life and reduce GP workload but also has demonstrated a small reduction in the need for medication.

4.6.6 Within NHSGGC a HSCP Prescribing Efficiencies Group has been established to help clarify and put into practice any potential cost efficiency areas that have been identified at recent prescribing discussions. These include:

- Greater use of Scriptswitch (software which shows more cost-effective choices at the point of issuing a prescription)
- Greater use of serial dispensing
- Development of a Care Home Programme looking at reducing waste.

4.7 Prescribing Team

A full prescribing team is now in place. This has allowed more consistent time to focus and deliver prescribing support services and consequently an improvement in budgetary performance.

4.8 Primary Care Investment

In Autumn 2015, the Scottish Government announced details of funding to recruit pharmacists to work directly with GP practices to support the care of patients with long-term conditions and free up GP time. This funding allowed

for the recruitment of an additional 1.8 whole time equivalent (wte) pharmacists for West Dunbartonshire by the summer of 2016.

4.9 New Ways of Working

Inverclyde HSCP was identified to pilot the new General Medical Services (GMS) contract model for New Ways of Working which resulted in the equivalent of about 0.5 wte of pharmacist resource per practice. This has been well received and shown to reduce GP workload through clinical activities. Efficiencies delivery has been slower as there is not the same time to have a targeted focus on specific prescribing efficiencies. Therefore it is important that our current Prescribing Support Team continues to concentrate on core prescribing support activities and maintain their focus on supporting all prescribers to deliver good, cost-effective prescribing.

5. People Implications

5.1 There are no people implications arising from this report.

6. Financial Implications

6.1 Discussions around the allocation of £8.5m of additional savings to Partnership areas are ongoing, but for West Dunbartonshire this equates to a further savings target of £656. This is in addition to the required savings of £825k.

7. Professional Implications

7.1 Not applicable

8. Locality Implications

8.1 Not applicable

9. Risk Analysis

9.1 The risk associated with the savings is the potential impact on revenue budgets and our ability to sustain community services at the current levels. These services are also subject to savings requirements.

10. Impact Assessments

10.1 An Impact Assessment on the prescribing pressures will be undertaken once the savings challenge is known.

11. Consultation

11.1 Consultation with stakeholders will be planned once the savings challenge is known.

12. Strategic Assessment

12.1 The actions which are outlined in this paper will mitigate some of the effects of the savings challenge.

12.2 Impact on the overall priorities for community based services will require further analysis.

Author: **Christine McNeill**

Date: **31 May 2017**

Person to Contact: Pamela Macintyre, Prescribing Lead
01389 828293
Pamela.Macintyre@ggc.scot.nhs.uk

Appendices: None

Background Papers:

1. Social and Economic Profile 2017. West Dunbartonshire Council
2. The Scottish Government. The Scottish Health Survey, Volume 1: Main Report
3. http://www.isdscotland.org/Health-Topics/General-Practice/Publications/data-tables.asp
4. Health Inequalities in Scotland. Audit Scotland 2012
5. Quality & Outcomes Framework (QOF) for April 2015 - March 2016, Scotland Prevalence reported from QOF registers (practices with any contract type). ISD Scotland
6. Hajjar ER, Cafiero AC, Hanlon JT. Polypharmacy in Elderly Patients. *Am J Geriatr Pharmacother* 2007; 5: 345-351

Notes

a. Weighted Population - The current method for deriving a weighting formula is detailed on the website for the National Resource Allocation Committee (NRAC) - http://www.nrac.scot.nhs.uk/
This formula is used to inflate or deflate actual populations to provide a needs weighted population at every organisational level e.g. NHS Board, practice.

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31 May 2017

Subject: Local Code of Good Governance and Sources of Assurance

1. Purpose

1.1 To establish a Local Code with sources of assurance for adoption by the Integration Joint Board to review and assess its governance arrangements.

2. Recommendations

2.1 The HSCP Board is recommended to:

- Approve the adoption of the Local Code as detailed in Appendix 1 for the West Dunbartonshire Health and Social Care Partnership;
- Consider the Sources of Assurance as detailed in Appendix 2, for assessing the Partnership's compliance for each governance principle, and
- Note that a report will be presented to a future Audit Committee to advise of the outcome of the annual review.

3. Background

3.1 The West Dunbartonshire Health and Social Care Partnership Board is a legal entity in its own right created by Parliamentary Order, following ministerial approval of the Integration Scheme. The HSCP Board is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

3.2 The HSCP Board is also responsible for putting in place proper arrangements for the governance of its affairs and facilitating the effective exercise of its functions, which includes arrangements for the management of risk. In discharging this responsibility, the Chief Officer has put in place arrangements for governance which includes the system of internal control. This is designed to manage risk to a reasonable level, but cannot eliminate the risk to failure to achieve policies, aims and objectives and can therefore only provide reasonable but not absolute assurance of effectiveness.

3.3 In discharging these responsibilities, the Chief Officer has a reliance on the NHS and Local Authority systems of internal control that support compliance with both parent organisations policies and promotes achievement of each organisations aims and objectives, as well as those of the Partnership Board.

3.4 In order to demonstrate this, a governance statement for the Partnership is produced each year, which is included within the Annual Accounts. The Partnership Board is also required to review and assess the effectiveness of its governance arrangements and control environment annually.

3.5 As part of this, the Chief Internal Auditor carried out a review of the Partnership Board's Governance, Performance and Financial Management. The report findings were presented to the 22 March 2017 Board and it was the Chief Auditor's opinion that "the systems examined are generally working effectively".

4. Main Issues

4.1 *Delivering Good Governance in Local Government: Framework,* published by CIPFA in association with Solace in 2007, set the standard for local authority governance in the UK. CIPFA and Solace reviewed the Framework in 2015 to ensure it remained 'fit for purpose' and published a revised edition in spring 2016. The new Delivering Good Governance in Local Government: Framework (CIPFA/Solace, 2016) applies to annual governance statements prepared for the financial year 2016/17 onwards.

4.2 While the Framework is written in a local authority context, most of the principles are applicable to the IJB, particularly as legislation recognises IJBs as a local government body under Part VII of the Local Government (Scotland) Act 1973, and therefore subject to the local authority accounting code of practice. Also, West Dunbartonshire Council, on 8 March 2017, adopted a revised Code of Good Governance based on this framework and many of the assurances will be contained in the same documents.

4.3 It is proposed that the Partnership establishes a Local Code of corporate governance (Appendix 1) based on the seven principles of CIPFA's and SOLACE's Framework:

- behaving with integrity, demonstrating strong commitment to ethical values and representing the role of the law;
- ensuring openness and comprehensive stakeholder engagement;
- determining outcomes in terms of sustainable economic, social and environmental benefits;
- determining the interventions necessary to optimise the achievement of intended outcomes;
- developing the entity's capacity, including the capability of its leadership and the individuals within it;
- managing risk and performance through robust internal control and strong public financial management and
- implementing good practices in transparency, reporting and audit to deliver effective accountability.

4.4 It is also proposed that an annual review and assessment of the Partnership's governance arrangements and control environment continues to be framed within the context of the seven CIPFA/SOLACE good governance principles. This will identify any weaknesses and improvement actions required. Attached at Appendix 2 are the proposed sources for assessing the Partnership's compliance for each governance principle.

5. People Implications

5.1 None.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Risk Analysis

8.1 Without a Local Code and sources of assurance for governance arrangements, there is a risk that the Partnership Board does not have an effective framework for assessment of its governance arrangements and control environment.

9. Impact Assessments

9.1 None. .

10. Consultation

10.1 This report was prepared in conjunction with the Partnership Board's Chief Internal Auditor, the Council's Chief Finance Officer and the Health Board's Assistant Director of Finance.

11. Strategic Assessment

11.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the strategic priorities of the Strategic Plan.

Julie Slavin
Chief Financial Officer
31 May 2017

Person to Contact:	Julie Slavin – Chief Financial Officer, Garshake Road, Dumbarton, G82 3PU, Telephone: 01389 737311 E-mail julie.slavin@ggc.scot.nhs.uk
Appendices:	Appendix 1 – WDHSCP Local Code of Good Governance Appendix 2 - Sources of Assurance
Background Papers:	Delivering Good Governance in Local Government Framework (CIPFA/SOLACE, 2016) Revised Local Code of Good Governance - WDC Audit and Performance Review Committee 8 March 2017. Audit Report – WDHSCP Governance, Performance and Financial Management Review – March 2017
Wards Affected:	All

Appendix 1

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Local Code of Good Governance

Document Title:	WDHSCP Board Local Code of Good Governance	Owner:	Chief Financial Officer
Version No.	v1	Superseded Version:	N/A
Date Effective:	31st May 2017	Review Date:	01/04/2020

1.0 Introduction

1.1 West Dunbartonshire Health & Social Care Partnership Board is responsible for the strategic planning and reporting of a range of health and social care services delegated to it by NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council (described in full within its approved Integration Scheme). The Council and the Health Board discharge the operational delivery of those delegated services (except those related to the Health Board's Acute Division services most commonly associated with the emergency care pathway) through the partnership arrangement referred to as West Dunbartonshire Health & Social Care Partnership. The Health & Social Care Partnership Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership.

1.2 The West Dunbartonshire Health & Social Care Partnership Board's:

- Mission is to improve the health and wellbeing of West Dunbartonshire.
- Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.
- Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.

1.3 The Partnership Board is a legal entity in its own right created by Parliamentary Order, following ministerial approval of the Integration Scheme. It is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a major function of management and, therefore, a responsibility placed upon the appointed members and officers of the Partnership Board.

1.4 The Health & Social Care Partnership Board positively promotes the principles of good governance within all areas of its affairs. Its Audit Committee is an essential component of the governance of the Health & Social Care Partnership Board detailed within its Financial Regulations.

1.5 The Chartered Institute of Public Finance & Accountancy (CIPFA) *Delivering Good Governance in Local Governance Framework* define a set of principles that should underpin the governance of local government organisations. The objective of the Framework is to help local government in taking responsibility for developing and shaping an informed approach to governance, aiming at achieving the highest standards in a measured and proportionate way. Whilst the Framework is written in a local authority context, most of the principles are applicable to the Partnership Board, particularly as the legislation recognises integration joint boards as Section 106 local government bodies (as per Part VII of the Local Government [Scotland] Act 1973) - and therefore subject to the local authority accounting code of practice.

1.6 Based on the Framework's principles, the following Local Code of Good Governance has been adopted by Partnership Board, namely:

- Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of law.
- Ensuring openness and comprehensive stakeholder engagement,
- Defining outcomes in terms of sustainable economic, social and environmental benefits.
- Determining the interventions necessary to optimise the achievement of intended outcomes.

- Developing the entity's capacity, including the capability of its leadership and the individuals within it.
- Managing risk and performance through robust internal control and strong public financial management.
- Implementing good practices in transparency, reporting, and audit to deliver effective accountability.

1.7 This Code reinforces the requirements of the Standards Commission for Scotland that - as per the approved Standing Orders of the Health and Social Care Partnership Board - members of the Partnership Board shall comply with the Code of Conduct for Members of Devolved Public Bodies and the Guidance relating to that Code of Conduct (both of which are incorporated into those Standing Orders). As such, this Code of Good Governance should be work in tandem with the Partnership Board's local *Code of Conduct for Members*, which emphasises the obligation on the Partnership Board – both individually and collectively – to exemplify in their conduct the following principles:

- **Duty**
  You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of West Dunbartonshire Health & Social Care Partnership Board and in accordance with the core functions and duties of the Partnership Board.
- **Selflessness**
  You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.
- **Integrity**
  You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.
- **Objectivity**
  You must make decisions solely on merit and in a way that is consistent with the functions of West Dunbartonshire Health & Social Care Partnership Board when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.
- **Accountability and Stewardship**
  You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that West Dunbartonshire Health & Social Care Partnership Board uses its resources prudently and in accordance with the law.
- **Openness**
  You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.
- **Honesty**
  You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership**
  You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of West Dunbartonshire Health & Social Care Partnership Board and its members in conducting public business.
- **Respect**
  You must respect fellow members of West Dunbartonshire Health & Social Care Partnership Board and employees of related organisations supporting the operation of the

Partnership Board and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of West Dunbartonshire Health & Social Care Partnership Board.

1.8 The Partnership Board has established its Audit Committee as a Committee of the Partnership Board to support it in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. The Terms of Reference for the Audit Committee reflect the span of responsibilities of the Partnership Board and requirements of its approved Financial Regulations, i.e.:

- The Strategic Plan.
- Financial plan underpinning the Strategic Plan.
- The operational delivery of those integrated services delegated to the Partnership Board (except for NHS acute hospital services).
- Relevant issues raised by the internal auditors of the Health Board, Council and the Partnership Board.

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board
Local Code of Good Governance – Assurance Review & Assessment
Owner: Chief Financial Officer Status: Draft Approval Date: Review Date:

Governance Principle		
Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of the law.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
• Integration Scheme • Governance Arrangements, Structures and Terms of Reference (Partnership Board and Audit Committee) • Standing Orders • Code of Conduct • Local Code of Good Governance • Declaration of Interests • Minutes of meetings of Partnership Board and Audit Committee • Strategic Plan • Workforce & Organisational Development Strategy - Health & Social Care Partnership Board Development • Participation & Engagement Strategy • Strategic Partnership Agreements • Financial Regulations • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Annual Audit Report 2015/16 by Audit Scotland as external (third party) auditors • Audit Plans (Internal and Third Party) • Information Governance (including Freedom of Information, Information	• Standing Orders • Scheme of Delegation • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Statutory Officers and Statutory Appointments • Financial Regulations/Procedures • Financial Reporting and Scrutiny across Management Structures (e.g., budget monitoring) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Chief Social Work Officer Annual Report • Information Governance (including Freedom of Information, Records Management, Information Sharing and Information and Physical Security) • Employee Code of Conduct • HR Policies and Procedures (including Whistleblowing Policy) • Declaration of Interests (required staff) • Gifts and Hospitality Declaration • Anti-Bribery/Fraud Policy	• Standing Orders • Schedule of Reserved Decisions • Scheme of Delegation and Standing Financial Instructions • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Financial Procedures • Financial Reporting and Scrutiny across Management Structures • Clinical Governance and Integrated Clinical and Professional Governance Arrangements and Reporting • Information Governance (Freedom of Information, Records Management, Information Sharing and Information Security) • Staff Survey (iMatters) • Employee Conduct Policy • NHSGGC Board Members Code of Conduct • eKSF Processes/Objective Setting • HR Policies and Procedures (including Whistleblowing Policy) • Complaints Handling Procedure

Governance Principle		
Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of the law.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
Sharing and Publication Scheme) • Governance Arrangements, Structures and Terms of Reference (Partnership Board and Audit Committee) • Complaints Handling Procedure • Equalities Mainstream Report • Integrated Clinical and Care Governance Arrangements and Reporting • Internal Audit Report of the Partnership Board's Governance, Performance and Financial Management Arrangements	• Complaints Handling Procedure • Equalities Arrangements (including EQIAs) • Health and Safety Arrangements (including policies and procedures and audits) • Workforce Plan (including Organisational Development Strategy) • Supervision and Personal Development Plan Framework • Staff Induction • Staff Survey • Communications Strategy • Staff Engagement Opportunities	• Equalities Arrangements (including EQIAs) • Health and Safety Arrangements (including policies and procedures and audits) • Workforce Plan (including Organisational Development Strategy) • Supervision and Personal Development Plan Framework • Staff Induction • Staff Survey • Communications Strategy • Staff Engagement Opportunities

Governance Principle		
Ensuring openness and comprehensive stakeholder engagement.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
• Governance Arrangements and Structure (Partnership Board and Audit Committee) • Partnership Board Membership (incl. Stakeholder Members for patients/service users, carers, third sector and Trade Unions) • Publication of Partnership Board and Audit Committee papers and minutes of public meetings • Strategic Plan • Annual and Quarterly Public Performance Report • On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning) • Strategic Partnership Agreements • Locality Group Work Plans • Participation and Engagement Strategy • Equalities Mainstreaming Report • Locality Engagement Networks • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • Complaints Handling Procedure • HSCP website	• Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Strategic Plan • Performance Management Framework and Reporting • Information Governance (Freedom of Information, Records Management and Information Sharing) • Publication of Committee papers • Workforce Plan (including Organisational Development Strategy) • Supervision Framework • Staff Survey • Practice Governance (social care) arrangements • Communications Strategy • Equalities Arrangements (including EQIAs) • Trade Union liaison and engagement	• NHSGGC Feedback Service • NHSGGC Local Delivery Plan • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Performance Management Framework and Reporting • Information Governance (including Freedom of Information, Records Management, Information Sharing and Information Security) • Publication of Board papers • Workforce Plan (including Organisational Development Strategy) • Supervision Framework • Staff Governance Framework • Staff Survey (iMatters) • Communications Strategy • Staff Engagement Opportunities • Equalities Arrangements (including EQIAs) • Trade Union liaison and engagement

Governance Principle		
Defining outcomes in terms of sustainable economic, social and environmental benefits.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
• Strategic Plan • Annual and Quarterly Performance Report • On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning) • Strategic Partnership Agreements • Locality Group Work Plans • Participation and Engagement Strategy • Equalities Mainstreaming Report • Locality Engagement Networks • Performance Management Framework and Reporting • Annual and Quarterly Public Performance Report	• Strategic Plan • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Performance Management Framework and Reporting • Annual Performance Report	• NHSGGC Local Delivery Plan • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Performance Management Framework and Reporting • Annual Performance Report

Governance Principle		
Determining the interventions necessary to optimise the achievement of intended outcomes.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
• Strategic Plan (including financial strategy) • Risk Management Strategy and Procedure and Reporting • Integrated Strategic Risk Register • Business Continuity Plan • Preparation of Budgets in accordance with Strategic Plan • Budget Monitoring and Reporting • Approved Savings and Recovery Plans • Annual and Quarterly Public Performance Reports • Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme)	• Strategic Plan • Risk Management Strategy and Procedure and Reporting • Resilience Plans and Arrangements (Business Continuity and Emergency Plans) • Preparation of Budgets in accordance with organisational objectives, strategies and the medium term financial plan • Budget Monitoring and Reporting • Medium Term Financial Strategy • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information and Physical Security) • Health and Safety Arrangements (including policies and procedures and audits)	• NHSGGC Local Delivery Plan • Risk Management Strategy and Procedure and Reporting • Resilience Plans and Arrangements (Business Continuity and Emergency Plans) • Budget Monitoring and Reporting • Preparation of Budgets in accordance with organisational objectives and strategies • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical Governance and Integrated Clinical and Professional Governance Arrangements and Reporting • Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information Security) • Health and Safety Arrangements (including policies and procedures and audits)

Governance Principle		
Developing the entity's capacity, including the capability of its leadership and individuals within it.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
• Standing Orders • Code of Conduct • Scheme of Delegation • Local Code of Good Governance • Workforce & Organisational Development Strategy - Health & Social Care Partnership Board Development • Complaints Handling Procedure • Equalities Mainstream Report • Integrated Clinical and Care Governance Arrangements and Reporting • Joint Management Teams • Internal Audit Report of the Partnership Board's Governance, Performance and Financial Management Arrangements	• Workforce Plan (including Organisational Development Strategy) • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Scheme of Delegation • Elected Member Induction • Staff Induction • Leadership, Leader Pairings and Staff Development and Training Opportunities • Supervision and Personal Development Plan Framework • Staff Groups for Equalities and Diversity • Trade Union liaison and engagement	• Workforce Plan (including Organisational Development Strategy) • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Clinical and Care Governance Arrangements and Reporting • Board Members Induction • Staff Induction • Leadership, First Line Management and Staff Development and Training Opportunities • Supervision and Personal Development Plan Framework • Staff Groups for Equalities and Diversity • Trade Union liaison and engagement

Governance Principle		
Managing risk and performance through robust internal control and strong public financial management.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
• Integration Scheme • Financial Regulations • Standing Orders • Audit Committee – Terms of Reference • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Annual Audit Report • Annual Governance Statement • Strategic Plan (including financial strategy) • Risk Management Strategy and Procedure and Reporting • Integrated Strategic Risk Register • Business Continuity Plan • Preparation of budgets in accordance with Strategic Plan • Budget Monitoring and Reporting • Approved Savings and Recovery Plans • Annual and Quarterly Public Performance Reports • Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme)	• Financial Regulations • Standing Orders • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Audit Committee – Terms of Reference • Risk Management Strategy and Procedures and Reporting • Anti-Bribery/Fraud Policy • Audit Plans and Assurance (Internal and Third Party) • Annual Governance Statement • Medium Term Financial Strategy • Budget Monitoring and Reporting • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information and Physical Security) • Procurement regulations, training and development • Contract Management Framework • Project Management Framework	• Schedule of Reserved Decisions • Scheme of Delegation and Standing Financial Instructions • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Financial Procedures • Annual Governance Statement • Budget Monitoring and Reporting • Financial Reporting and Scrutiny across Management Structures • Risk Management Strategy and Procedures and Reporting • Fraud Policy • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Records Management, Information Sharing and Information Security)

Governance Principle		
Implementing good practices in transparency, reporting and audit to deliver effective accountability.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
• Integration Scheme • Financial Regulations • Governance Arrangements and Structure (Partnership Board and Audit Committee) • Publication of Partnership Board and Audit Committee papers and minutes of public meetings • Strategic Plan (including financial strategy) • Annual and Quarterly Public Performance Report • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Annual Audit Report • Risk Management Strategy and Procedure and Reporting • Integrated Strategic Risk Register • Business Continuity Plan • Preparation of budgets in accordance with Strategic Plan • Budget Monitoring and Reporting • Approved Savings and Recovery Plans • Annual and Quarterly Public Performance Reports • Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party)	• Committee Reporting Framework and Schedule • Publication of Committee papers • Financial Regulations/Procedures • Financial Reporting and Scrutiny across Management Structures (e.g., Budget Monitoring) • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Risk Management Strategy and Procedure and Reporting • Performance Management Framework and Reporting • Annual Performance Report • Audit Plans and Assurance (Internal and Third Party) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • Council Website	• Committee Reporting Framework and Schedule • Publication of Board papers • Financial Regulations/Procedures • Financial Reporting and Scrutiny across Management Structures (e.g., Budget Monitoring) • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Risk Management Strategy and Procedure and Reporting • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • Board Website

Governance Principle		
Implementing good practices in transparency, reporting and audit to deliver effective accountability.		
Sources of Assurance		
Partnership Board	**WDC**	**NHSGGC**
• Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • HSCP website		

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31 May 2017

Subject: 2016/17 Financial Performance and 2017/18 Annual Revenue Budget Updates Report

1. Purpose

1.1 To provide the Health and Social Care Partnership Board with:

- An update on the financial performance of the West Dunbartonshire Council Health & Social Care Partnership for the period to 31th March 2017;
- An update on the level and utilisation of reserves based on this financial performance; and
- An update on the 2017/18 revenue budget position.

2. Recommendations

2.1 The HSCP Board is recommended to:

- Agree that the 2016/17 Unaudited Accounts for the Partnership will be presented to the 22 June 2017 Audit Committee for review prior to submission to external audit;
- Note that the revenue position is reporting an underspend of £3.112m (2.16%) for the period 1 April 2016 to 31 March 2017;
- Note that management action on reducing cost pressures and maximising income has resulted in an improved year end position of £0.245m;
- Approve the movement in the reserves position for both earmarked and unearmarked funds for inclusion in the 2016/17 unaudited annual accounts;
- Approve the proposals on the application of reserves to underwrite potential delays in delivery of 2016/17 health care savings, prescribing pressure and transformation/service redesign programmes in line with Strategic Plan priorities;
- Note the contents of the letter from the outgoing Chief Executive of NHSGG&C regarding the application of the £3.6m reduction in the 2017/18 budget allocation across all HSCPs; and
- Note the updated position in relation to the 2017/18 budget.

3. Background

2016/17 Year End Position and Unaudited Annual Accounts

3.1 Integrated Joint Boards are specified as 'section 106' bodies in terms of the Local Government (Scotland) Act 1973, and consequently are expected to prepare their financial statements in compliance with the Local Authority Accounts (Scotland) Regulations 2014 (the regulations) and the Code of Practice on Accounting for Local Authorities in the United Kingdom.

3.2 The Scottish Government introduced the regulations to update the governance arrangements relating to the authorisation and approval of a section 106 body's annual accounts. The regulations require that unaudited accounts are submitted to the auditor no later than 30 June immediately following the financial year to which they relate.

3.3 Scottish Government guidance states that best practice would reflect that the IJB or committee whose remit includes audit and governance should consider the unaudited accounts prior to submission to the external auditor.

3.4 As per West Dunbartonshire Health and Social Care Partnership Audit Committee "Terms of Reference" the unaudited accounts of WDHSCP will be presented to the 22 June 2017 Audit Committee for consideration and review.

3.5 Work is currently underway preparing the draft unaudited accounts, however an interim outturn position as at 31March 2017 (Period 12) is provided below which updates on the 1 March 2017 finance report to the Board which covered the period to 31December 2016 (Period 9).

3.6 For the purpose of providing direction to both the Health Board and the Council changes to the budget allocation since the 1 March report are detailed below:

Health Board Allocation

3.7 At the meeting of Health Board on 28th June 2015, NHS Board Members agreed the revenue estimates for 2016/17, including a total net Partnership budget of £74.494m.

3.8 Since the previous reported budget the following adjustments have taken place from Period 9 to Period 12 revising the net expenditure budget to £82.899m.

	£'000
Budget at Period 9 2016/17	**82,692**
Additional Allocations of:	
CFO 50% Funding from Corporate	26
Recurring GP Issues Budget to HSCPs (stationery/supplies etc)	53
Recurring GMS Xchg 16/17	36
Non recurring Specialist Children CAMHS – Scottish Govt	17
Recurring FHS Other Recharges	901
Recurring transfer of Hospital Based Prescriptions to HSCPs	10
Recurring Learning Disability RAM – unregistered nurse funding	9
Deductions of:	
WD Live Action Post transfer to Corporate PHI	-25
Transfer Telecoms Budget to Corporate Facilities	-79
Prescribing Final Sch 4 Adjustment to Outturn	-28
Recurring FHS Other Recharges	-713
Revised budget at Period 12 2016/17	**82,899**

Council Budget Allocation

3.9 At the meeting of West Dunbartonshire Council on 24 February 2016, Members agreed the revenue estimates for 2016/2017, including a total net West Dunbartonshire Health & Social Care Partnership budget of £61.539m.

3.10 There have been some small budget movements reported throughout the year, but no further changes since the last report as at period 9 of £61.514m.

4.0 Main Issues

Summary Position 2016/17 as at 31 March 2017

4.1 The West Dunbartonshire Health & Social Care Partnership revenue position is reporting for the period 1 April to 31 March 2017 an underspend of £3.112m (2.16%), an improvement of £0.245m on the projection as at 31 December 2016.

4.2 The Partnership's NHS Health Care budget is reporting an overall break even position. As reported to the 1 March 2017 Board, this position reflects the transfer of underspends in other funding streams such as Delayed Discharge and Integrated Care Fund to earmarked reserves and a number of direct service delivery underspends to unearmarked reserves, see section 4.11 below.

4.3 The Social Care budget is reporting a net underspend for the year of £3.112m (5.06%). All but £0.118m relates to the flow through of the unallocated Social Care Fund, which for accounting purposes requires to be transacted within

revenue expenditure budgets before any residual (£2.994m) is transferred to Reserves at year end, see section 4.11 below.

4.4 The summary position is reported within the following table. Additional detailed breakdown of individual costs at care group level are reported in Appendix 1 of this report.

	Annual Budget	YTD Actuals	Variance	Variance	Forecast	Variance	Movement
	£000's	£000's	£000's	%	Variance	%	Variance
Health Care	87,439	87,439	0	0.00%	0	0.00%	0
Social Care	87,232	84,136	3,096	3.55%	3,124	3.58%	(28)
Expenditure	**174,671**	**171,575**	**3,096**	**1.77%**	**3,124**	**1.79%**	**(28)**
Health Care	**(4,541)**	**(4,541)**	**0**	0.00%	0	0.00%	0
Social Care	**(25,718)**	**(25,734)**	**16**	-0.06%	(257)	1.00%	273
Income	**(30,259)**	**(30,275)**	**16**	**-0.05%**	**(257)**	**0.85%**	**273**
Health Care	82,899	82,899	0	0.00%	0	0.00%	0
Social Care	61,514	58,402	3,112	5.06%	2,867	4.66%	245
Net Expenditure	**144,413**	**141,301**	**3,112**	**2.16%**	**2,867**	**1.99%**	**245**

4.5 Within Health Care services there were a small number of minor changes to the previously reported variances, mainly around securing additional turnover within Adult Community Mental Health and Learning Disability in response to the required delivery of 2016/17 approved savings from the start of 2017/18.

4.6 As per 4.2 above, year end service underspends, secured through proactive management action, will be held in reserve to mitigate any future budget volatility and underwrite the delivery of approved savings plans.

4.7 Within Social Care, the table at 4.4 above highlights that additional income was the main reason for the increase to the previously reported underspend. Higher than anticipated client contributions to the cost of older people's residential care is the main source of this.

4.8 General Fund Reserve Position

4.9 The opening reserves position for 2016/17 was £0.492m unearmarked and £1.119m earmarked. There have been a number of draw downs on the earmarked reserves in line with planned service expenditure (detailed below).

4.10 The Annual Accounts will include a Movement in Reserves Statement which presents how the Income and Expenditure account surplus for the year reconciles to the final reserves position.

4.11 Subject to audit the anticipated reserves position is shown below:

2017/18 General Fund Reserve - estimated position	2016/17 Opening Balance	2016/17 Projected Drawdown	2016/17 Projected Additions	2016/17 Closing Balance
	£000			
Unearmarked - General	492.2	0.0	108.4	600.6
Unearmarked - Social Care Fund	0.0	0.0	1,993.5	1,993.5
	492.2	**0.0**	**2,101.9**	**2,594.1**
Earmarked				
Integrated Care Fund	300.9	-300.9	555.3	555.3
Delayed Discharge	275.3	-191.3	86.9	170.9
GIRFEC NHS	205.0	-30.4	0.0	174.6
GIRFEC Council	24.5	-9.7	0.0	14.8
MSK Physio	46.0	-46.0	0.0	0.0
Opthalmolgy	20.6	-20.6	0.0	0.0
Criminal Justice - transitional funds	47.0	47.0	60.3	154.3
DWP Conditions Management	200.0	-15.8	0.0	184.2
TEC (Technology enabled care) project	0.0	0.0	117.6	117.6
Cluster lead funding	0.0	0.0	25.5	25.5
SMT Leadership development fundng	0.0	0.0	3.0	3.0
Social Care Fund - Service Redesign and Transformation	0.0	0.0	1,000.0	1,000.0
Prescribing	0.0	0.0	656.0	656.0
	1,119.3	**-567.7**	**2,504.6**	**3,056.2**
Total Reserves	**1,611.5**	**-567.7**	**4,606.5**	**5,650.3**

4.12 In line with the Reserves Policy the anticipated 2016/17 year end reserves position was presented to the partnership board in the 1 March 2017 Annual Budget Report. This contained the proposal that a proportion of the unallocated 2016/17 Social Care Fund be earmarked for service redesign and transformation projects, in particular the delivery of the new older people care homes and day centres in Dumbarton and Clydebank. Subject to audit review this approval is sought from the board.

4.13 Also detailed in the report was an update on the expected delivery of the 2016/17 approved Health Care savings gap of £0.955m, deferred to 2017/18 after the application of non recurring relief from NHSGG&C Health Board. It is anticipated that approximately 70% (£0.661m) can be deliverable by the start of 2017/18; however it is recommended that any delay and the residual balance should be "smoothed out" by the application of general unearmarked reserves.

4.14 It is also recommended that an element of the reserves balance is earmarked for 2017/18 prescribing savings pressure as reported to the March 2017 Board and explained in more detail in section 5 below.

5.0 2017/18 Annual Revenue Budget Update

5.1 This section of the report is a continuation of previous 2017/18 budget update reports presented to the Partnership Board on 1st and 22nd March 2017, detailing the impact the Scottish Government's budget announcements had on the budget allocation offers made by our funding partners. The key messages from the financial settlement offers were:

- NHS contributions to Integration Authorities (IAs) for delegated health functions will be maintained at least at 2016/17 cash levels;
- Local authorities will be able to adjust their allocations to IAs by up to their share of £80 million below the level of budget agreed in 2016/17; and
- An additional £107m of Social Care funding, routed through Health Boards, in addition to the £250m received in 2016/17.

5.2 The Health Board's indicative budget allocation (formal approval of budget by NHSGG&C Board is not anticipated until June/July 2017) was not accepted on the basis that the application of historic savings targets of £3.6m (originally £7.8m) would bring the contribution below 2016/17 cash levels.

5.3 The 2017/18 Annual Revenue Budget Update Report of the 22 March 2017, provided members with an update on the progress made with regard to the indicative funding allocation for 2017/18 from NHSGG&C and the recommendation to approve an anticipated budget allocation of £80.676m. This was based on the recurring budget as at 31st December 2016 (Period 9), subject to adjustment for actual prescribing outturn and its impact on the 2017/18 budget level.

5.4 This indicative flat cash allocation is inclusive of the 2016/17 Social Care Fund recurring allocation of £4.921m, of which £1.260m was passed to the Council for previously funded pressures. The 2017/18 Social Care Fund allocation of £2.087m, detailed below, is in addition to the flat cash £80.676m anticipated budget allocation approved on 22nd March 2017.

	Scotland £m	WD HSCP £m (1.95%)
Full year effect of the Living Wage of £8.25/hr	50	0.975
Increase Living Wage to £8.45/hr	20	0.390
Sleepovers	10	0.195
Sustainability	20	0.390
Implementation of Carers Legislation	2	0.039
Veterans Pension Disregard	5	0.098
TOTAL	**107**	**2.087**

5.5 Current Position - NHS Greater Glasgow and Clyde

5.6 The previous March 2017 budget reports sets out the budget negotiations through the correspondence between the Chief Officer and the former Chief Executive of NHSGG&C. Including, formal notification by the Chief Officer on 7th March 2017 (Appendix 2), of the Partnership Board's decision not to accept the indicative budget allocation.

5.7 The Chief Officer received a response on 29th March 2017 (Appendix 3), detailing that in line with the Board's Standing Orders the decision, approved on 21st February 2017, to reduce the £7.8m 2015/16 saving to £3.6m would stand and would therefore be reflected in 2017/18 budget allocations.

5.8 The new Chief Executive has been briefed on the current position and all 6 Chief Officers continue to pursue a satisfactory resolution. As detailed in the 1st March budget report the total inflation and other pressures faced by the HSCP are as follows:

Inflation and Pressures	**WD HSCP £m**
Salaries	0.336
Contracts, PPP & Supplies	0.031
Prescribing Uplift	0.656
Resource Transfer	0.145
Apprentice Levy	0.129
Pension Costs	0.095
Total Inflation & Pressures	**1.392**
2015/16 Unachieved CHCP Savings	0.274
Total Pressure	**1.666**

Prescribing

5.9 The last reported position to the Partnership Board was an anticipated GP prescribing overspend of £0.070m based on November data. Latest projections based on February 2017 data is reporting an improved position of £0.010m (0.06%) overspend against a full year prescribing allocation £19.3million. It is anticipated that WDHSCP achieve financial balance by end of the financial year and will not require its position to be neutralised under the risk sharing arrangements. The final 2016/17 prescribing outturn is due by the end of May 2017 and until this information is available the 2017/18 budget allocation cannot be confirmed, however NHSGG&C is projecting an overall outturn underspend of £1.5m (0.7%) for 2016/17 financial year.

5.10 This position has already been factored into the NHSGG&C's overall prescribing pressure for 2017/18, which before the application of £8m of savings and efficiency plans stood at £16.5m budget shortfall. The remaining £8.5m pressure attributable to HSCPs is being considered by a newly formed Prescribing Efficiency Group, consisting of cross party representation across HSCPs, GP practice and the Board's prescribing advisors.

5.11 This group held its first workshop on 26th April 2017 with a follow up scheduled for 8th June 2017. Headline areas from this initial seminar include the application of ScriptSwitch, Polypharmacy, Serial Dispensing, Repeat Prescribing and Care Home reviews aimed at driving down volumes and costs and influencing current prescribing practice across both Acute and Community.

5.12 If these measures fail to deliver additional savings in 2017/18 the likely share of the £8.5m shortfall to this partnership is in the region of £0.656m. However this cannot be confirmed until 2017/18 budget allocations are considered and following on from this whether a new risk sharing arrangement can be agreed among the six HSCPs and the Board.

5.13 Given the financial risk around covering the likely shortfall of £0.656m, on top of an already ambitious £8.0m programme for savings and efficiencies, it is the recommendation of the Chief Financial Officer that an element of the reserve balance is earmarked (see 4.11 above), to underwrite this risk until a more definitive position is agreed and plans put in place to delivery this on a recurring basis.

Set Aside Budget

5.14 There has been no update on the 2017/18 set aside budget for large hospital services or any developments on how this significant resource plays into shifting the balance of care. However the Scottish Government has committed to working with Integration Authorities and Health Boards to better understand the effectiveness of current arrangements.

5.15 For 2016/17 the partnership was allocated an indicative set aside budget of £17.066m. The final allocation will require to be presented in the annual accounts where it will be reported that activity levels match budget allocated.

National Care Home Contract (NCHC) Uplift 2017/18

5.16 The COSLA Leaders Group approved a 2.8% uplift in the 2017/18 NCHC effective from 10th April 2017, which requires providers to pay all adult social care workers £8.45/hr from 1st May 2017.

5.17 The approved budget allocation from WDC included an uplift of 2.5% for the NCHC, thus leaving a shortfall of 0.3% or approximately £0.036m which will require to be funded from the £2.087m additional Social Care funding for Living Wage detailed in 3.5 above.

Living Wage

5.18 The Partnership Board previously approved the commitment to pay all adult social care workers £8.25/hr from 1st October 2016 and £7.20/hr for sleepovers from the 2016/17 Social Care Fund.

5.19 The Scottish Government's commitment to the Scottish Living Wage will see the rate increase to £8.45/hr from 1st May 2017. This £0.20 increase equates to a 2.4% uplift on the basic rate, however the 2017/18 allocation of Social Care funding (refer 3.5 above) requires consideration be given to provider sustainability.

5.20 There have been initial discussions with our providers on the available funding and the overall budget position of the HSCP. There is recognition that current service delivery models which rely heavily on the use of sleepovers require to be reviewed and must be factored into current negotiations. Work is underway on how the living wage commitment can be delivered within existing resources.

Savings Performance

5.21 The previous March budget reports approved the application of £2.0m of 2016/17 recurrent Social Care funding to cover the gap between the approved budget allocation from WDC and the projected cost of service delivery in 2017/18.

5.22 The Health Care budget pressure linked to a "flat cash" allocation, detailed in 5.8 above was also considered in the March budget reports. Excluding the on-going work around the prescribing budget gap and the continuation of the risk sharing arrangement, it was approved that the pay and inflation pressure be covered with the least disruption to front line services by the application of a 2% turnover target to all service areas. Budget holders will be expected manage this within the totality of their service budgets. This will be closely monitored and regular updates will be provided in future finance reports.

6.0 People Implications

6.1 None.

7.0 Financial Implications

7.1 All known financial implications are covered in the report above.

8.0 Professional Implications

8.1 None

9.0 Risk Analysis

9.1 If agreement cannot be reached between the HSCP and NHSGG&C on the 2017/18 budget allocation then Dispute Resolution measures may require to be implemented.

10.0 Impact Assessments

10.1 None.

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11.0 Consultation

11.1 The Council's Section 95 Chief Financial Officer and the Health Board's Assistant Director of Finance have been consulted on this report. The Chief Financial Officer would like to extend thanks to both colleagues for their input into the budget setting process.

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12.0 Strategic Assessment

12.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the strategic priorities of the Strategic Plan.

Julie Slavin
Chief Financial Officer
31 May 2017

Person to Contact:	Julie Slavin – Chief Financial Officer, Garshake Road, Dumbarton, G82 3PU, Telephone: 01389 737311 E-mail julie.slavin@ggc.scot.nhs.uk
Appendices:	Appendix 1 – Health & Social Care Financial Statement as at 31 March 2017 (Period 12) Appendix 2 – Chief Officer's letter of 7 March 2017 to Chief Executive NHSGG&C Health Board Appendix 3 - Chief Executive NHSGG&C Health Board of 29 March 2017 to Chief Officer
Background Papers:	HSCP Board Reports 1st and 22nd March 2017 – 2017/18 Annual Revenue Budget/Update
Wards Affected:	All

West Dunbartonshire Health & Social Care Partnership — **Appendix 1**

Financial Year 2016/17 period 12 covering 1 April to 31 March 2017

Health Care Expenditure	Annual Budget £000's	Actual £000's	Variance £000's	Variance %
Planning & Health Improvements	935	928	7	1%
Children Services - community	2,626	2,615	11	0%
Children Services - specialist	1,657	1,657	0	0%
Adult Community Services	13,138	13,110	28	0%
Community Learning Disabilities	582	588	(6)	-1%
Addictions	1,890	1,845	44	2%
Mental Health - Adult Community	4,377	4,201	177	4%
Mental Health - Elderly Inpatients	3,415	3,415	0	0%
Family Health Services (FHS)	24,406	24,406	0	0%
GP Prescribing	19,294	19,294	0	0%
Other Services	1,445	1,784	(340)	-24%
Resource Transfer	12,828	12,828	0	0%
Hosted Services	848	770	78	9%
Expenditure	87,439	87,439	0	0%
Income	(4,541)	(4,541)	0	0%
Net Expenditure	**82,899**	**82,899**	**0**	0%

Social Care Expenditure	Annual Budget £000's	YTD Budget £000's	Variance £000's	% Variance %
Strategy Planning and Health Improvement	1,043	1,029	14	1%
Residential Accommodation for Young People	3,625	3,796	(171)	-5%
Children's Community Placements	3,429	3,344	85	2%
Children's Residential Schools	638	790	(152)	-24%
Childcare Operations	3,809	3,811	(2)	0%
Other Services - Young People	3,905	3,857	48	1%
Residential Accommodation for Older People	7,746	7,921	(175)	-2%
External Residential Accommodation for Elderly	12,042	11,708	334	3%
Homecare	13,588	13,790	(202)	-1%
Sheltered Housing	1,926	1,842	84	4%
Day Centres Older People	1,155	1,245	(90)	-8%
Meals on Wheels	75	75	0	0%
Community Alarms	342	375	(33)	-10%
Community Health Operations	2,868	2,881	(13)	0%
Residential - Learning Disability	13,605	13,299	306	2%
Day Centres - Learning Disabilty	1,633	1,668	(35)	-2%
Physical Disability	2,850	2,753	97	3%
Addictions Services	1,848	1,784	64	3%
Mental Health	3,549	3,504	45	1%
Criminal Justice	3,674	3,755	(81)	-2%
HSCP - Corporate	3,882	909	2,973	77%
Expenditure	**87,232**	**84,136**	**3,096**	3.5%
Income	(25,718)	(25,734)	16	0%
Net Expenditure	**61,514**	**58,402**	**3,112**	**5.1%**

Consolidated Expenditure	Annual Budget £000's	Actual £000's	Variance £000's	Variance %
Older People Residential, Health and Community Care	39,292	39,157	135	0.3%
Homecare	13,588	13,790	(202)	-1.5%
Physical Disability	2,850	2,753	97	3.4%
Children's Residential Care and Community Services (incl specialist)	19,689	19,869	(181)	-0.9%
Strategy Planning and Health Improvement	1,978	1,957	21	1.1%
Mental Health Services - Adult & Elderly Community and Inpatients	11,341	11,120	222	2.0%
Addictions	3,738	3,629	108	2.9%
Learning Disabilities - Residential and Community Services	15,820	15,555	265	1.7%
Family Health Services (FHS)	24,406	24,406	0	0.0%
GP Prescribing	19,294	19,294	0	0.0%
Hosted Services	848	770	78	9.2%
Criminal Justice	3,674	3,755	(81)	-2.2%
Resource Transfer	12,828	12,828	0	0.0%
HSCP Corporate and Other Services	5,327	2,693	2,633	49.4%
Gross Expenditure	174,671	171,575	3,096	1.8%
Income	(30,259)	(30,275)	16	-0.1%
Total Net Expenditure	**144,413**	**141,301**	**3,112**	**2.16%**

West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

Chief Officer: Keith Redpath

Robert Calderwood
Chief Executive
NHS Greater Glasgow & Clyde
JB Russell House
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Council Offices
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Date: 7 March 2017
Direct Line: 01389 737599
E-Mail: keith.redpath@ggc.scot.nhs.uk

Dear Robert

Re: 2017/18 Financial Allocation to HSCPs

I refer to your letter of 23 February 2017 in regard to the above.

West Dunbartonshire HSCP met on 1 March 2017 and considered a report from our Chief Financial Officer in regard to the setting of the budget for 2017/18 including the offer from NHS Greater Glasgow and Clyde.

In general terms, the Integration Joint Board recognises and accepts the position in respect of pensions, rates and prescribing (subject to final details on the inflationary provision for 2017/18).

However, specifically, the IJB voted to reject the position in respect of the allocation of historic savings.

The IJB noted your proposal that the "Board will confirm with Scottish Government that it is appropriate to make this adjustment" in respect to historical savings.

However, it was clear that my IJB were of the view that any formal representations to Scottish Government should be made jointly and not individually by either the Health Board or the IJB.

The IJB agreed to schedule an additional meeting for 22 March 2017 in anticipation that by that time there will have been further discussion on the issue.

Yours sincerely

R Keith Redpath
Chief Officer

Greater Glasgow and Clyde NHS Board

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Keith Redpath
Chief Officer
West Dunbartonshire Health and Social Care Partnership
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Date: 29th March 2017
Our Ref: RC/LL027

Enquiries to: Robert Calderwood
Direct Line: 0141-201-4614
E-mail: robert.calderwood@ggc.scot.nhs.uk

Dear Keith

Budget Allocations to Health and Social Care Partnerships for 2017/18

I refer to previous correspondence and the Board's subsequent decision on 21st February 2017 to allocate the £7.8m across the Board (Corporate and Acute Services) and the 6 Health and Social Care Partnership's (HSCPs) in 2017/18 on a pro rata basis to the Budget. The Board's Standing Orders do not allow a motion which contradicts a previous decision to be competent within a six month period. The Board's allocations to HSCPs from 1st April 2017 will therefore incorporate a deduction of £3.6m in accordance with the decision taken by the Board on 21st February 2017. I appreciate that HSCPs have not accepted this position and there will be ongoing discussions over the next few weeks which may ultimately require arbitration.

However, as the Accountable Officer for NHS Greater Glasgow and Clyde it is my expectation that as the Accountable Officer for your partnership you will operate within the budget offer from NHS Greater Glasgow and Clyde until such time the above matter is finally resolved.

Yours sincerely

Robert Calderwood

Robert Calderwood
Chief Executive
NHS Greater Glasgow and Clyde

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31st May 2017

Subject: Public Performance Report October to December 2016

1. Purpose

1.1 To present the Partnership Board with the Health & Social Care Partnership's Public Performance Report for the third quarter of 2016/17 (October to December 2016).

2. Recommendations

2.1 The Partnership Board is recommended to approve the Public Performance Report for October to December 2016 for publication.

3. Background

3.1 The Health & Social Care Partnership's Strategic Plan 2016-2019 was approved by the Partnership Board at its August 2016 meeting.

3.2 As the Partnership Board will recall, the strategic performance framework for the Strategic Plan reflects two key principles articulated within the National Framework for Clinical and Care Governance, namely that:

- Values of openness and accountability are promoted and demonstrated through actions.
- All actions are focused on the provision of high quality, safe, effective and person-centred services.

3.3 Building on the well-received Annual Performance Report 2015/16 (received by the Partnership Board at its May 2016 meeting), a quarterly public reporting cycle has been introduced to further enhance the in-year scrutiny of the delivery of the Strategic Plan. The third quarterly Public Performance Report is attached here for consideration.

4. Main issues

4.1 The Public Performance Report for October to December 2016 focuses on those key strategic performance indicators for the Partnership where performance data is available for that specific time period. It has been augmented with data on key aspects of workforce and financial performance (the latter of which have been previously reported to the Partnership Board by the Chief Financial Officer for that period).

4.2 The Public Performance Report has already been formally scrutinised internally by the Partnership's Senior Management Team as part of the internal performance management regime. Once considered by the Partnership Board, this second quarterly Public Performance Report will be

published on the Health & Social Care Partnership's website and cascaded to stakeholders.

5. People Implications

5.1 The Public Performance Report has been augmented with data on key aspects of workforce performance linked to the Partnership's Workforce & Organisational Development Strategy 2015-2018 (approved by the Partnership Board at its November 2015 meeting).

6. Financial Implications

6.1 The Public Performance Report has been augmented with data on key aspects of financial performance (the latter of which have been previously reported to the Partnership Board by the Chief Financial Officer for that period).

6.2 As detailed by the Chief Financial Officer in their 1st March 2017 Finance Report to the Partnership Board, the Partnership's NHS Health Care budget reported a overall break even position; and the Social Care budget reported a net underspend of £2.774m (6.68%) for the same period. All but £0.030m related to the flow through of the unallocated Social Care Fund, which for accounting purposes required to be transacted within revenue expenditure budgets before any residual was transferred to Reserves at year end..

7. Professional Implications

7.1 No specific implications associated with this report.

8. Locality Implications

8.1 No specific implications associated with this report.

9. Risk Analysis

9.1 Audit Scotland has stated that public reporting is an important element of best value. This Public Performance Report has been informed by the practice promoted by Audit Scotland, and work will continue to develop local arrangements accordingly.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The Public Performance Report has been produced to enhance in-year scrutiny of the delivery of the Strategic Plan in an open and accountable manner.

Author: Soumen Sengupta - Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Care Partnership

Date: 31st May 2017

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E-mail: soumen.sengupta@ggc.scot.nhs.uk
Telephone: 01389 737321

Attached: West Dunbartonshire Health & Social Care Partnership Public Performance Report July to September 2016

Background Papers: HSCP Board (1st March 2017): Finance Report

HSCP Board Report (August 2016): Strategic Plan 2016-2019

HSCP Board Report (May 2016): Annual Performance Report 2015/16

HSCP Board Report (November 2015): Workforce & Organisational Development Strategy & Support Plan

Audit Scotland (2010) Best Value Toolkit: Public Performance Reporting: http://www.audit-scotland.gov.uk/docs/best_value/2010/bv_100809_public_performance_reporting_toolkit.pdf

Wards Affected: All

Public Performance Report
October–December 2016

West Dunbartonshire
Health and Social Care Partnership

Introduction

Welcome to West Dunbartonshire Health and Social Care Partnership's third Public Performance Report for 2016/17.

Building on our Strategic Plan for 2016-2019 we are committed to providing clear and transparent updates on our progress in key priority areas; on an ongoing basis.

More information about Health and Social Care Partnership services is available on our website at www.wdhscp.org.uk.

We are always keen to receive feedback, so whether you want to provide constructive comments on the contents of this report or any of our services more generally, please contact us at www.wdhscp.org.uk/contact-us/headquarters/.

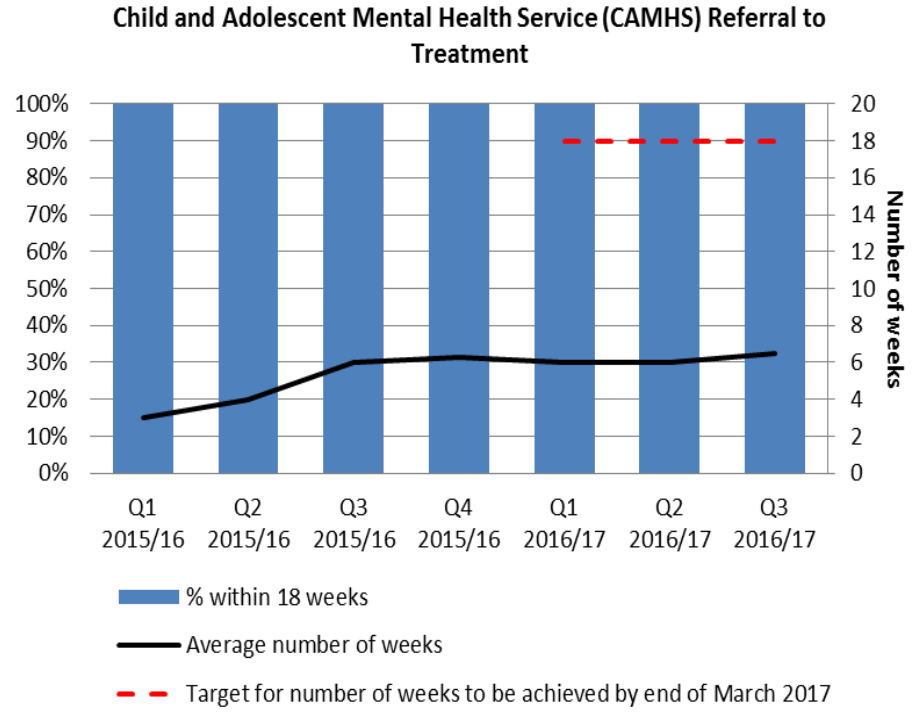
Mr Soumen Sengupta

Head of Strategy, Planning & Health Improvement

The West Dunbartonshire Health and Social Care Partnership Board's:

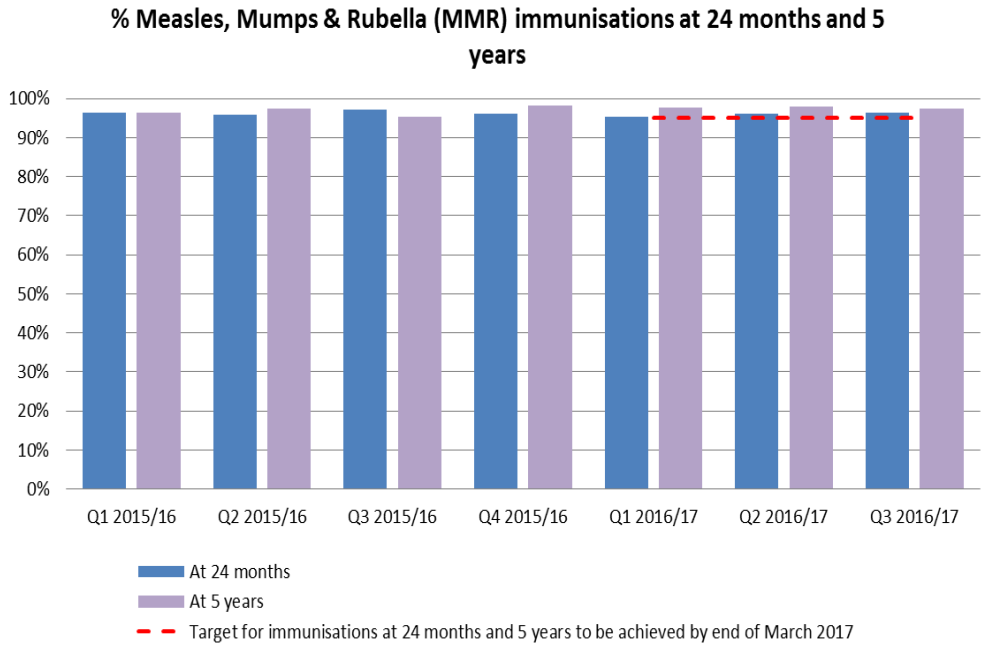
- **Mission is to improve the health and wellbeing of West Dunbartonshire.**
- **Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.**
- **Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.**

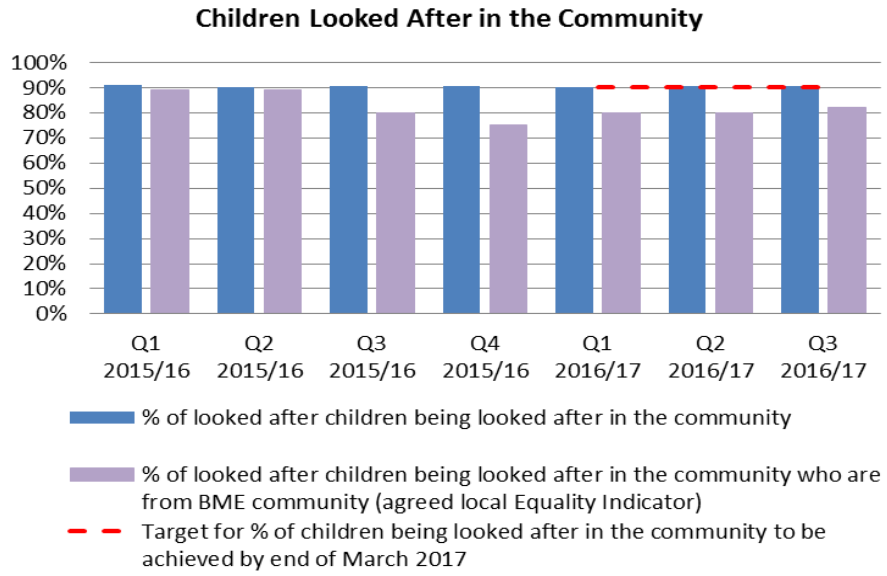
Supporting Children and Families



99 children and young people were referred to CAMHS in Qtr3 2016/17. The average time from referral to treatment continues to be well below the 18 week target at 6.5 weeks.

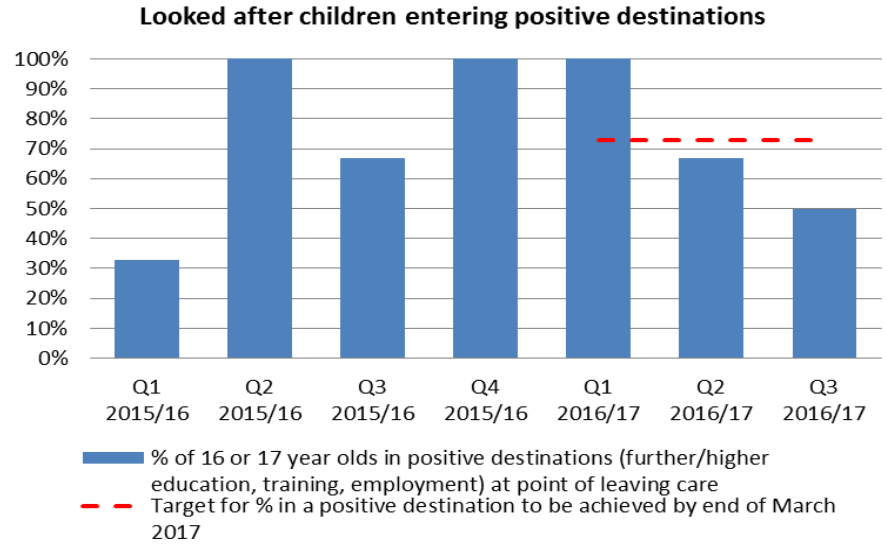
213 children had an MMR immunisation at 24 months (96.4%) and 283 children had an MMR immunisation at 5 years (97.3%) in Qtr3 2016/17 meeting the March 2017 target of 95%.





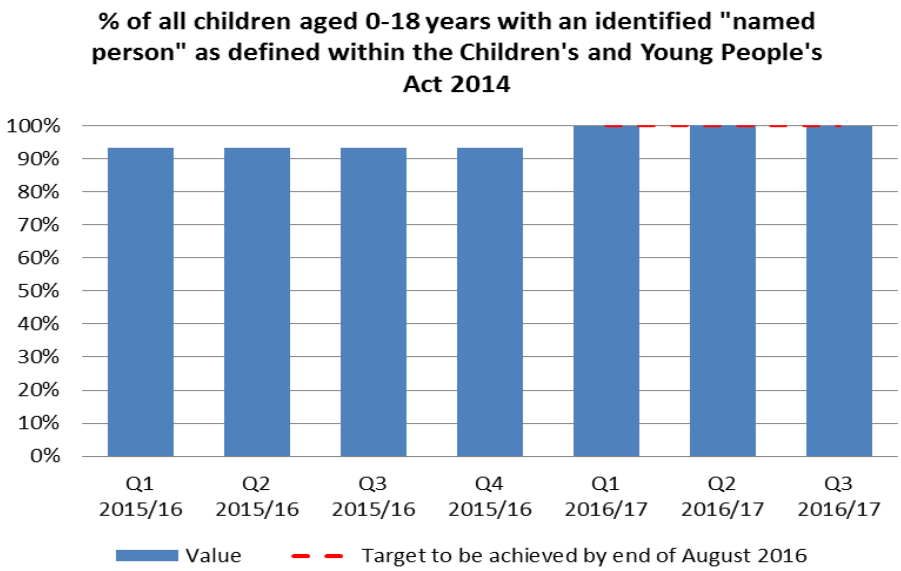
366 of the 404 looked after children were looked after in the community (90.6%) in Qtr3 2016/17 continuing to exceed our March 2017 target of 90%.

Of the 11 looked after children who happened to be BME (Black & Minority Ethnic), 9 were looked after in the community (82%) in Qtr3 2016/17.



1 of the 2 children (50%) who left care in Qtr3 2016/17 entered a positive destination.

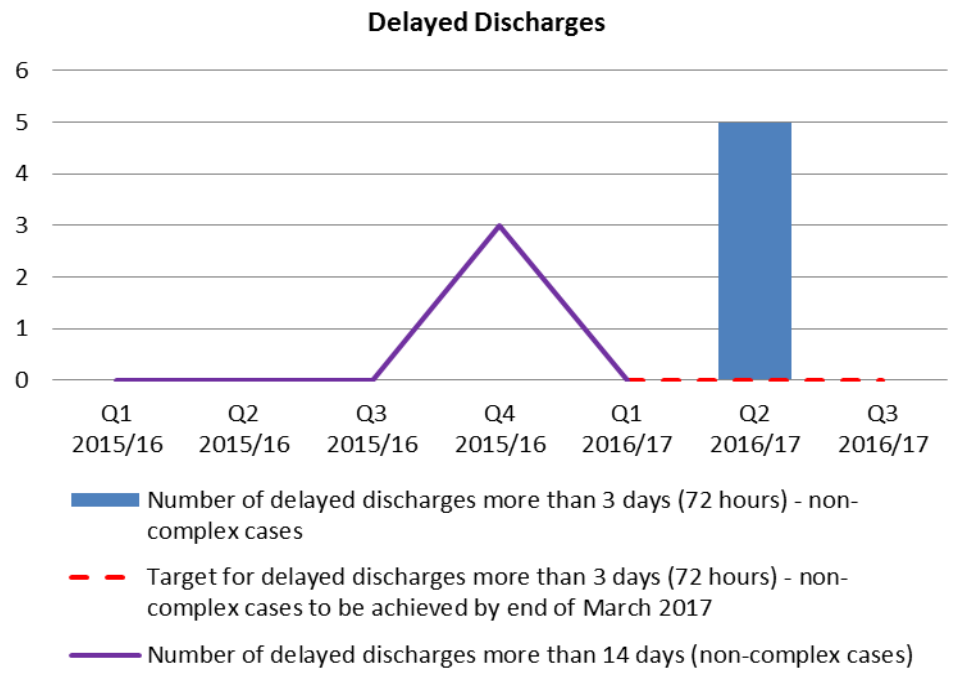
This indicator relates to a very small number of children and therefore the percentage can fluctuate significantly.



18,702 children (99.8%) had an identified named person against a 2015 mid-year 0 to18 year old population of 18,734 in Qtr3 2016/17.

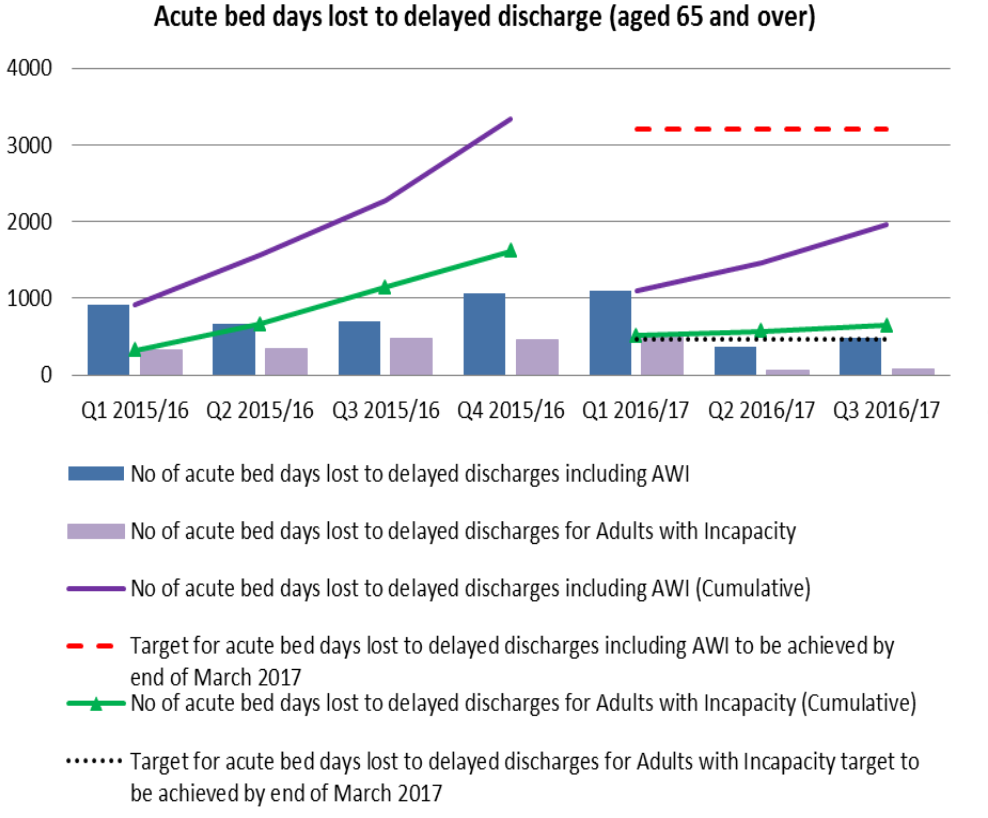
It is expected that the March 2017 target of 100% will be achieved as this indicator will be calculated against a more accurate 2016 mid-year population figure from National Records of Scotland (NRS).

Supporting Older People



The Scottish Government have changed the way delayed discharges are counted from 1st July 2016. The previous figure for delays of more than 14 days has been included in the chart for context/ comparison.

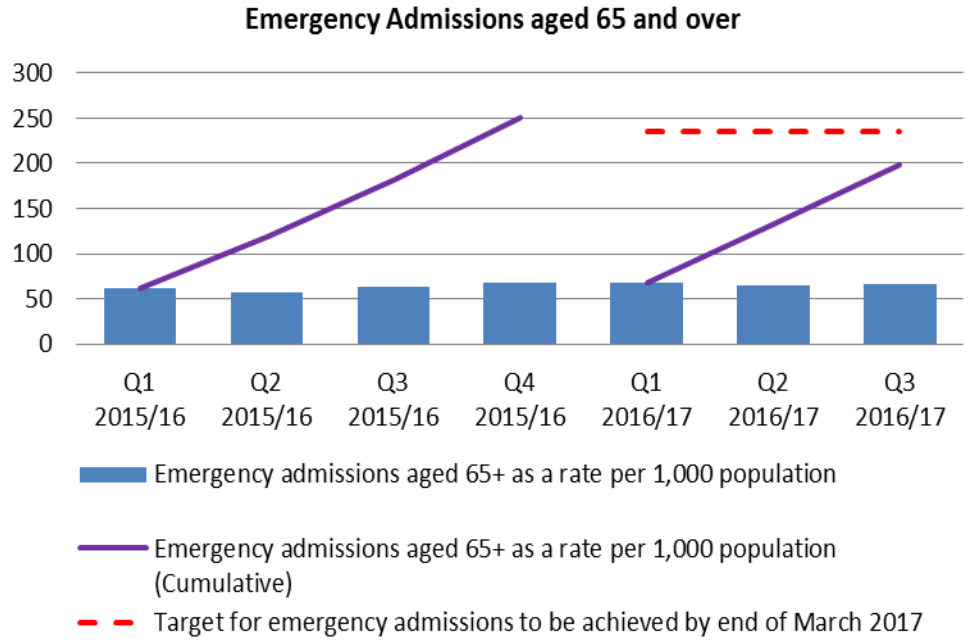
There were 0 delays of more than 3 days for non-complex cases in Qtr3 2016/17 in line with the national target.



485 bed days were lost to delayed discharge for people aged 65 and over in Qtr3 2016/17. With a year to date total of 1,954, it is likely we will meet our March 2017 target of no more than 3,210 bed days lost.

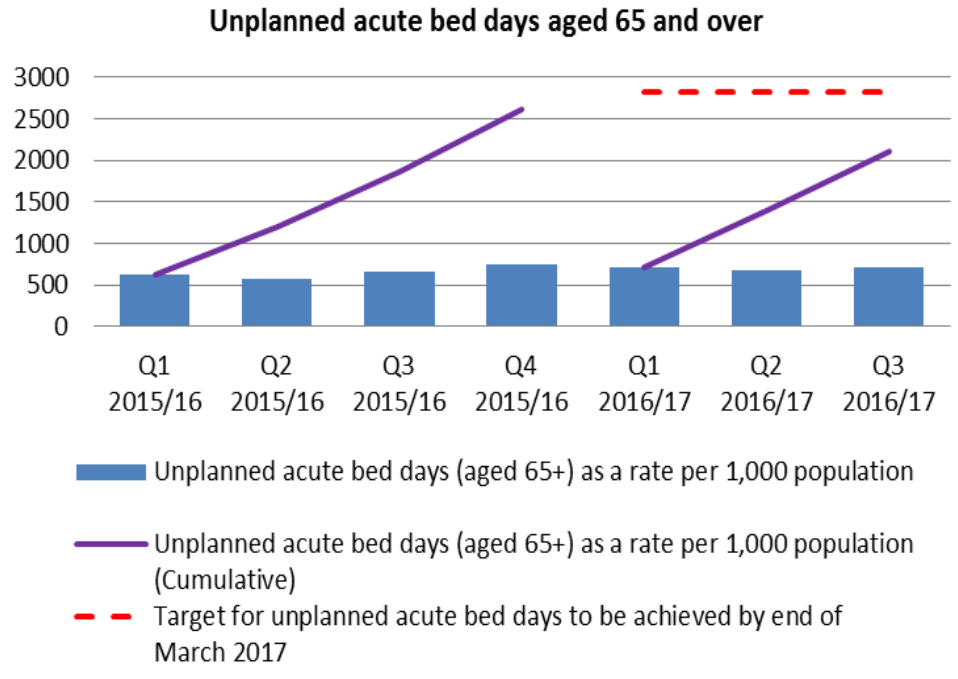
74 bed days were lost to delayed discharge for Adults with Incapacity (AWI) aged 65 and over in Qtr3 2016/17 making a year to date total of 647.

Although performance in Qtrs 2 and 3 has greatly improved we have already exceeded our March 2017 target of 466 bed days lost.



There were 1,052 emergency admissions of people aged 65 and over in Qtr3 2016/17.

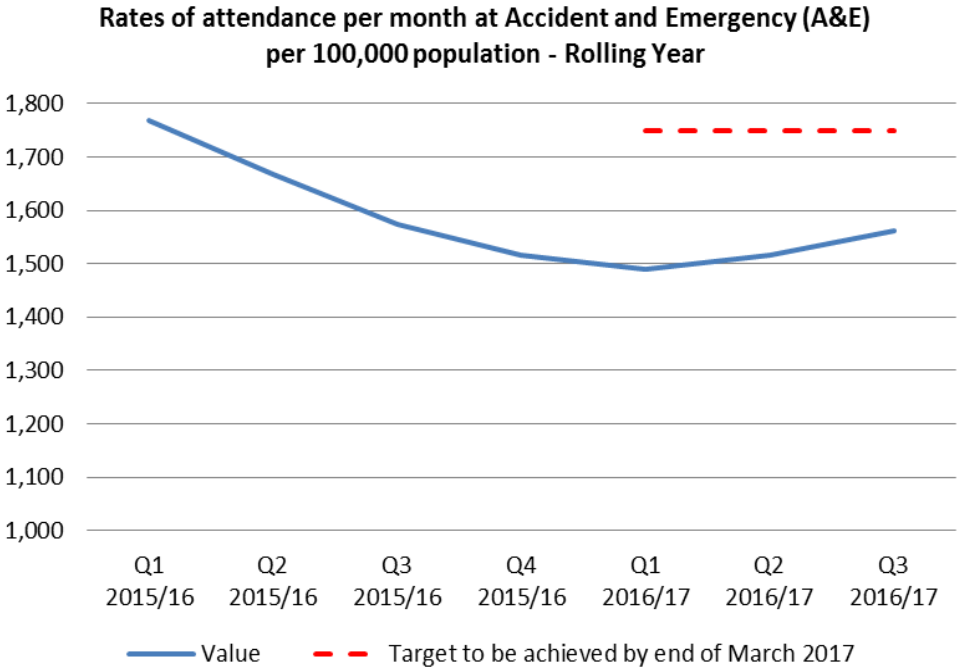
As our year to date rate is 199 (3,160 admissions), performance would require to improve considerably during Qtr4 to meet our March 2017 target of no more than 236 admissions per 1,000 population which equates to 3,750 admissions.

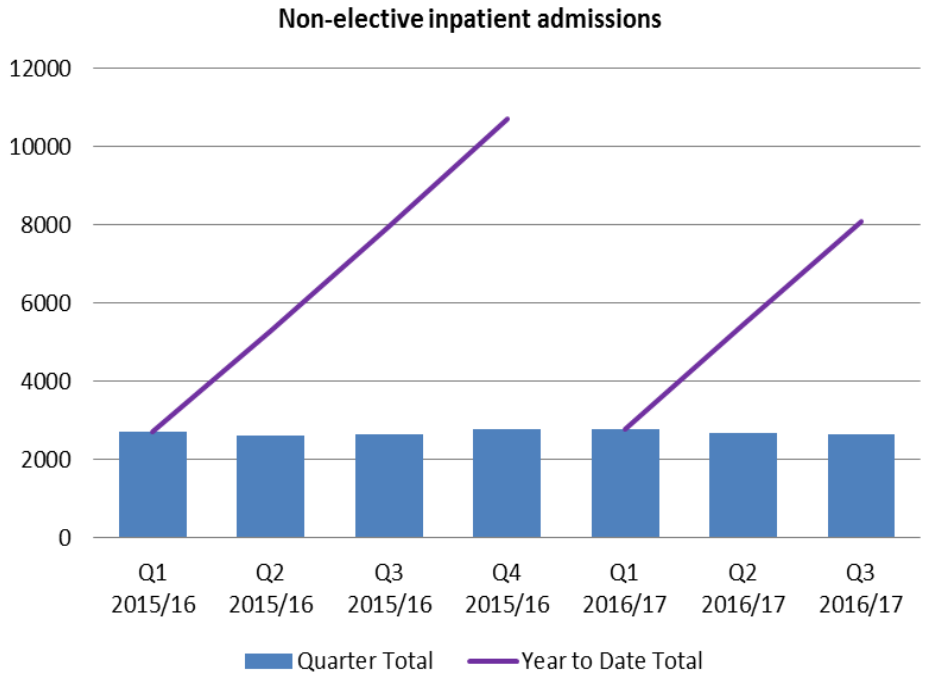


There were 11,419 unplanned acute bed days used by people aged 65 and over in Qtr3 2016/17.

As our year to date rate is 2,112, we are likely to be very close to the March 2017 target of no more than 2,831 bed days per 1,000 population.

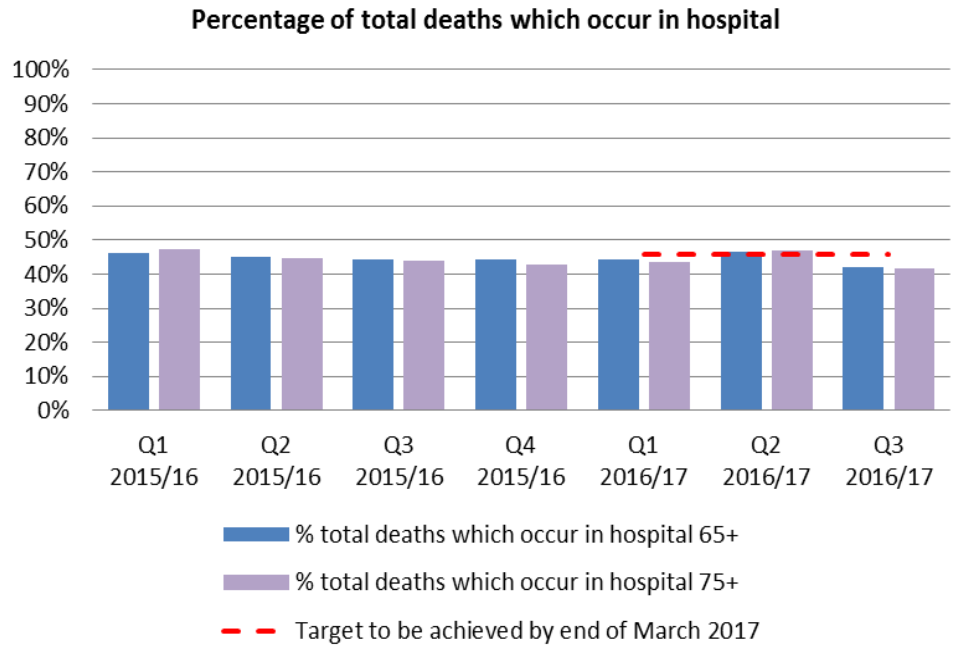
4,333 people attended A&E in Qtr3 2016/17. With a Qtr3 rate of 1,562 we expect to be well below the March 2017 target rate of no more than 1,750 attendances per 100,000 population each month (by rolling year).



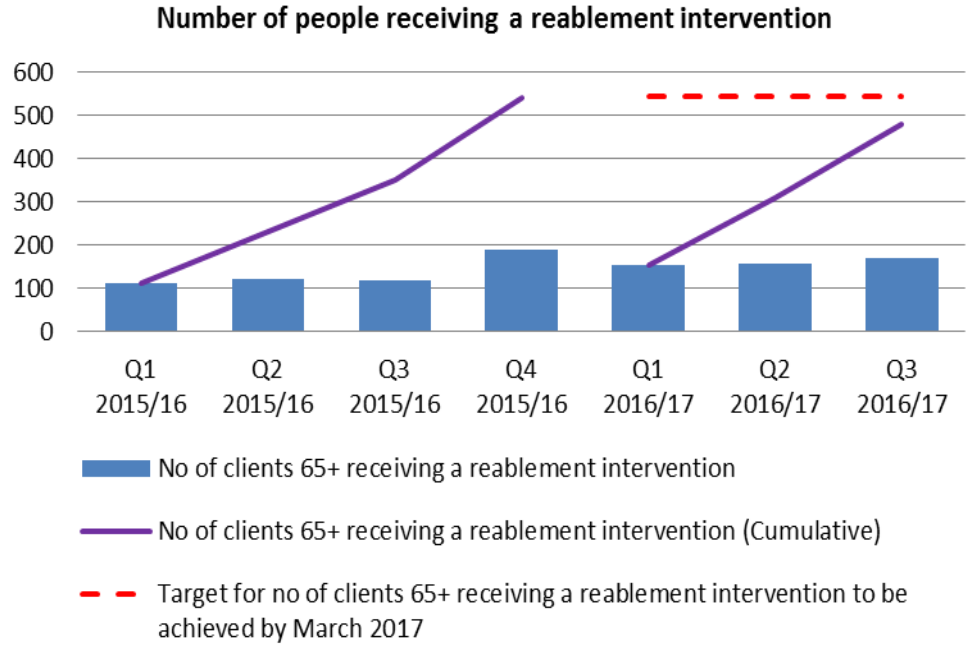


There were 2,648 non-elective inpatient admissions in Qtr3 2016/17 making a year to date total of 8,096.

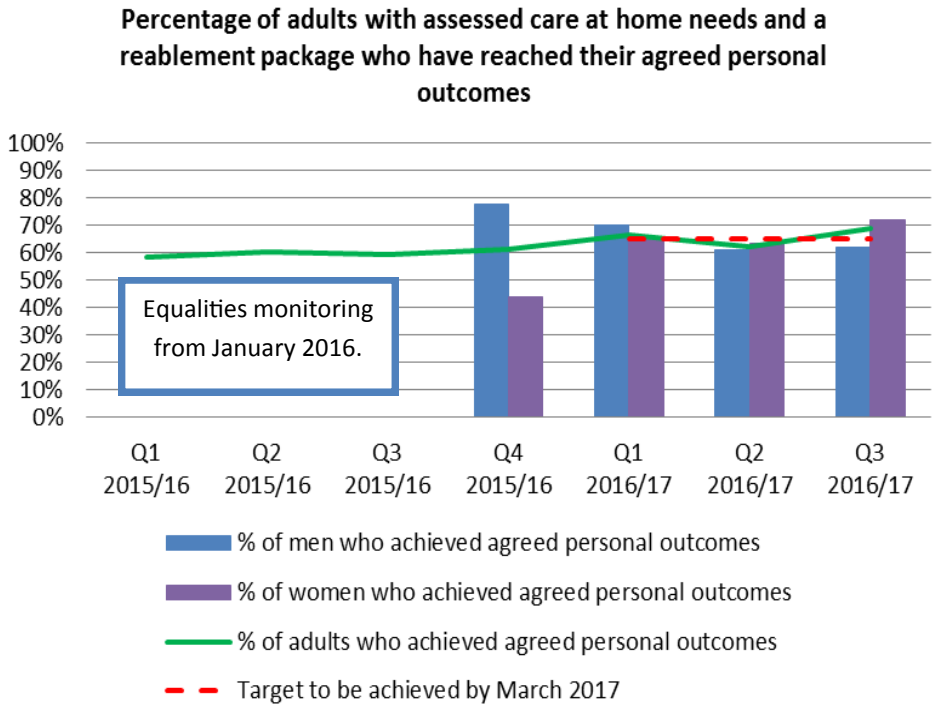
This is a new indicator from NHS GGC and a target has yet to be confirmed.



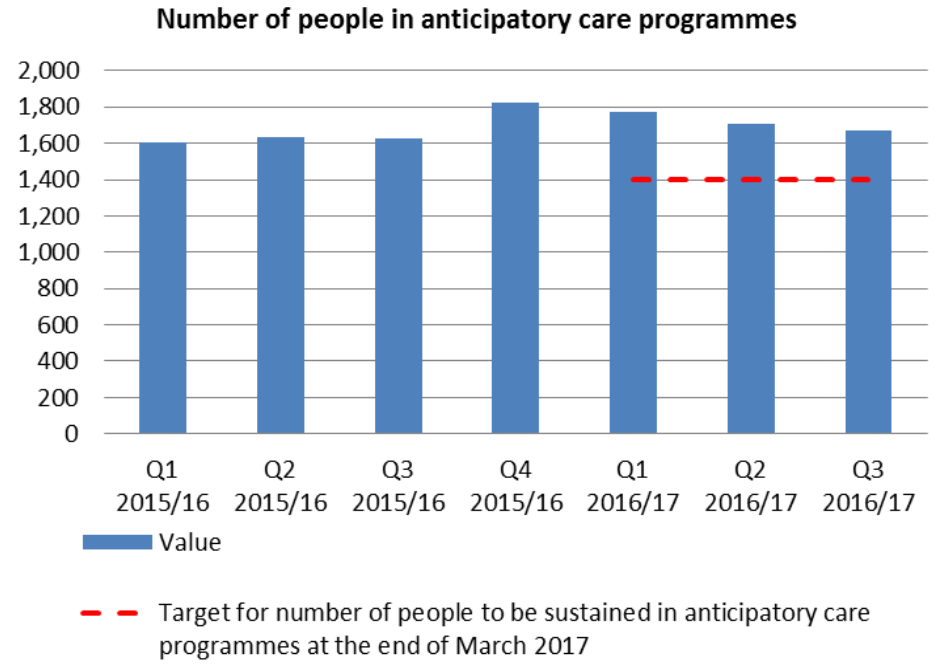
The proportion of people aged 65 and over dying in hospital rather than at home or in a homely setting continues to decrease, and in Qtr3 2016/17 is lower than at any point since April 2015 at 42.2%. We expect to meet the March 2017 target of 45.9%.



169 people received a reablement service in Qtr3 2016/17 making a year to date total of 479. We expect to provide more reablement interventions in the year than the March 2017 target of 545.

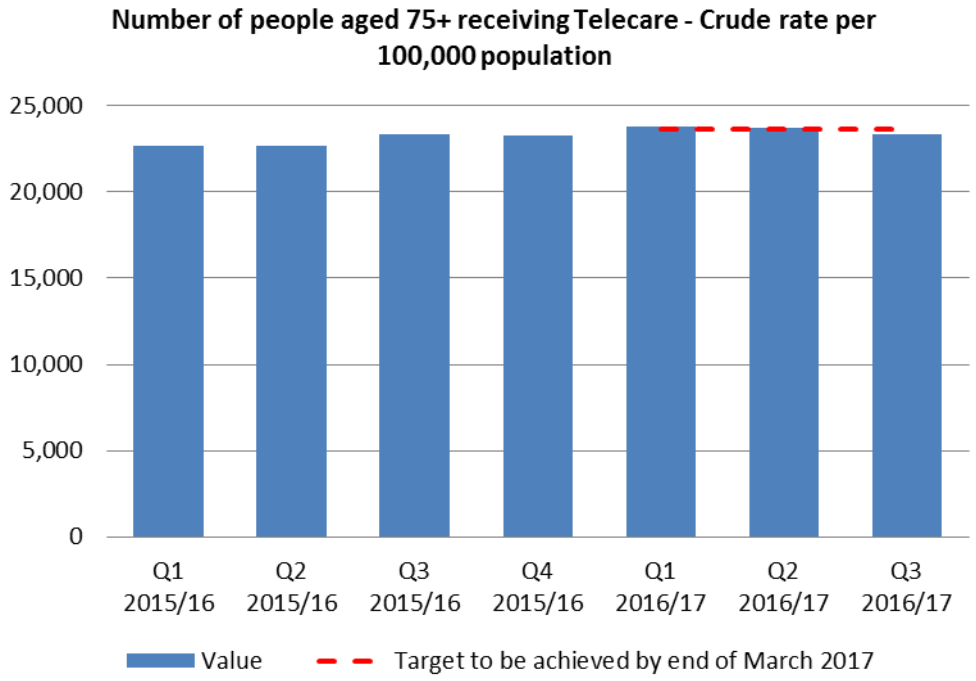


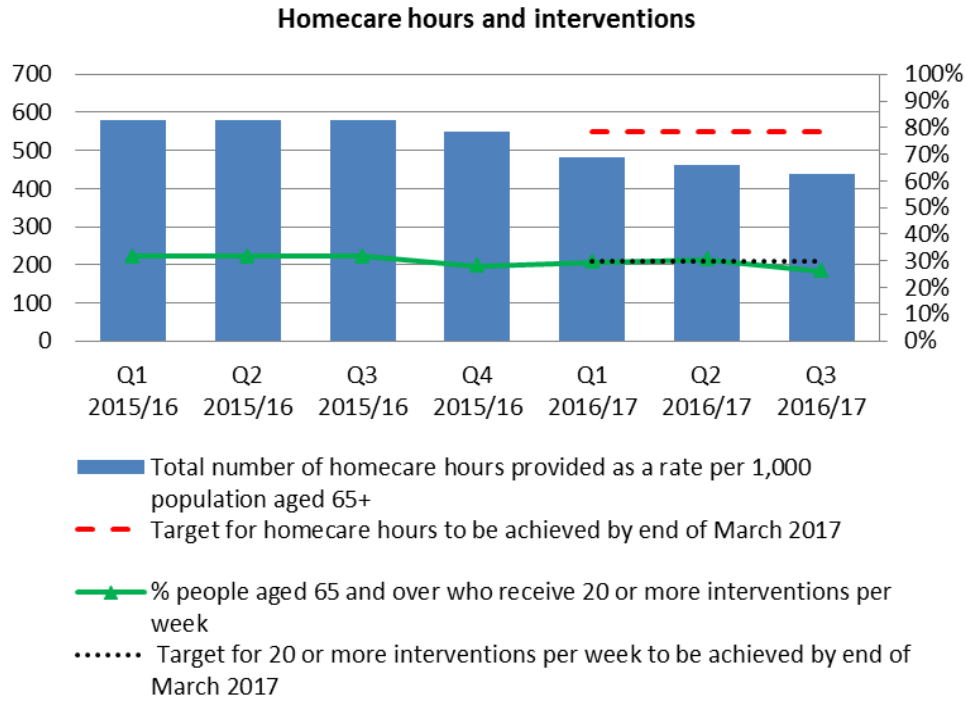
116 out of 169 people (69%) achieved their agreed personal outcomes through a reablement service in Qtr3 2016/17: 62% of men and 72% of women. The March 2017 target is 65%.



1,669 people had an Anticipatory Care Plan (ACP) in place in Qtr3 2016/17. We expect to sustain the level of ACPs above the March 2017 target of 1,400 throughout 2016/17.

1,655 people aged 75 and over received a Telecare service in Qtr3 2016/17. Performance will require to improve in Qtr4 to meet our March 2017 target of 23,670 per 100,000 population.

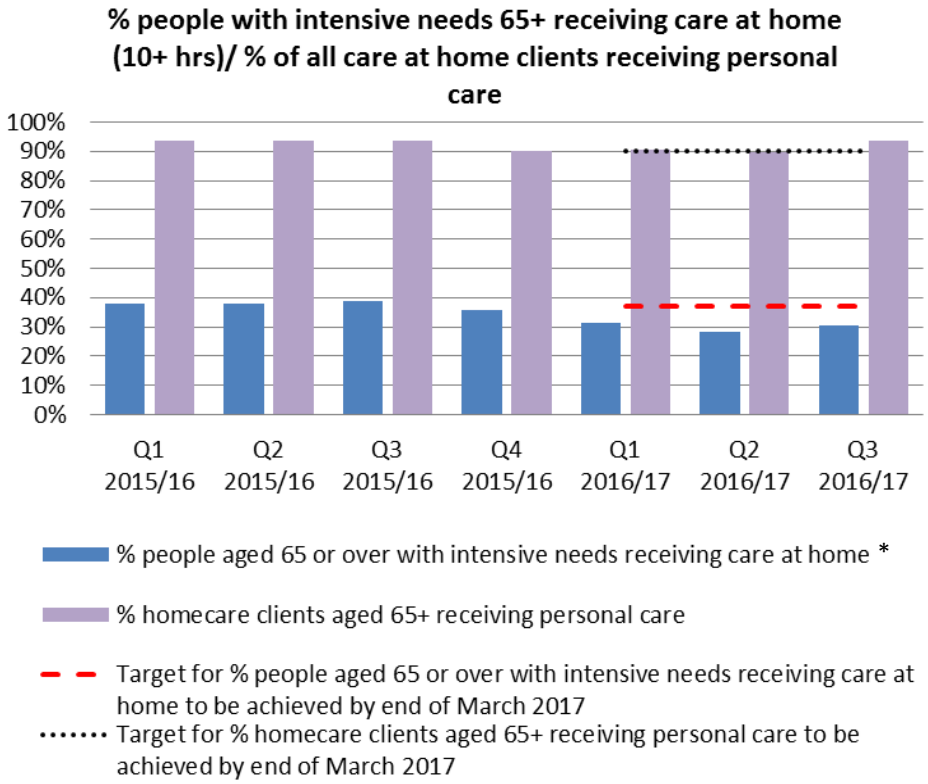




6,940.5 hours of homecare per week were provided to 1,171 people aged 65 and over in Qtr3 2016/17. This equates to a rate of 436.7 hrs per 1,000 population which is below our March 2017 target of 550.

306 people received 20 or more interventions per week (26.1%). This is below the 30% target which is due to be achieved by the end of March 2017.

Work is underway to improve recording compliance rates within the new homecare scheduling system.

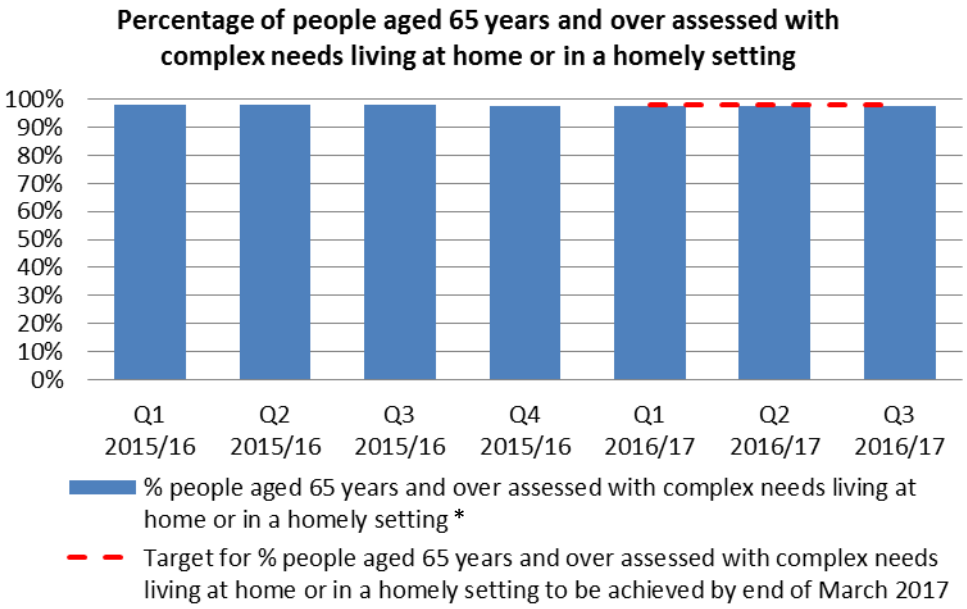


244 people aged 65 and over with intensive needs received 10 or more hours of care at home in Qtr3 2016/17. Performance will require to improve considerably to meet the March 2017 target of 37%.

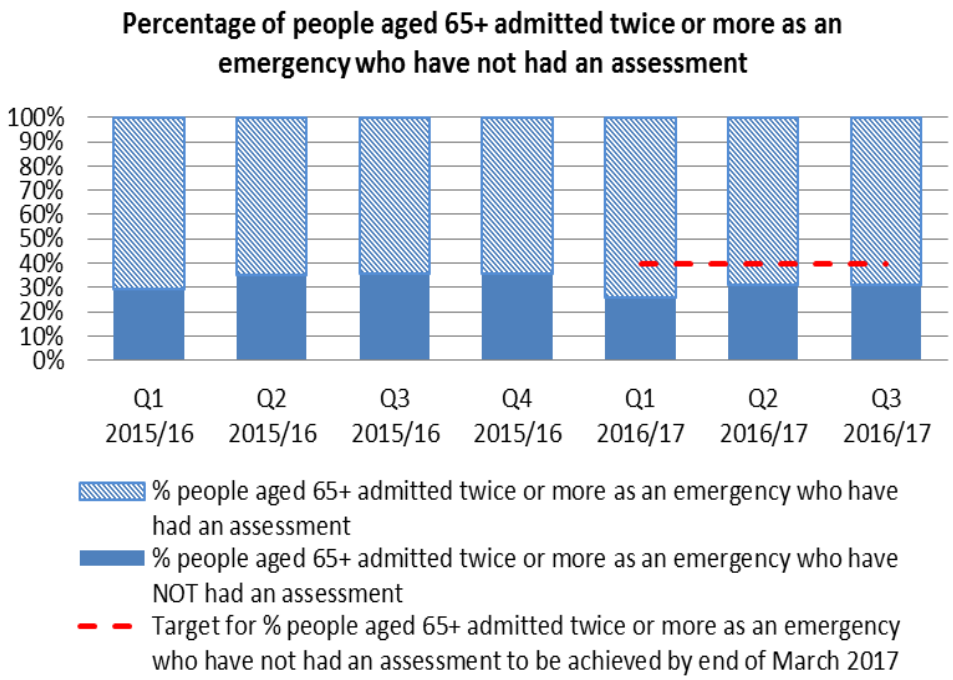
This indicator is published by the Local Government Benchmarking Framework and measures volume rather than appropriate targeting or alternative supports which may augment homecare such as telecare.

1,095 of 1,171 people aged 65 and over received personal care at home in Qtr3 2016/17 exceeding the March 2017 target of 90%.

782 people aged 65 and over with complex needs were living in a homely setting in Qtr3 2016/17. We are very slightly below the March 2017 target of 98% at 97.5%.



*A change in the 2015/16 guidance for the collection of Continuing Care data will affect comparability with previous figures. Scottish Government are currently examining options to resolve this and this may result in an update to the data presented here.

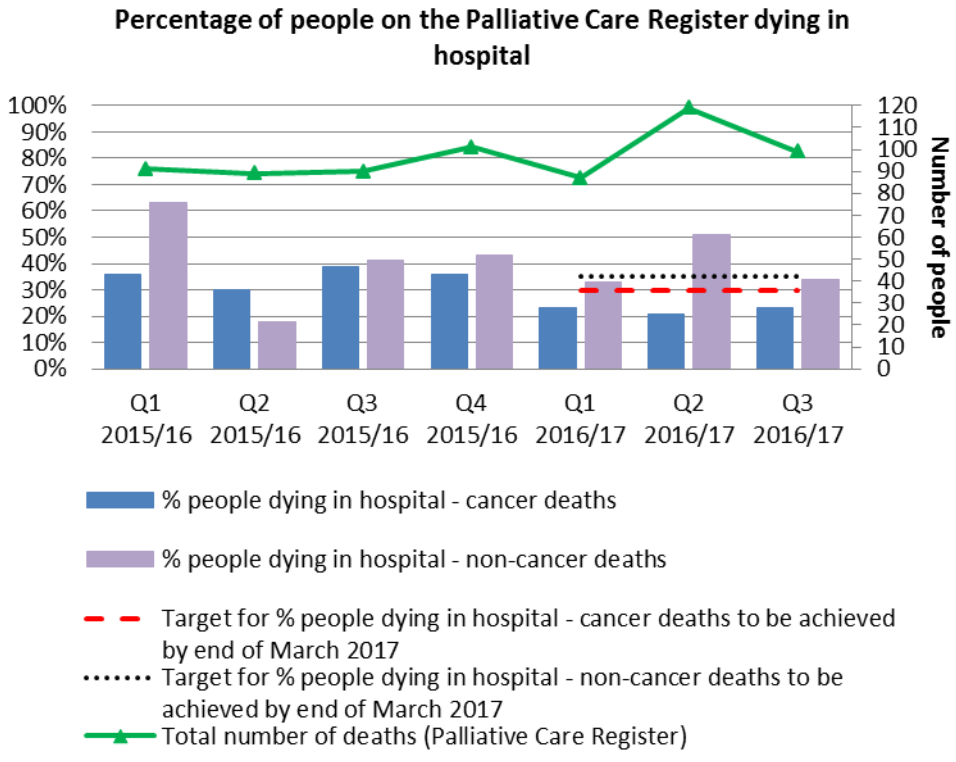


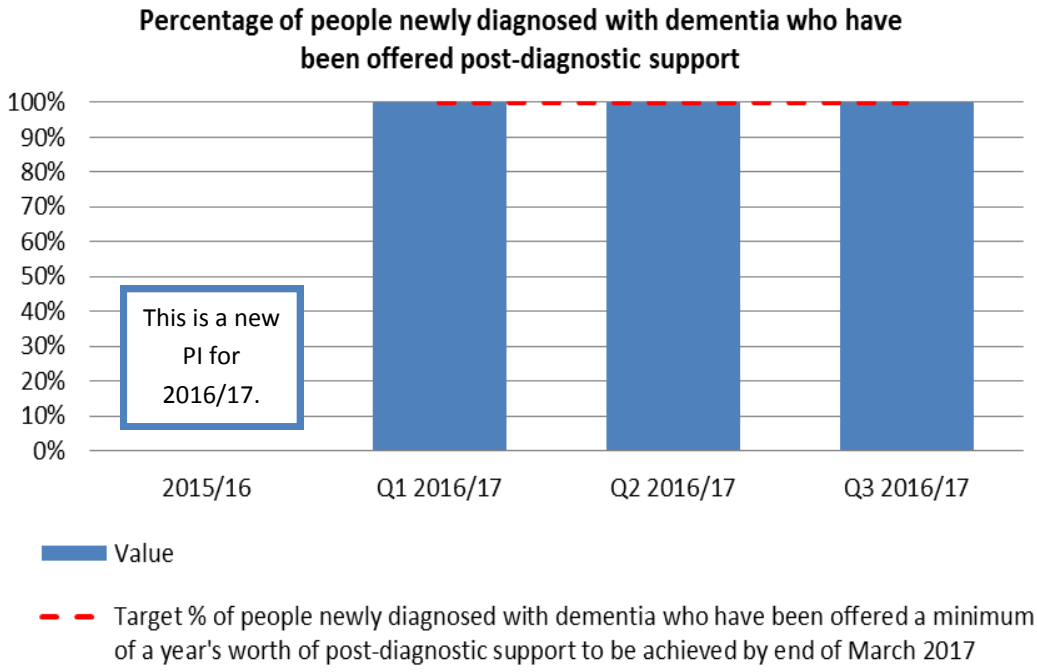
618 people (68.8%) aged 65 and over admitted to hospital twice or more received an assessment of their needs in Qtr 3 2016/17.

280 people (31.2%) did not have an assessment which is well within our March 2017 target of no more than 40% of people not being assessed.

99 people on the Palliative Care Register died in Qtr3 2016/17, 27 of whom died in hospital: 15 people (23%) due to cancer and 12 people (34%) due to non-cancer conditions.

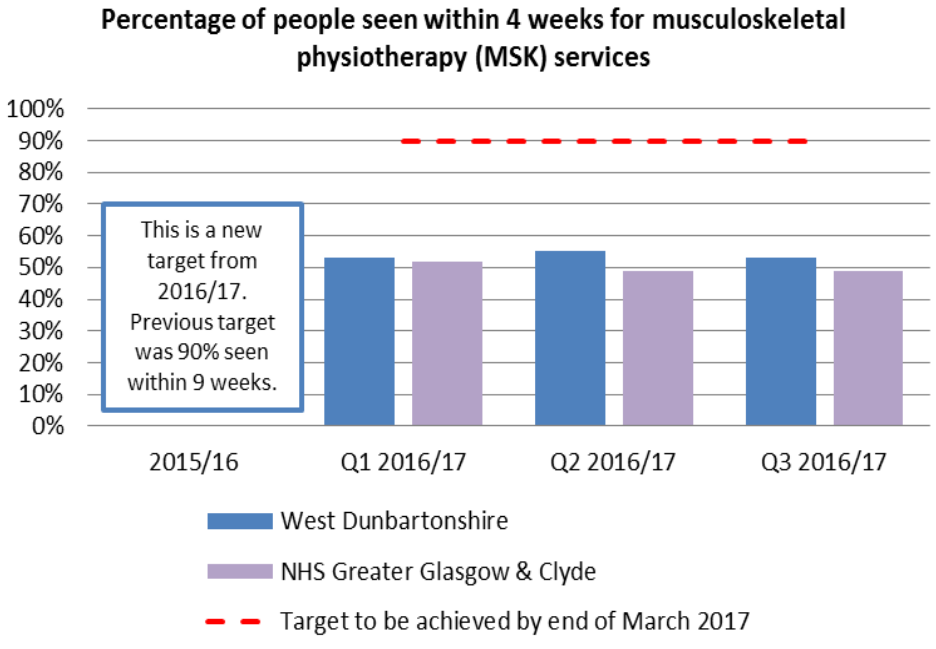
Year to date figures indicate that the 30% target for cancer deaths in hospital should be achieved at March 2017. Performance will require to improve in Qtr4 in relation to non-cancer deaths in hospital to meet the 35% target.

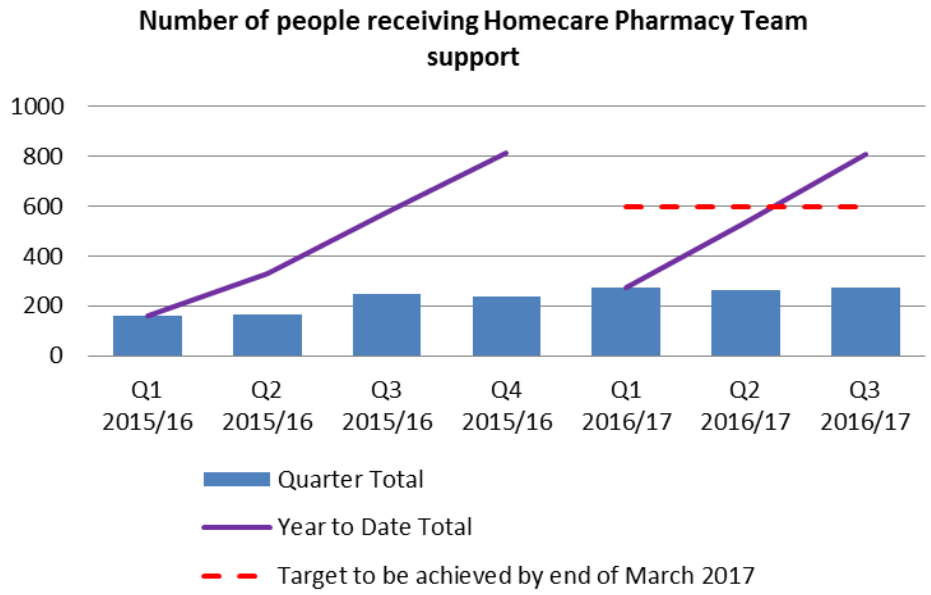




All 13 people newly diagnosed with dementia were offered post-diagnostic support in Qtr3 2016/17 meeting the 100% target for March 2017.

1,572 people from West Dunbartonshire and 17,655 from across NHS GGC were referred to the MSK service in Qtr3 2016/17. The 90% seen within 4 weeks target is proving to be difficult to achieve across NHS GGC.



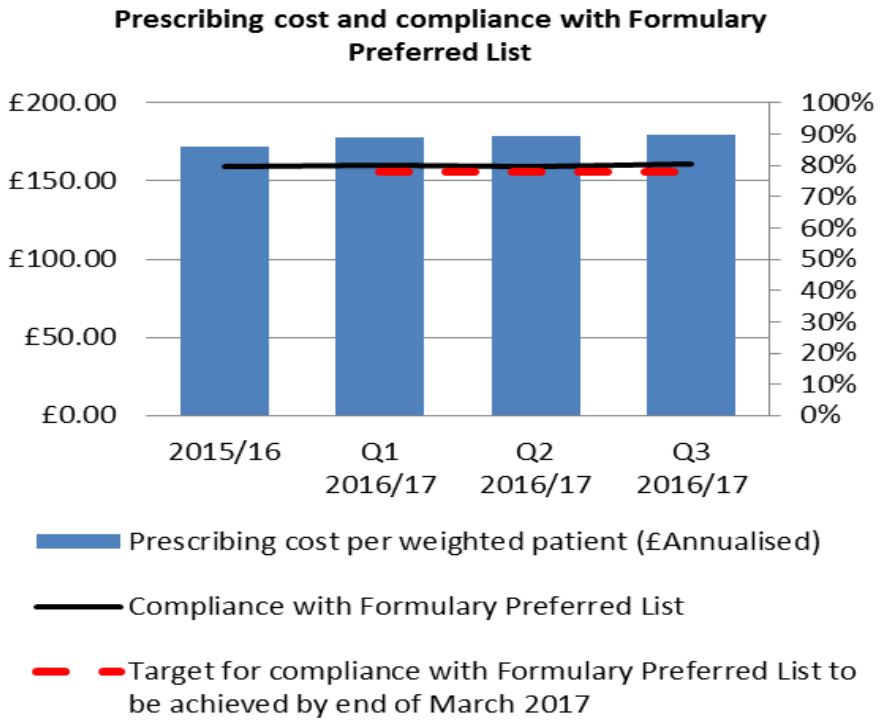


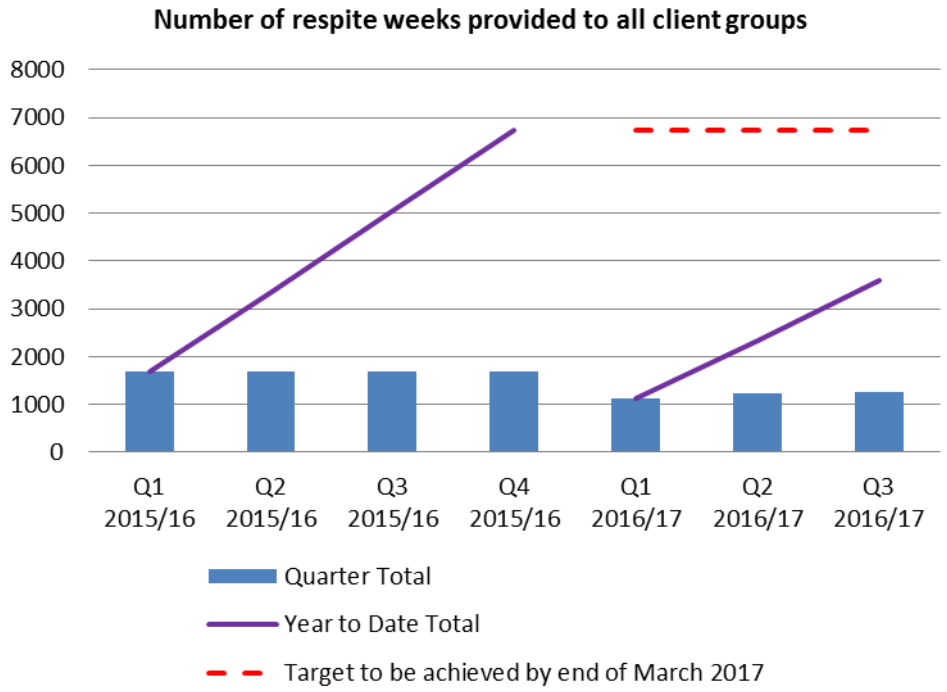
451 people were referred to the Homecare Pharmacy Team in Qtr3 2016/17. 83 people declined the support and 47 people were being supported by other service teams.

808 people have received support during the year to date already exceeding the March 2017 target of 600.

Compliance with the Formulary Preferred List continues to exceed the March 2017 target of 78% at 80.4% in Qtr 3 2016/17.

WDHSCP's prescribing cost target is the average cost across NHS Greater Glasgow & Clyde as calculated at the end of March 2017.

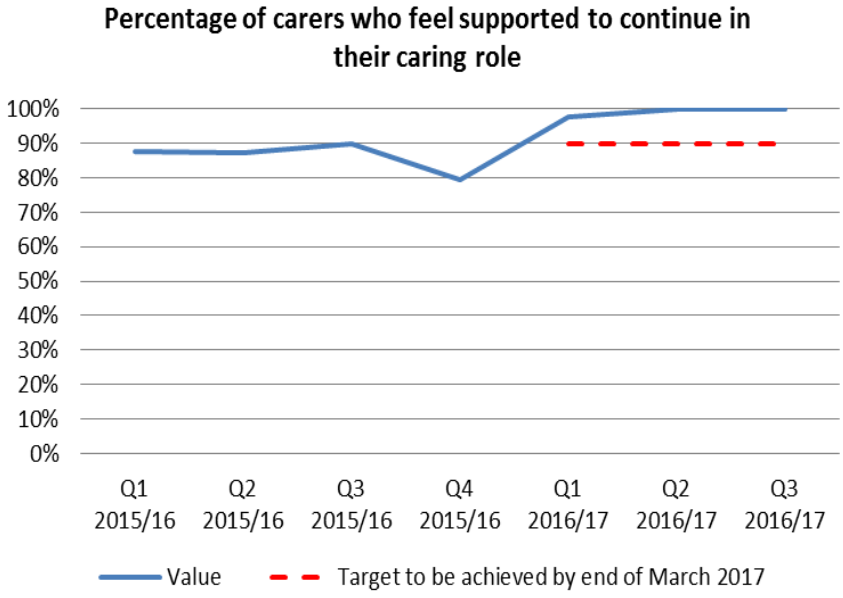




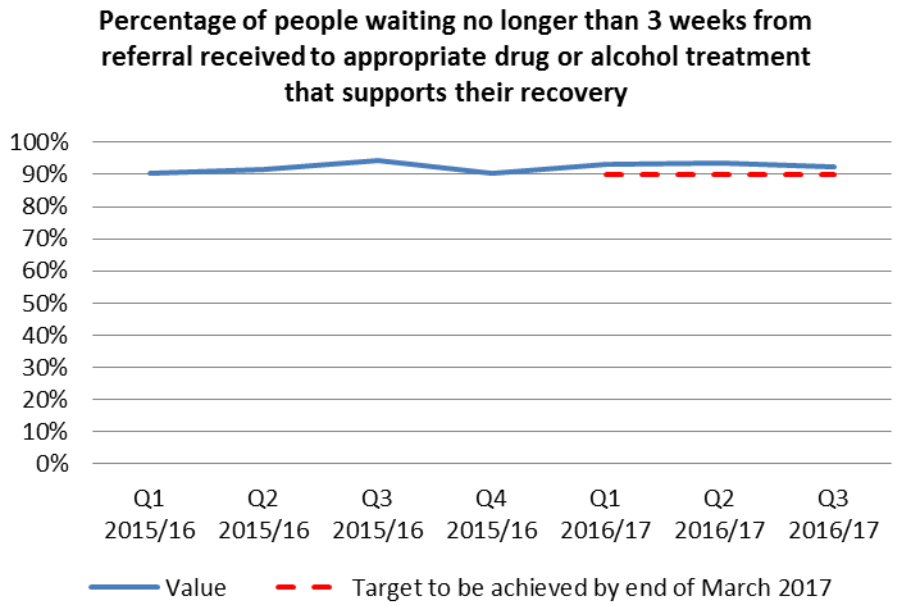
492 people received respite in Qtr3 2016/17. The year to date total of 3593.1 weeks means that performance would have to improve substantially to meet the March 2017 target of 6,730 weeks. Day Care recorded as being provided for the benefit of the client which may also provide a break for a carer is no longer being counted as respite from April 2016.

All 47 carers asked felt supported to continue in their caring role during Qtr3 2016/17. * We are continuing to exceed our March 2017 target of 90%.

* Sample data from Carer Support Plans completed during Qtr3 2016/17.



Supporting Safe, Strong and Involved Communities

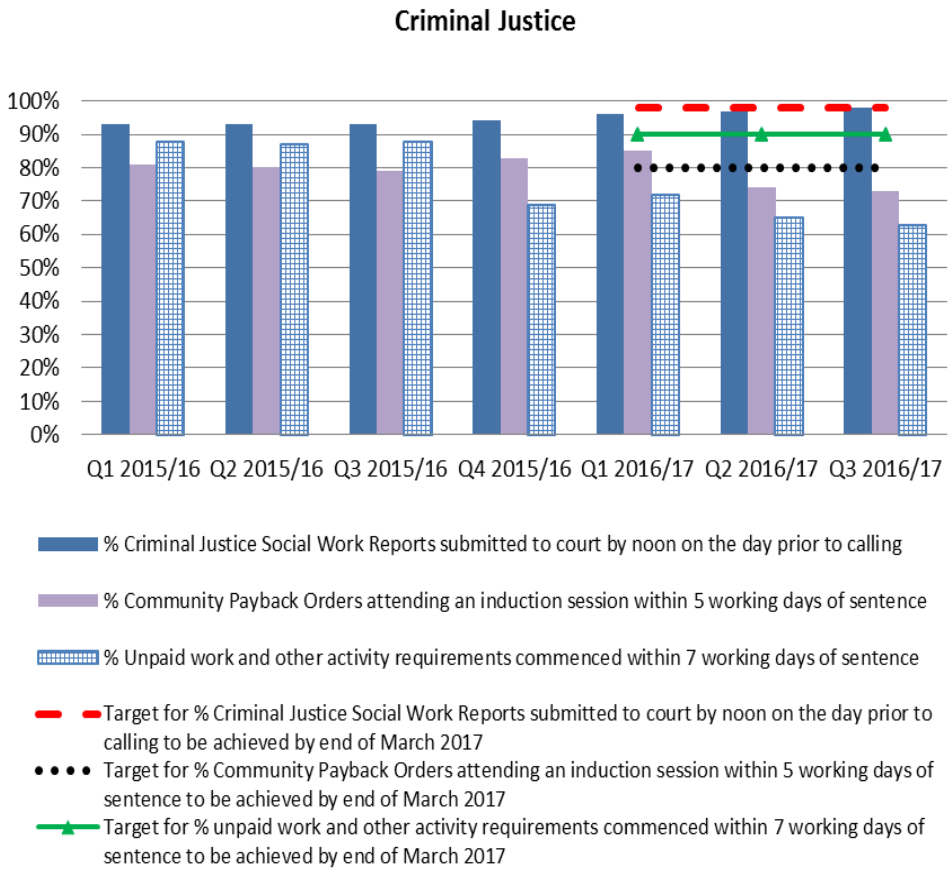


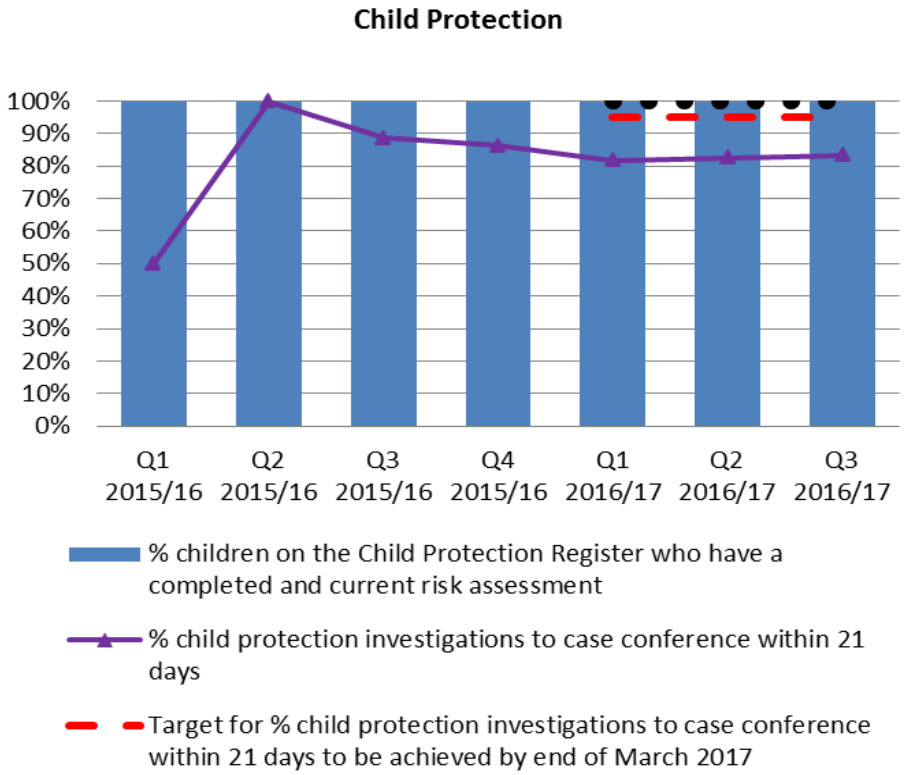
192 of 208 people (92.3%) received treatment within 3 weeks of referral in Qtr3 2016/17. We continue to exceed the March 2017 target of 90%.

208 of the 213 (98%) Social Work Reports were submitted on time in Qtr3 2016/17.

75 of the 103 (73%) new Community Payback Orders attended induction within the timescale and 99 of the 158 (63%) unpaid work requirements commenced within 7 days in Qtr3 2016/17.

Performance would have to substantially improve to meet the March 2017 targets for Community Payback Orders (80%) and unpaid work requirements (90%).

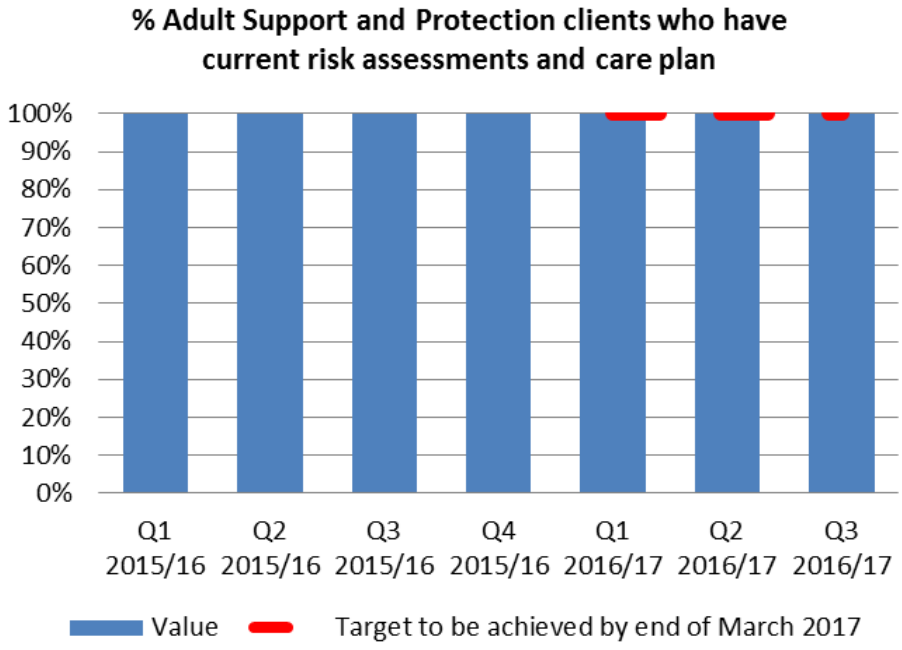




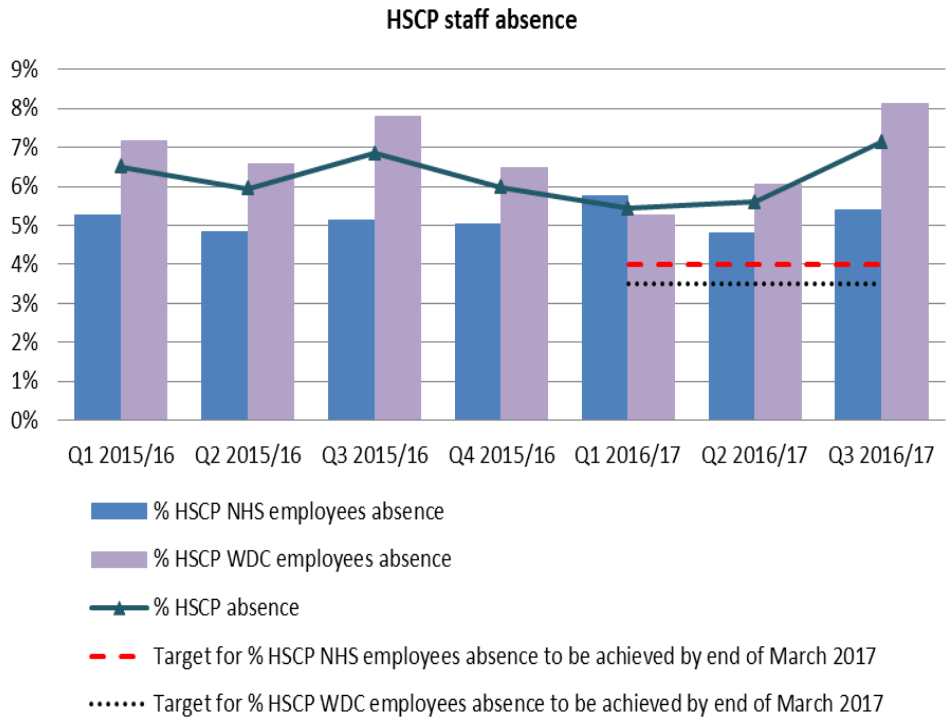
There were 75 children on the Child Protection Register at the end of Qtr3 2016/17.

45 out of 54 (83.3%) case conferences were carried out within 21 days during Qtr3 2016/17 missing our March 2017 target of 95%.

All 6 Adult Support and Protection clients had a current risk assessment and care plan in Qtr3 2016/17 continuing our 100% performance against the March 2017 target.

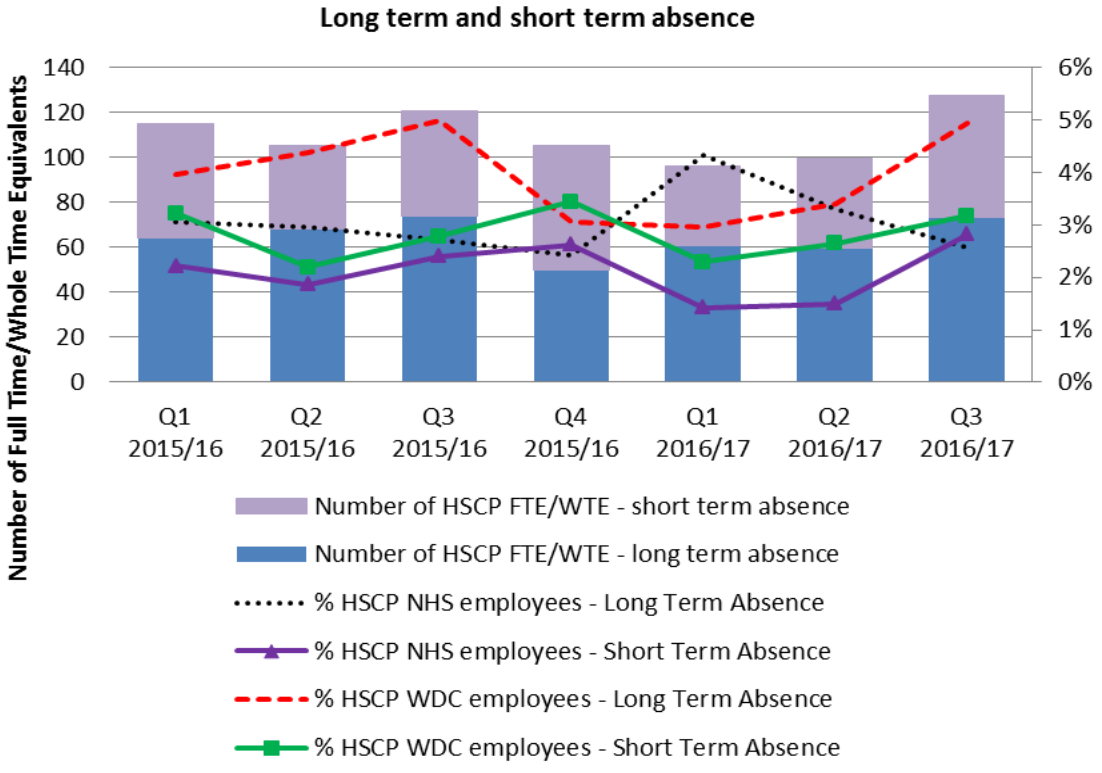


Our Staff

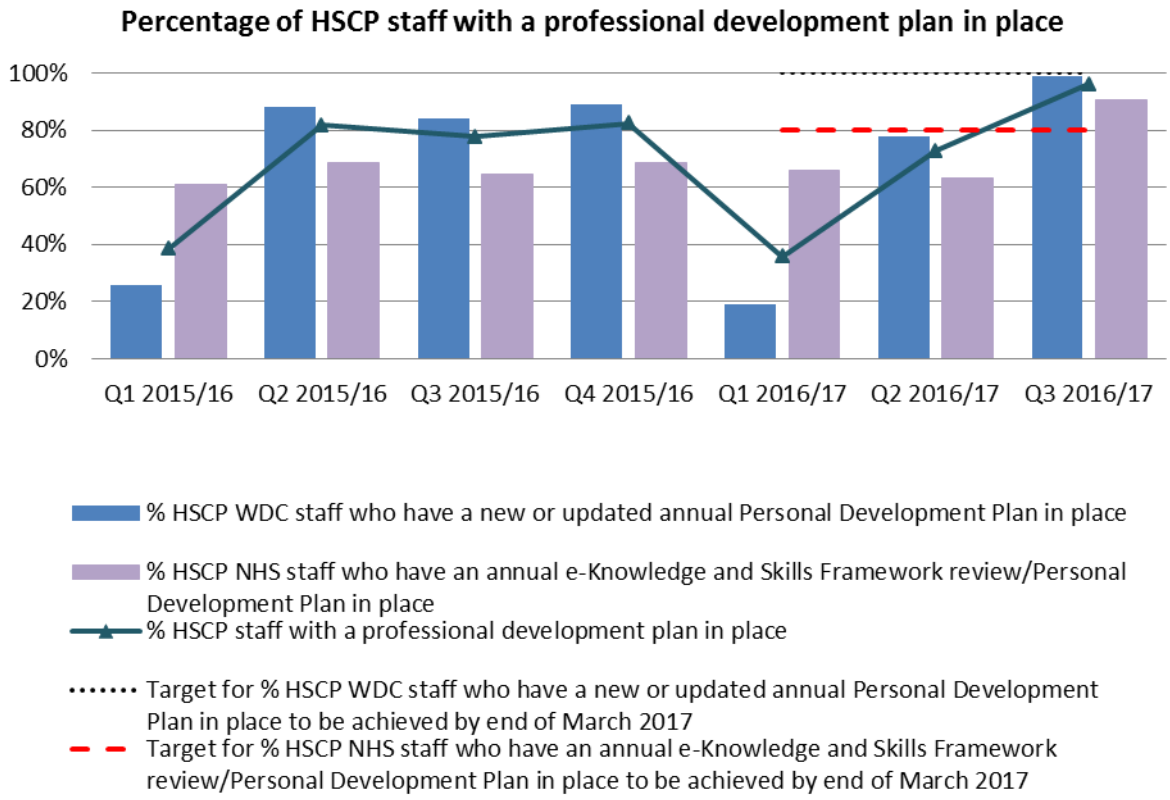


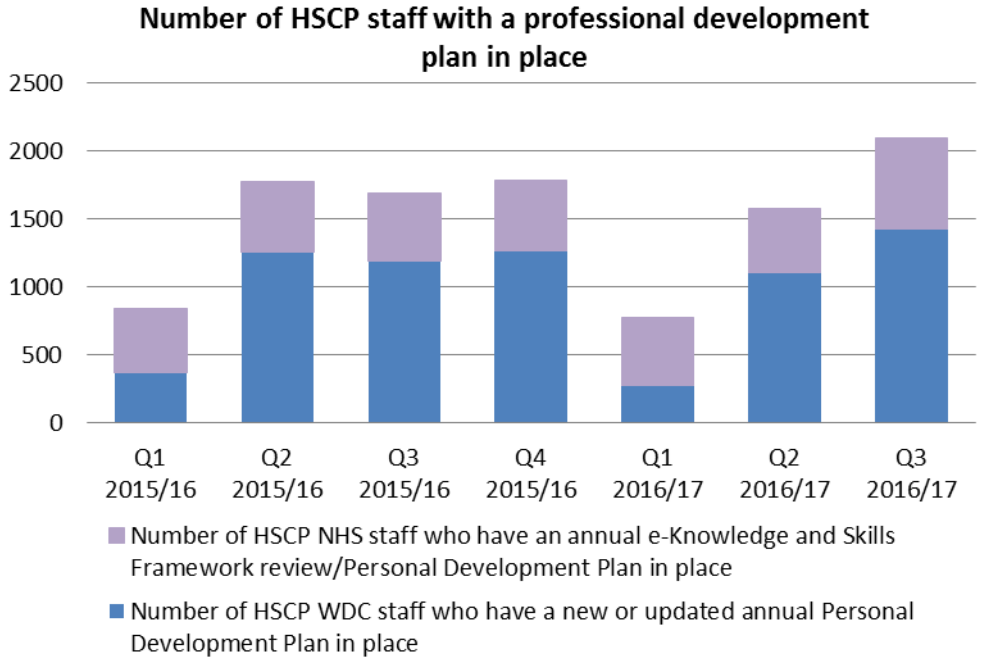
There were 745 NHS employees (627.28 Whole Time Equivalent) and 1,434 WDC employees (1,156.53 Full Time Equivalent) working within the HSCP during Qtr3 2016/17.

Overall HSCP absence was 7.15% in Qtr3 2016/17: 8.11% WDC employees and 5.39% NHS employees.



Our Staff

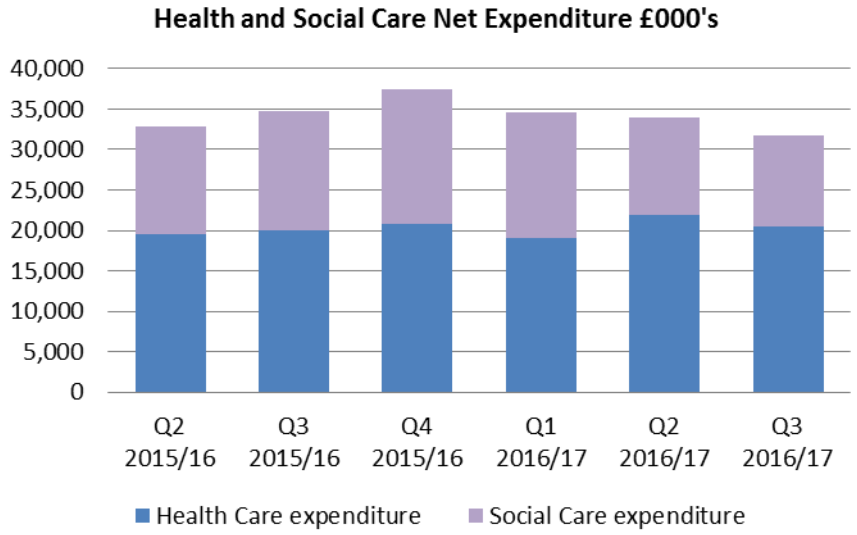




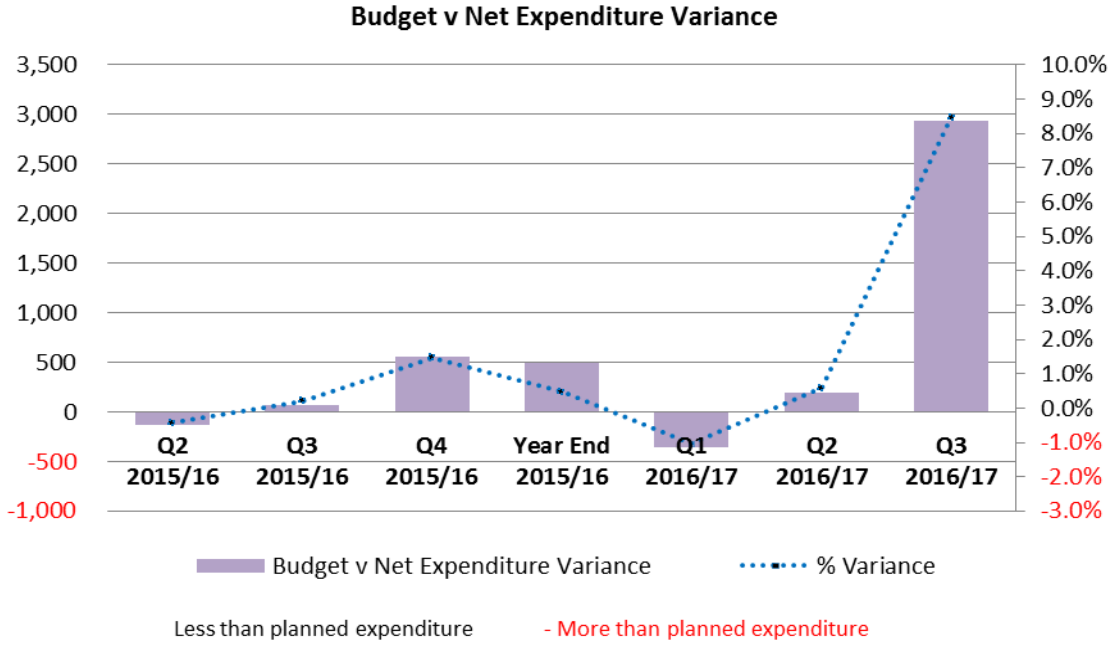
The NHS target for March 2017 of 80% has already been exceeded in Qtr3 2016/17 at 90.56%.

The WDC target for March 2017 of 100% looks achievable at 99% in Qtr3 2016/17.

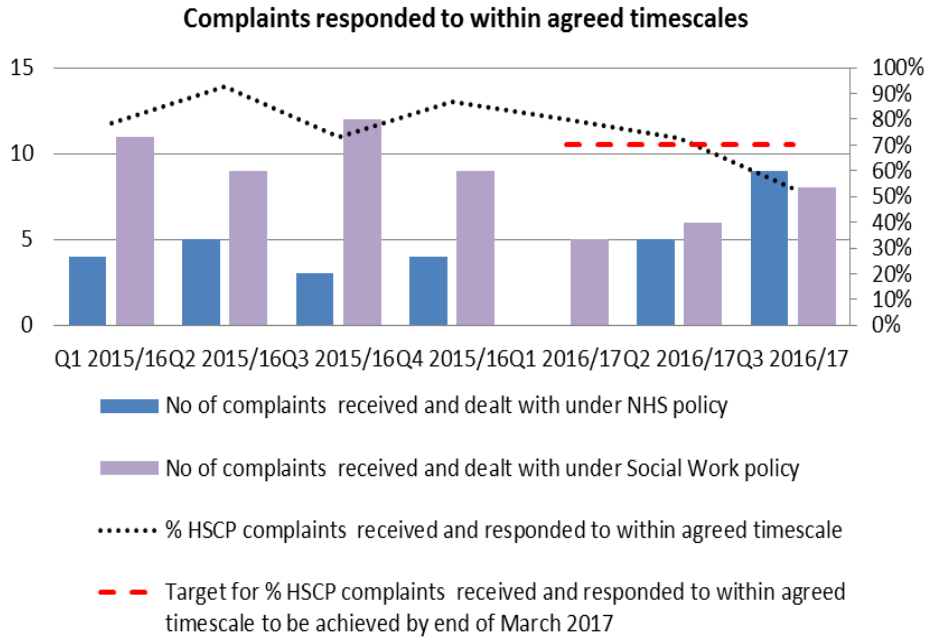
Our Finance



HSCP Expenditure to the end of December 2016 of £100.246m against a budget of £103.019m (not including Set-Aside).

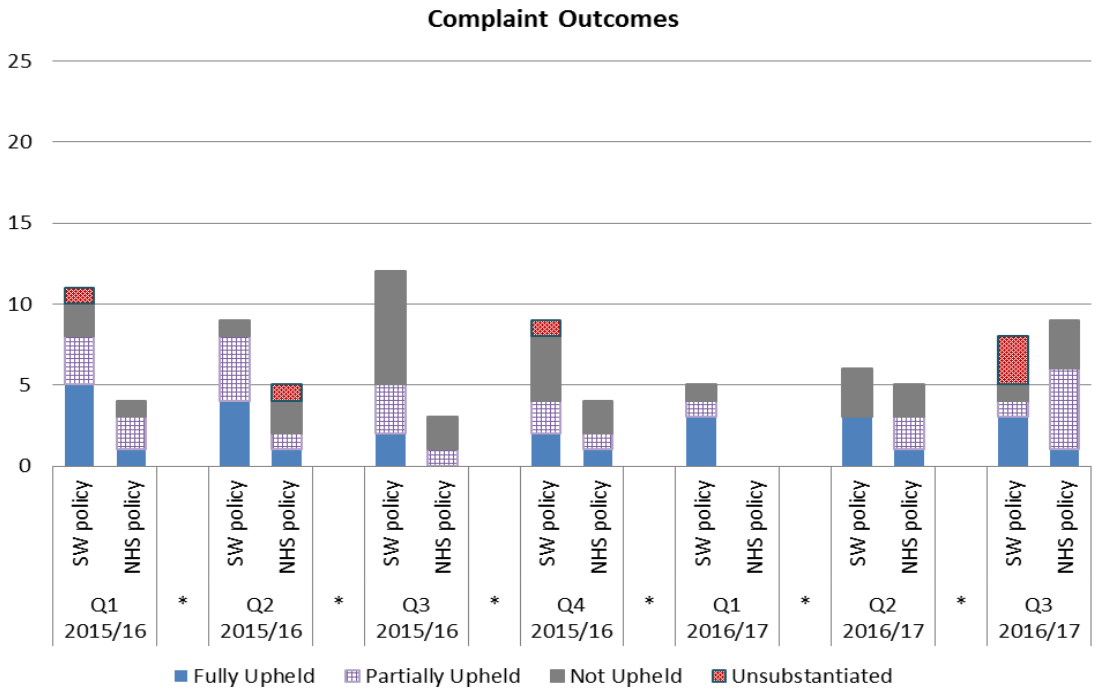


Complaints



8 complaints were dealt with through the Social Work Complaints policy and 9 through the NHS policy in Qtr3 2016/17.

8 complaints were responded to outwith the timescales. These were between 5 and 43 days late. The longest delay related to a complex complaint which required further review.



Upheld complaints in Qtr3 2016/17 concerned Employee Attitudes (1), Statutory Responsibilities (1), Communication (1) and Quality of Service (1). Any learning from these complaints is being considered within the relevant service areas.

Service Improvement Linked to Performance: HSCP recognition at national and local awards

The HSCP Care at Home Service was recognised as sector leading in being awarded the Scottish Association of Social Work (SASW) Award for 'Best example of collaboration in an integrated setting' as well as being finalists in the Team of the Year award at the national awards ceremony in March 2017.

The award recognises both the worth of the team itself and its impact as part of the wider integrated health and social care provision for adults and older people in West Dunbartonshire. The dedicated and skilled staff are successful through a combination of their hard work, knowledge and commitment to working in partnership, in supporting people to live as independently as possible and safely within a homely setting as long as possible.

Recognising the impact of our services for both young and old in our community, at the same awards ceremony, the HSCP's Looked after Children's Service were also finalists for the Team of the Year award.

Looked after Children's Services include our Residential Children's Houses, Permanence, Foster Care, Throughcare and Aftercare provision and Alternative to Care service. They were shortlisted in recognition that as individual services and as a whole team, they strive to be sector leading; to maintain a culture with the needs and voices of each individual child at the centre; and with staff motivated to go the extra mile.

West Dunbartonshire Council Employee Recognition Awards

The HSCP has also seen continued success at West Dunbartonshire Council's annual Employee Recognition Awards.

Day Care Officer Karen McNab was awarded the Council's Community's Award, recognising her outstanding commitment to the health and wellbeing of the older people in her care.

The HSCP's Day Care services can help adults and older people stay active, socialise and provides their carers with a break. Karen leads Langcraigs Day Care's fundraising ventures with money raised used to stage live entertainment, support outings and purchase activities which are recreational, educational and therapeutic for people using Day Care services.

This success was added to at the awards with commendations for Wendy Jack (Team Leader of the Year award category) and the Community Paediatric Speech and Language Team (Team of the Year award category).

For more information on our services and their performance please visit
http://www.wdhscp.org.uk/about-us/public-reporting/

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 31st May 2017

Subject: Glasgow City HSCP-led Review of Sexual Health Services across Greater Glasgow & Clyde

1. Purpose

1.1 To bring to the Partnership Board's attention the Glasgow City HSCP-led Review of Sandyford Sexual Health Service across Greater Glasgow & Clyde.

2. Recommendation

2.1 The Partnership Board is recommended to:

- Note the review.
- Agree that a further report will be brought back to the Partnership Board once the review is completed.

3. Background

3.1 Sandyford Sexual Health Service is a service for the whole of NHS Greater Glasgow and Clyde, hosted by Glasgow City HSCP. The service provides universal sexual health services for the population provided for by NHS Greater Glasgow and Clyde as well as specialist services for complex procedures and specific population groups. Many of the specialist services are provided on a regional or national basis.

3.2 The service provides a core universal service which includes:

- Testing and treatment for sexually transmitted infections and blood borne viruses including HIV.
- Comprehensive reproductive health care
- Provision of contraception including long acting reversible methods
- Termination of Pregnancy Services.

3.3 Specialist Services include:

- The Archway service for people who have been raped or sexually assaulted,
- The Steve Retson Project for gay and bisexual men,
- Young People's Services,
- Counselling and Support services,
- Complex gynaecology including for women with long term conditions,
- Sexual Problems service and
- The Gender Identity Service.

3.4 The service has specific public health responsibilities particularly in relation to the prevention of STI and unintended pregnancies. This includes providing testing for HIV and STIs but also involves managing partner notification (i.e. sexual contact tracing to encourage sexual partners of clients to be tested and treated). This is provided for the wider primary care and NHS service. The service also provides emergency post exposure prophylaxis treatment to people who may have been exposed to HIV within the previous 72 hours, which reduces the likelihood of becoming HIV positive. The Free Condoms Service is provided to population groups most at risk of STI and HIV acquisition across 400 venues across the health board area.

3.5 The health improvement service develops strategic partnerships to influence and build capacity with a range of partners including local authorities, HSCPs and third sector providers to enable their staff to deliver sexual health behavioural interventions to the wider population. This includes staff training and policy development for teaching staff in schools and the looked after children's sector and community development work with gay and bisexual men.

3.6 Additionally, the service provides a range of specialist services, including the management of complex sexual and reproductive health needs that cannot be managed by general practice alone, a sexual assault and referral centre which provides forensic examinations for those who have experienced sexual assault or rape, services for those involved in the selling of or exchanging money for sex, gender identity services for young people and adults and a counselling & support service.

3.7 The gender service for young people is the only one in Scotland and the adult gender service is the main one and takes a lead national role. Funding for the gender service relies on cross-boundary charging with other health boards. There are also service level agreements in place for with other boards for vasectomy and psycho-sexual treatments. Archway is the only Sexual Assault Referral Centre in Scotland and has service level agreements with three other board areas.

3.8 Sandyford is also a significant training centre for new consultants in genito-urinary medicine and gynaecology and receives significant funding from NES (NHS Education for Scotland) to facilitate this.

3.9 The service is universal but has a particular focus on vulnerable patients. Sandyford has, over a number of years, developed a lead role across the Board area in the delivery of the aforementioned services, unlike some other Board areas where parts of this service (e.g. the provision of long-acting contraception) is more widely provided by general practice and specialist gynaecology is provided by acute. It has a lead role across the health board area in relation to meeting key national outcomes for sexual health.

3.10 The core services are delivered by a number of consultant genitourinary physicians, consultant gynaecologists, specialty doctors, nursing and, over

recent years, four advanced nurse practitioners have been introduced to the service. The gender service is provided by psychiatry, psychology and specialty physicians.

3.11 Increasingly the service has faced problems with the shortage of specialty medical cover (reflected nationally) which has resulted in the service carrying some medical vacancies. This problem, combined with the current service model, has resulted in Glasgow City HSCP finding it increasingly difficult to deliver the existing service. Consequently, Glasgow City Integration Joint Board has agreed a review of how the service is delivered and what improvements can be made.

4. Main Issues

4.1 The Sandyford Sexual Health Service is managed through the North West Locality of Glasgow City HSCP. It delivers services across 15 sites as follows:

Location	**Number of Days per Week**
Sandyford Central (located in North West)	5
Glasgow North West, Drumchapel	1
Glasgow North East, Parkhead	4.5
Glasgow North East Springburn	3
Glasgow North East, Easterhouse	1
Glasgow South, Govanhill	3
Glasgow South Pollok	3
Glasgow South, Castlemilk	1
Total No. of Days in Glasgow per week	**22.5**
East Renfrewshire, Barrhead	2
Renfrewshire, Paisley	4.5
Renfrewshire, Johnstone	1
Inverclyde, Port Glasgow	3
West Dunbartonshire, Alexandria	2
West Dunbartonshire, Clydebank	1
East Dunbartonshire, Kirkintilloch	1
Total No. of Days in other HSCPs Per Week	**14.5**

4.2 Since its inception, Sandyford services have never been formally reviewed. In light of the current financial climate and the newly established operating environment that is the integration of health and social care, Glasgow City HSCP are taking forward a review and reform process which will:

- Improve the use of existing resources and release efficiencies through service redesign which will consider team structures, skill mix, localities and patient pathways.
- Encourage those who could be self-managing to be supported differently,
- Ensure that Sandyford services are accessible and targeting the most vulnerable groups.

4.3 Feedback from young people's surveys across the health board area have indicated to the Sandyford Service that it is not open at the right times and is not easily accessible in some locations. The sexual health profile of the health board area also indicates that there are areas that could benefit from increased services over others.

4.3 There is a need to look at how the core Sandyford service is structured particularly in relation to team structure, skill mix, localities, opening hours and accessibility. Very reduced numbers of young people attending clinics requires the service to re-think its model in relation to opening times, locations and what outreach services could be developed and delivered.

4.4 In attempting to target resources to the most vulnerable, there is a need to look at more innovative ways of enabling those who can self-manage their sexual health to do so, thus freeing up more clinic time for the most needy.

4.5 There is a clear need to engage with GP and pharmacy services regarding the relationships and pathways between services. The report approved by Glasgow City Integration Joint Board recognises that if it would be beneficial to direct some of Sandyford's routine activity towards GP and pharmacy services then consideration would be required regarding the nature of that activity and how it should be resourced.

4.6 Improved partnership working - perhaps with innovative and very different future arrangements with addiction services, homelessness, criminal justice and the third sector - will also deliver better sexual health outcomes through staff training and the development of outreach. This will be considered as part of the review.

4.7 With the improvements in HIV management and care which means that for most people it is now a long term manageable condition, there is a requirement to look at how outpatient care for this patient group is provided and whether this should continue to be delivered from the acute outpatient based Brownlee Centre in Gartnavel.

4.8 The report approved by Glasgow City Integration Joint Board stresses that it is imperative that this review and reform involves key stakeholders from HSCP services, acute services, education and the third sector utilizing joint commissioning approaches recently approved by the Glasgow City Integration Joint Board.

4.9 This is an extensive programme of change that will be expected to deliver sustainability to the service beyond the 2017/18. Because the service has never been formally reviewed, it will require to be both robust and comprehensive. The Terms of Reference drafted for the Programme Board overseeing the review is appended here.

4.10 The report approved by Glasgow City Integration Joint Board states that the review is expected to be concluded by the end of September 2017, with any subsequent changes agreed taking effect from the beginning of 2018.

5. People Implications

5.1 No implications from this report for West Dunbartonshire HSCP staff.

6. Financial Implications

6.1 No financial implications from this report for West Dunbartonshire HSCP.

7. Professional Implications

7.1 No financial implications from this report for West Dunbartonshire HSCP.

8. Locality Implications

8.1 No financial implications from this report for West Dunbartonshire HSCP.

9. Risk Analysis

9.1 As per 3.11, increasingly the service has faced problems with the shortage of specialty medical cover (reflected nationally) which has resulted in the service carrying some medical vacancies. This problem, combined with the current service model, has resulted in the Glasgow City HSCP service finding it increasingly difficult to deliver the existing service.

10. Impact Assessments

10.1 None required for this report. Glasgow City HSCP have confirmed that an EQIA will be carried out in relation to any reform proposals that come forward as a consequence of the review of the overall service.

11. Consultation

11.1 Any significant service changes recommended by the review will be subject to appropriate consultation by Glasgow City HSCP.

12. Strategic Assessment

12.1 The principles underpinning this review by Glasgow City HSCP mirrors those underpinning the strategic commissioning approach articulated within the West Dunbartonshire HSCP Strategic Plan 2015-16.

Author: Mr Soumen Sengupta – Head of Strategy, Planning & Health Improvement West Dunbartonshire Health & Social Care Partnership.

Date: 31st May 2017

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Appendices: Greater Glasgow & Clyde Sexual Health Service Review 2017/18 - Programme Board Terms of Reference

Background Papers: Glasgow City Integration Joint Board Report (February 2017): REVIEW AND REFORM OF SEXUAL HEALTH

Wards Affected: All

Chief Officer
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Sexual Health Service Review 2017/18

Programme Board Terms of Reference

1.0 Programme Objectives

1.1 In line with the strategic plan for sexual health, to lead on a service review of the Board-wide Sandyford Sexual Health Service, with particular emphasis on the delivery of the core genito-urinary (GUM) and sexual and reproductive health (SRH) services that it currently provides.

1.2 The review will look at options for service improvements/ modernisation and deliver a revised management & staffing structure which will offer a more efficient service and will contribute efficiencies for the financial recovery plan.

1.3 The review will be informed by the findings of the recent organisational development work, The Cultural Web. This made six recommendations for improving "how things are done" in Sandyford and bringing about transformational change. These were;-

- Develop a service strategy
- Develop a service improvement plan
- Review organisation structure, roles and accountabilities
- Create a positive work culture through improved leadership, management and communication
- Develop effective processes for communication, management information and change management
- Review training and development

2.0 Span of Review

2.1 The review will focus on how the service is delivered rather than what it delivers. What the service delivers is set out in the strategic plan.

2.2 The review will not include Sandyford services that already have been formally reviewed and / or are in a process of development, this includes: -

- Archway Sexual Assault & Referral Centre
- Gender Identity Services
- Sandyford Counselling & Support Service (SCASS)
- Termination of Pregnancy and Referral Service (TOPAR)

2.3 Specifically, the review will look to identifying and agreeing: -

- A revised model for the delivery of an integrated GUM and SRH service that will be based on localities with identified team structures.
- The medical, nursing and administrative skill mix required to deliver the service in these localities

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- The management structure required to support the new model and the range of other Sandyford services.
- Improvements to service access, including telephone, electronic access, opening hours and locations.
- Improvements to patient / service user engagement though the development of self-care methods and outreach.

3.0 Programme Executive and Programme Board Responsibilities

3.1 The Programme Sponsor and Programme Board is responsible for: -

- Delivery of the development of the review programme, implementation proposals and operational implementation programme.
- Agreeing the supporting resources required to deliver the programme in accordance with programme objectives and timescales.
- Making the ultimate decisions in relation to action, relative priorities, programme sequencing and implementation.
- Delivering the review outcomes within the agreed financial framework.
- Receiving reports from the identified work-streams and agreeing appropriate recommendations.
- Identifying any internal and external risks resulting from the change programme and responding accordingly.
- Evaluating the impact of any service changes / improvements.

4.0 Programme Sponsor and Programme Board Members

4.1 The Board will comprise of as follows: -

Jackie Kerr, Head of NW Locality	Programme Sponsor & Chair
Rhoda Macleod	Head of Sexual Health
Dr Pauline McGough	Clinical Director, Sandyford
Lorraine Forster	Nurse Consultant and Professional Lead
Gareth Greenaway	Planning Manager – NW Sector
Dr Kerri Neylon	General Practitioner / Clinical Director
Alan Harrison	Community Pharmacy
Sandra Cairney Marie Hedges Jacqui McGinn Fiona MacKay	East Dunbartonshire HSCP East Renfrewshire HSCP West Dunbartonshire HSCP Renfrewshire HSCP
Shona McGregor	People & Change Manager
Michele Minacoulis	Management Accountant
Representative	Public Health
Ann McDaid Bernie Scott	RCN BMA
Mildred Zimunya	Third Sector – Waverley Care
Work-stream leads	
Service User Representation	Reference Group

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4.2 Work-stream leads will require to be identified to take forward the aforementioned programme agenda. These leads will identify a range of appropriate personnel to contribute to their work-stream, ensuring that they are properly representative of the sexual health service.

5.0 Communication and lines of Accountability

5.1 The Programme Sponsor is accountable to the Chief Officer for Glasgow City HSCP. Review progress will be reported via this route to the Chief Officer's Group for Partnerships.

5.2 The representatives from each HSCP will have responsibility for reporting back to their Partnerships.

5.3 The Head of Sexual Health will have responsibility for ensuring that there is effective communication with sexual health staff and other key stakeholders as the review progresses.

ARGYLL, BUTE AND DUNBARTONSHIRES' CRIMINAL JUSTICE SOCIAL WORK PARTNERSHIP JOINT COMMITTEE

At a Meeting of the Argyll, Bute and Dunbartonshires' Criminal Justice Social Work Partnership Joint Committee held in Committee Room 2, Council Offices, Garshake Road, Dumbarton on Thursday, 9 March 2017 at 2.30 p.m.

Present: Councillors Anne Horne and Elaine Robertson (Argyll and Bute Council); Councillor Gemma Welsh (East Dunbartonshire Council) and Councillor Jim Finn (Substitute Member for West Dunbartonshire Council).

Attending: **Argyll and Bute Council:** Louise Long, Head of Children's Services; Kirsteen Green, Business Support Manager, Criminal Justice Services; Becki Emmett, Criminal Justice Manager and Craig McNally, ADP Co-ordinator.

East Dunbartonshire Council: Keith Gardner, Criminal Justice Manager.

West Dunbartonshire Council: Norman Firth, Criminal Justice Partnership Manager, Mary Holt, Transitions Programme Officer; Terry Wall, Finance Business Partner - Corporate Functions and Nuala Borthwick, Committee Officer.

Apologies: Apologies for absence were intimated on behalf of Councillors Gail Casey and Jonathan McColl (West Dunbartonshire Council), Councillor Michael O'Donnell (East Dunbartonshire Council); and Jackie Irvine, Head of Children's Health, Care and Criminal Justice Services.

Councillor Elaine Robertson in the Chair

CHAIR'S REMARKS

Councillor Robertson, Chair, apologised for the late start to the meeting and thereafter welcomed everyone to the final meeting of the Criminal Justice Partnership. In particular, she welcomed Councillor Jim Finn, substitute member for West Dunbartonshire Council, to the meeting.

MINUTES OF PREVIOUS MEETINGS

The Minutes of Meetings of the Joint Committee held on 9 June 2016 and 15 December 2016 were submitted and approved as correct records.

REVENUE BUDGETARY CONTROL REPORT 2016/17 AS AT PERIOD 9 (31 DECEMBER 2016)

A report was submitted by the Treasurer to the Partnership Joint Committee providing an update on the financial performance of the Criminal Justice Partnership to 31 January 2017.

After discussion and having heard the Partnership Manager – Criminal Justice and the Finance Business Partner in further explanation of the report and in answer to Members' questions, the Partnership agreed:-

(1) to note the contents of the report which indicated an adverse variance of £0.010m as at 31st January 2017 with a full year projected overspend of £0.012m to 31 March 2017; and

(2) to thank Officers for their hard work in achieving the substantial reduction in the original budget gap identified.

FUTURE OPPORTUNITIES FOR JOINT WORKING AND COLLABORATION BETWEEN ARGYLL AND BUTE, WEST DUNBARTONSHIRE AND EAST DUNBARTONSHIRE CRIMINAL JUSTICE SOCIAL WORK SERVICES

A report was submitted by the Chief Officer, Health & Social Care Partnership seeking consideration of the future relationship between Argyll and Bute, West Dunbartonshire and East Dunbartonshire Councils with regard to the future delivery of criminal justice social work services.

After discussion and having heard the Partnership Manager in further explanation of the report and in answer to Members' questions, the Partnership agreed:-

(1) to approve the proposals for future planning and delivery of Criminal Justice Social Work Services and collaboration as suggested in Section 4 of the report;

(2) to note that it would continue to be co-ordinated on a North Strathclyde basis and that each Council would be required to consider its own resilience in relation to MAPPA in addition to continuing arrangements for mutual support;

(3) to note that the Joint Management Forum's remit would be to review all collaborative/joint working arrangements and report back to the respective authorities on progress and outcomes whilst making recommendations on the merits or otherwise of continuing, amending or bringing arrangements to a conclusion;

(4) to note that opportunities for joint planning with reference to national community justice strategy and local outcome improvement plans would be taken up in appropriate circumstances;

(5) to note that Members were keen to ensure that the route for reporting of Criminal Justice Services to each of the three Partnership authorities would be clear in the near future; and

(6) to thank Officers for their dedicated work over the years in contributing to the Partnership's success.

PARTNERSHIP STRATEGIC PLANNING FRAMEWORK: 2017-20

A report was submitted by the Chief Officer, Health & Social Care Partnership advising of the completion of the Partnership Planning and Performance Framework 2017-2020 and revisions to ensure compatibility with the needs of each partner authority.

After discussion and having heard the Head of Children's Services, Argyll and Bute Council and the Partnership Manager in further explanation of the report and in answer to Members' questions, the Joint Committee agreed:-

(1) to approve the Planning and Performance Improvement Framework 2017-20;

(2) to note that the Planning Performance and Improvement Framework had been designed to accommodate the needs of individual authorities beyond the lifetime of the Argyll, Bute and Dunbartonshires' Criminal Justice Social Work Partnership; and

(3) to note that there would require to be a link between the Partnership Strategic Plan and the Criminal Justice Improvement Plan.

COMMUNITY PAYBACK ORDER BREACH RATES 2014/15

A report was submitted by the Chief Officer, Health & Social Care Partnership providing information on the most recent Community Payback Order breach rates for the Partnership (2014/15).

After discussion and having heard the Partnership Manager in further explanation of the report and in answer to Members' questions, the Joint Committee agreed:-

(1) to note that local authorities would continue to monitor and review breach rates as part of their performance improvement strategy;

(2) to note that Members were keen to know how the future reporting of Breach Rates would be provided to Elected Members; and

(3) to otherwise note the contents of the report.

AGGREGATE RETURN 2014/15

A report was submitted by the Chief Officer, Health & Social Care Partnership providing information on the most recent Aggregate Return report for the Partnership (2014/15).

After discussion and having heard the Partnership Manager and the Business Support Manager in further explanation of the report and in answer to Members' questions, the Joint Committee agreed:-

(1) to note that Local Authorities would continue to monitor local and national performance with regard to the Aggregate Return; and

(2) to otherwise note the contents of the report.

ANY OTHER COMPETENT BUSINESS - COMMUNITY JUSTICE TRANSITION PLAN: PROGRESS BRIEFING MARCH 2017

A copy of the Community Justice Transition Plan: Progress Briefing March 2017 was distributed to Members. Having heard the Partnership Manager and the Transitions Officer in further explanation, the Joint Committee agreed to note:-

(1) that Community Planning Partnerships in each of the three local authority areas are committed to developing an improved community understanding in order to build capacity to maximise involvement;

(2) that the transitions year scoping work identified the extensive range of targeted and personalised service provision that is delivered to support access to services and the multi-agency development sessions in each of the local authority areas provided a suite of ideas and suggestions for improvement activity during 2017-18 and beyond;

(3) that the consultation on the draft Community Justice Outcome Improvement Plans for Argyll and Bute, West Dunbartonshire and East Dunbartonshire would be open from 10 March 2017 until 24 April 2017; and

(4) that interim results from the survey would be taken on 25 March 2017 and plans finalised and published by 31 March 2017 for implementation from 1 April 2017.

CHAIR'S CLOSING REMARKS

Councillor Robertson, Chair, referred to it being the final meeting of the Joint Committee and took the opportunity to extend her thanks to all Members and Officers for their valued contributions and achievements during their time with the Joint Committee.

The Partnership Manager then thanked Councillor Robertson for her own contributions, having been associated with Criminal Justice Services in Argyll and Bute Council since 2003, and wished everyone best wishes with their future endeavours.

The meeting closed at 3.50 p.m.

West Dunbartonshire Health & Social Care Partnership

Meeting: **SMT Clinical & Care Governance Group**

Date: **29 March 2017**

Time: **9.30am**

Venue: **Golden Jubilee Conference Hotel, Inspiration 3**

DRAFT MINUTE

Present: Keith Redpath, Chief Officer (Chair)
Ken Ferguson, Clinical Director
Julie Lusk, Head of Mental Health
Chris McNeill, Head of Community Care
Soumen Sengupta, Head of Planning
Wilma Hepburn, Professional Nurse Adviser
Serena Barnatt, Head of People and Change
Janice Miller, MSK Physiotherapy Manager
Jackie Irvine, CSWO, Head of Children's Services

Apologies: Julie Slavin
Lynette Cameron

In Attendance: Lorna Fitzpatrick (Minute)

1. Welcome & Introductions

The Chair welcomed the group to the meeting.

2. Minute of Meeting Held on 25 January 2017

The minute of the meeting of 25 January was accepted as an accurate record.

3. Matters Arising

i. There were no matters arising not covered elsewhere on the agenda.

4. Quality Assessment

i. Care Inspectorate Grades for Independent Providers SS

Soumen Sengupta introduced the Update paper. The Care Inspectorate regulates and inspects care services in Scotland, which are subject to routine inspections at least once per year. The paper provides details of recent inspection activity. The content of the report was noted and it was agreed that the paper would be submitted to the next Audit Committee in June.

5. Risk Management

i. Review of Out of Hours Arrangements across NHS Board Area and 6 HSCPs

Jackie Irvine introduced the Review paper. The Chief Officers group have agreed to a review of Out of Hours services. This review is being led by Glasgow HSCP with Suzanne Miller as the Chair of the Review Group.

After discussion, it was agreed that Chris McNeill would request to become a member of the Executive Operational Group. Jackie Irvine will continue to be a member of the Steering Group. Chris McNeill will attend the next Steering Group meeting with Jackie Irvine. CMcN JI

Serena Barnatt agreed to discuss having HR representation on the Steering Group with Sybil Canavan. SB

The SMT agreed to:

- Note the content of the report
- Consider the three key messages within the report
- Request that further progress reports are provided to SMT

The content of the Minute of the Out of Hours Steering Group held on 23 March 2017 was noted.

Keith Redpath advised that there had been some discussion around HSCPs managing the budget for Out of Hours GP Services alongside the service. It was agreed to share the proposal paper with the SMT.

ii. Business Continuity Plan

Soumen Sengupta introduced the paper and the contents were noted.

6. Service User Feedback

i. Integrated Complaints Handling Protocol

Soumen Sengupta introduced the new Integrated Complaints Handling Protocol which covers the three complaints handling procedures which will be introduced on 1 April 2017. The issue of early resolution was discussed. The approach and timescales for handling complaints for all three Complaints Handling Procedures (CHP)are described in the report. . There is no additional stage in any of the procedures which would involve referring to the Chief Officer.

ii. Complaints Report
Soumen Sengupta introduced the Complaints Report and the content was noted. After discussion it was established that staff were now fully aware of complaints procedures and further training on the new protocol is being undertaken across all staff groups.

iii. FOI Report
Soumen Sengupta introduced the FOI Report and the content was noted.

7. Continuous Improvement

i. Jackie Irvine tabled the Community Planning Partnership Joint Children's Services Inspection Improvement Action Plan 2017. The Plan represents a number of improvement actions and milestones which will in effect be developed and implemented across the various CPP strategic planning fora. The template is therefore a collection of the actions that will be taken to address the learning arising from the joint inspection of children's services carried out in 2016 by the Care Inspectorate. It was agreed that Jackie would arrange for development sessions around other care services to support future inspections.

It was agreed to use a future Clinical and Care Governance Forum around Case File Audits and Chronologies and invite front line staff to that. (13 June 2017) Jackie Irvine will take a lead with support from Janice Miller and Wilma Hepburn. The presentation will show a chronology and review how that informs the assessment. Agreed to include some multi-professional group work at the session.

It was agreed to review whether a Case File Audit could be recorded on Care First.

Jackie Irvine went on to provide an update on the work of the newly established Care First User Group. There was also discussion around the production of management reports from Care First. Care First is being transferred on to the Eclipse host which should make the system more streamlined.

8. Staff Governance

i. HR Report March 2017
Serena Barnatt introduced the SMT HR Report which provides the latest workforce information and provides updated figures until the end of February 2017. Serena confirmed that there is a lot of tension around with both the Council and the NHS Board around absence and she has been attending monthly meetings.

After discussion, the SMT agreed to note the contents of the report and the need for specific action as appropriate.

Absence is above target for both NHS and Council, hot spots have been identified and the HR teams are working with managers to support the management of attendance through absence management procedures. SMT agreed to review with service managers absence cases in hotspot areas in particular on a regular basis as part of update meeting.

The SMT noted the need for specific action in relation to KSF and PDP for the NHS.

The importance of following proper procedures was stressed once more.

Serena pointed out that she has a note of cases where improvement notices have not been issued and it was agreed that this information would be shared with heads of service to allow them to address directly. SB

ii. Response to National Consultation on Workforce Planning
The content of the response was noted.

iii. iMatter Update
iMatter is the NHS Scotland continuous improvement tool where staff have the opportunity to engage in developing a Team Action Plan with a view to making small scale improvements to how their team operate and how their service is provided. The paper describes:

- The Statistics
- Feedback from Teams
- Next Steps

There was some discussion around the inclusion of Council staff within iMatter and the importance of excluding those staff from any other model used by the Council.

9. Date of Next Meeting
31 May 2017

West Dunbartonshire Health & Social Care Partnership

Meeting: **Joint Staff Forum**

Date: **18 April 2017**

Time: **10.00am (Staffside pre meeting at 9.30am)**

Venue: **Committee Room 2, Garshake Road**

DRAFT MINUTE

Present: Peter O'Neill (Chair)
Robert McFarlane, Joint Ops Manager
Simon McFarlane, Regional Organiser, Unison
Val Jennings, Unison Convener
Diana McCrone, Unison, NHS
Soumen Sengupta, Head of Strategy
Carron O'Byrne, Manager LAC
Serena Barnatt, HOPAC
Gillian Gall, HR

Apologies: Esther O'Hara
Julie Lusk, Head of Mental Health
Jackie Irvine, CSWO
Chris McNeill, Head of Community Health & Care
Keith Redpath, Chief Officer

In Attendance: Lorna Fitzpatrick (Minute)

Item	Description	Action
1.	**Welcome & Introductions** The Chair welcomed the group to the meeting and there was a request that papers for future meetings be numbered. There was a discussion around having CSP representation on this group and Serena Barnatt confirmed that there would also be future representation from RCN.	
2.	**Minute of Meeting held on 17 January 2017** The Minute of the meeting held on 17 January was accepted as an accurate record.	
3.	**Minutes from Other Meetings for noting:** a) APF Minute The content of the APF meeting was noted. The main	

	issue was around finance for the NHS. b) JCF Minute The content of the JCF meeting was noted. c) Employee Liaison Group Minute The content was noted and it was also noted that there were some concerns around changes to payroll.	
4.	**Matters Arising** a) Finance Update There has been no major progress since the IJB meeting. Chief Financial Officers continue to meet to consider the final NHS settlement. Council settlement is finalised. Within Greater Glasgow, all HSCPs with the exception of Inverclyde have rejected the NHS settlement offer. b) Unison Ethical Care Charter There was a discussion around the content of the draft paper. It was felt that it was short on commitment. Trade Unions are looking for a commitment to sign up to the Charter. This has been going on for a long time and while most of the paper has been adopted, we need to do a bit of work with our providers before full sign up. It was agreed to have a further meeting with Keith Redpath and Chris McNeill ahead of the IJB meeting in May. Soumen Sengupta described the work that the HSCP want to undertake with external providers. Scottish Care dialogue continues. If we get to the position where we agree, then we will do a paper for IJB. Colleagues will be kept informed in either event.	
5.	**SSSC Update** a) Commencement of registration of Support Workers in Care at Home and Housing Support Services Carron O'Byrne advised that there is further legislation expected around registration and this will cover training and registration issues. There are a number of opportunities to support staff. As qualification requirements become clearer support can be provided	

	from TU Learning Fund. New starts from October will be registered and thereafter there will be a phased catch up with existing staff. Serena Barnatt agreed to provide an update on the number of staff who have SVQ Level 2. b) Confirmation of Fee Increase The content of the paper was noted and Carron O'Byrne described the proposed increases to the various staff groups. c) Consultation on Changes to Adult Care Qualifications The consultation was noted.	**SB**
6.	**Service Updates:** a) **Children Services and Criminal Justice** **i)** Criminal Justice Redesign Update There is no detriment in any of the changes and existing grade 5 staff will be able to apply for the new grade 6 post. **ii)** Joint Children's Services Inspection Update The Inspection Report has now been received. There are three recommendations in the report and a draft action plan is currently with the Care Inspectorate. A report will go to the next meeting of the IJB in May. A new Integrated Children's Services Plan is also being worked on. **iii)** Update on Facebook Protocol for use in Children's Homes The draft protocol was initially sent to trade unions in December 2016. It was re-circulated following the last JSF and no comments were received. The protocol will now be circulated among staff with the hope of early sign off. **iv)** Historical Child Sexual Abuse Enquiry Carron O'Byrne advised on the enquiry which has been under way for some time. 69 places across Scotland are being reviewed. The Review is currently reviewing the culture of Hill Park. Once there is more information from the enquiry team, a further update will be provided. It was agreed that an update for staff would be provided when appropriate.	**CO'B**

	v) School Nursing Update There is a redesign of school nursing to provide £1.5m savings across Greater Glasgow. There have been two meetings to set the strategic direction of the review. Deirdre McCormack is leading on the National Redesign and that will be fed into the Greater Glasgow discussion. Unison declined to take part in the initial meetings. Diana McCrone expressed a great deal of concern for the service. b) **Community Care** **i)** Care Home/Day Centre Redesign The content of Minute was noted. Trade Unions remain fundamentally opposed to the staffing model. Serena Barnatt described the process undertaken with staff and the various options available to them. Hustings have been organised for this week and notes have been issued to care homes. **ii)** Integrated Care Fund The content of the Minute was noted. **iii)** Sheltered Housing Agreed to provide an update at the next Convenors meeting on 6 May.	**CMcN**
7.	**Standing Items:** a) Health & Social Care Partnership Board Soumen Sengupta described the content and confirmed that the next meeting was scheduled for 31 May 2017. Representation for this will be decided at a meeting of the Council before then. b) HR Report a. Discipline & Grievance Report Gillian Gall and Serena Barnatt introduced the report which advises the JSF on progress on discipline, grievance and dignity at work cases for employees within the HSCP for the period 1 January t0 31 March. The JSF agreed to note the content of the report. b. Attendance Management Report Gillian Gall and Serena Barnatt introduced the absence paper and provided a verbal update for March figures.	

	c. Health and Safety The Minute of the meeting held on 24 January 2017 was discussed. Serena Barnatt advised that Reliance was being rolled out across the HSCP. This replaces Guardian 24. The group next meets on 25 April.	
8.	**Items for Noting:** a) Duty of Candour Policy The content of the policy was noted. b) National Health & Social Care Workforce Plan Response The content of the response was noted.	
9.	**Vaccination Transformation Programme** Diana McCrone introduced the paper. The business case proposes the establishment of a Vaccination Transformation programme as a national programme, led by Government, and with NHS Boards as local business change authorities to provide leadership on local delivery solutions.	
10.	**HR Working Group** Serena Barnatt introduced the paper and described the content. Concerns were expressed around the restrictive approach proposed. The paper does not appear to have moved on in the way that partnerships have.	
11.	**AOCB** There was no further competent business.	
12.	**Date of Next Meeting** Tuesday 18 July 2017, 10.00am (Staffside pre meeting 9.30am), Committee Room 2, Garshake Road. Apologies: Simon MacFarlane	

West Dunbartonshire Health & Social Care Partnership

Meeting: **Dumbarton and Alexandria Locality Group**

Date: **27 January 2017**

Time: **10:00 am**

Venue: **Seminar Room, Vale Centre for Health and Care**

MINUTE

Present:	Saied Pourghazi	GP, Levenside Practice
	Kirsteen MacLennan	Integrated Operations Manager
	Yvonne Milne	Team Lead, Mental Health
	Craig Farish	MSK Physiotherapy Team Leader
	Gillian Bonar	Practice Manager, Levenside
	Amanda Brooks	Practice Manager, Levenside
	Marjorie Johns	Planning Manage, Acute
	Pamela Macintyre	Lead for Prescribing and Clinical Pharmacy
	Lynne McKnight	Integrated Operations Manager Care at Home
	David Clark	GP, Lennox
	Stephen Dunn	GP, Dun Practice
	Neil Mackay	GP, Bank Street
	Claire McGonagle	GP, Neilson & McGonagle/SAS
	Jennifer Perry	GP, Logan & Perry
	Jane Young	GP, Riverview
	Fiona Wilson	GP, Oakview
	Anna Crawford	Primary Care Development Lead
	Kathryn McLachlan	GP, Furneaux
	Brian Polding-Clyde	Local Integrated Lead
	Selena Ross	CEO, Community Volunteering Service
	Mary Angela McKenna	Integrated Operations Manager, COPT
	Chris McNeill	Head of Adult Health and Care Services
	Lesley Traquair	Minutes

Apologies: Val McIver/William Wilkie/Tracy Cassidy/ Kenneth Ferguson

Item	**Description**	**Action**
1.	**Welcome & Introductions** Dr. S. Pourghazi opened the meeting and apologies were noted.	
2.	**Minute of Meeting Held on 9 November 2017** Minutes of meeting were agreed as an accurate record.	

3. Matters Arising

- C. McNeill awaiting a response from Consultant in Acute regarding engaging with Frailty Group.
- W. Wilkie looking for GP representation to be involved in education sessions with optometrists and community pharmacy. P. Macintyre to identify date with Community Pharmacists. W. Wilkie to provide information on local opticians.
- A draft leaflet to encourage patients to visit Optometrists rather than GP for eye problems was shared with the group, W Wilkie asked that any suggestions be sent to him before final version published.
- Dr. N. Mackay highlighted that referrals being made by secondary care specialists and as a result of these referrals letters being generated are being sent to the GP and not the referring Consultant. This has been raised by M. Johns at the Referral Management Group and is an issue with the Trackcare system which is being reviewed.

4. Scottish Ambulance Service

C. McGonagle provided a presentation on the work within the Scottish Ambulance Service and highlighted the New Clinical Response Model and response times for ambulance requests. This was informed by an analysis of a year's Scottish Ambulance Service data. C. McGonagall asked for GPs to flag any issues with ambulance request, as this will help in reviewing the effectiveness and safety of the model. C. McNeill asked C. McGonagle to speak to the Clydebank Locality meeting.

C. McGonagle explained that eKIS is available within the Scottish Ambulance Service but not always used operationally. This is being taken forward within the Scottish Ambulance Service.

5. Cluster Update Report

Cluster update provided at Business Meeting.

6. Frailty Work Plan Update

An overview of the Frailty Sub Group work was presented. Community Teams to consider incorporation of Dalhousie Frailty Scale within services. A frailty template has been developed which can be imported into EMIS and has been shared with Levenside practice. EMIS can support the sharing of this information through eKIS. The group will engage with national falls and frailty leads to consider national work.

Falls to be discussed at sub group meeting as a clear pathway is required. Falls to be added to agenda at Frailty Sub Group.

7. COPD Workplan Update

J. Young updated the group on the work undertaken at the last

meeting held on 18 November. J Young circulated details of the COPD service in West Dunbartonshire. Discussion was had around referral activity to pulmonary rehabilitation and how this can be increased. Natasha Breen, Respiratory Nurse, Pulmonary Rehabilitation Team has contacted Practice Managers/ Practice Nurses to highlight that assessments are now being provided within Dumbarton Health Centre.

Nebuliser access and use was discussed. No repairs are being carried out but product can be replaced by acute pharmacy.

George Murphy, Public Involvement Officer, West Dunbartonshire Health and Social Care Partnership attended the last meeting and agreed to explore if there is an appetite for a local support group.

The next COPD sub-group will look at palliative and end of life support for COPD patients and consider the draft COPD Smoking service report.

8. Technology Enhanced Care (TEC)

P. McIntyre advised the TEC service is up and running for COPD with a few patients to test out the Florence system and processes.

Text messages are sent to patients and alert sent to the COPD Nurse for follow-up in line with the agreed self management pathway. Community alarms have started on a small level at present but it is hoped to increase this in the future.

The Health and Social Care Partnership have equipment to carry out enhanced assessments for frail patients. This is designed for use with patients recently discharge from hospital, or whose condition has changed in the community. The equipment will help make decisions about an appropriately tailored package of care for individual patients. This work links with the Dalhousie Frailty Score currently being considered by the locality. It is anticipated the TEC will be rolled out within the next few weeks with three kits available at the moment.

9. Any Other Business

Discussion was had on future dates of these meetings. It was agreed that Fridays was the preferred date. C. McNeill agreed to update K. Ferguson on what has been discussed and his attendance at future meetings. **C McN**

10. Date of Future Meetings

Friday, 24 March 2017
Friday, 19 May 2017
Friday, 23 June 2017.

West Dunbartonshire Council | NHS Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

Chief Officer: Keith Redpath

West Dunbartonshire Health & Social Care Partnership

Meeting: **HSCP Clydebank Locality**

Date: **Tuesday 21st February, 2017.**

Time: **10.00 – 12.00**

Venue: **Conference Room, Clydebank Health Centre**

MINUTE

Present :-

Name	**Designation**
Chris McNeil	Head of Community Health & Care Services
Dr. Alison Wilding	GP Red Wing (Chair)
Dr. Eddie Crawford	GP Orange Wing
Dr. Anthony Kearney	GP Old Kilpatrick Medical Practice
Pamela McIntyre	Prescribing Lead
Dr. Neil Murray	GP Green Wing
Jane McNiven	Practice Manager, Green Wing
Kirsteen MacLennan	Integrated Operations Manager, Hospital Discharge
Jackie Irvine	Head of Child Health, Care & Criminal Justice
Anna Crawford	Primary Care Development Lead
Pamela Ralphs	Planning Manager, Acute
Dr. Arun Rai	GP Purple Wing
Dr. Neil Chalmers	GP Yellow Wing
Dr. Mai MacSorley	GPST 3 Green Wing
William Wilkie	Lead Optometrist

Apologies :-

Name	**Designation**
Brian Polding Clyde	Development Officer
Dr. Ralph Cunningham	GP Blue Wing
Maggie Ferrie	Practice Nurse Blue Wing
Patricia Rhodie	Integrated Operation Manager, Addictions Team
Dr. Kenneth Ferguson	Clinical Director
Val McIver	Senior Nurse
Mary Angela McKenna	Integrated Operations Manager, Community Older People Team
Marie Rooney	Integrated Operations Manager, Mental Health Team

Item	**Description**	**Action**
1.	**Welcome & Introductions**	
2.	**Minute of Meeting Held on 13.12.16** • Agreed as correct	

3. Cluster Update :-

- A Wilding updated the group on meeting in January, work is ongoing, Practices are looking at the Quality Outcomes Framework, mental health and diabetic foot pathways.
- In addition the Cluster is having ongoing discussions about the Pain Clinic and Direct Oral Anticoagulants.

4. Mental Health Workplan :-

- Dr. Wilding provided an update in M Rooney's absence.
- The Cluster will consider physical health check for patients accessing mental health services.
- The Group noted changes to the Out Of Hours crisis team with the merging of Addictions, Learning Disabilities and Mental Health Services out of hours.
- Dr Wilding has contacted M Rooney about the current waiting times for Primary Care Mental Health Team.

5. Addictions Work Plan :-

- Patricia Rhodie, Integrated Operations Manager replaces Julie Lusk within West Dunbartonshire's Addiction Team.
- SCI Gateway change has been approved at the Referral Management Group and will be implemented over the next few months.
- No change in shared care at present.
- A Wilding advised that the lunchtime education sessions on New Psychoactive Substances was very informative.

6. Children's Service Workplan (Jackie Irvine) :-

- No update in terms of action plan
- A Crawford to contact SCI Gateway regarding previous request for inclusion of parental consent on the referral form to Community Adolescent Mental Health Service (CAMHS). **AC**
- Following last meeting, J Irvine met with A Wilding and R Cunningham regarding referrals for CAMHS. They reviewed the referrals and criteria (67% accepted as appropriate referrals)
- It was noted clinicians were unsure if action was required when they received a letter from the CAMHS team. J Irvine clarified that standard practice is parent gets a letter from the service which is copied to GP, the onus is on the parent or child to make the next steps.
- Guiding through the Maze for Children's Services has a lot of information for all users. J Irvine agreed to condense this for General Practice. **JI**
- J Irvine agreed to re-schedule the meeting with Community Adolescent Mental Health Service and GPs. **JI**

7. Eye Problems :-

- A joint meeting on the 25th April 2017 (6.30pm is being arranged with Pharmacy, Optometry and GPs in relation to Falls. W Wilkie welcomed GP representatives at meetings (25th April).
- W Wilkie asked for feedback on the advice document for GP reception staff to use for guiding patients to Optometry services for eye problems. W Wilkie asked the group for their thoughts on Optometrists reviewing children from birth, the group agreed this was appropriate with the correct training.
- GPs will see neonatal patients (under 3 months) after which children will be seen by optometrists for eye problems
- Optometry Practice staff are being trained on how to triage patients

requesting immediate appointments with the optometrists

- Retinal screening service down at present (changing to new computer system) due to come back up in around 2 weeks time if transfer of data works. Risk to patient is minimal at present.

8. Practice Activity Report :-

- The report was circulated prior to meeting, it was noted that more up to date data will be available via the SPIRE system which is being rolled out to General Practice.
- The PAR is reviewed as part of the Cluster meeting agenda.

9. AOCB :-

April Meeting :-

- Patricia Moylan, Consultant for Care of Elderly Services in Gartnavel General Hospital will attend the locality meeting in April and provide an overview of the Day Hospital at Gartnavel General Hospital.
- An overview of community older people services will be provided and will include ACP Nurses and criteria for referral. M A McKenna will provide an overview of the Frailty work being progressed within Alexandria and Dumbarton Locality.
- In addition a demonstration of the Technology Equipment will be provided.

Prescription requests from Secondary Care :-

- An issue was highlighted where prescription requests from Secondary Care are received via telephone, GP highlight that the patient knew nothing about medication and possible side effects as consultant had phoned patients wife about the treatment.
- The group asked if it was feasible for consultants to indicate (tick a box) they have spoken with the patient about potential side effects. It was agreed this was an issue for the primary care/secondary care interfacing.
- Practices were advised to email Business Managers regarding any issues to highlight concerns.

Dementia :-

- Post diagnostic support for dementia patients is sourced from Alzheimer Scotland, patients are entitled to twelve months of support post diagnosis. It was noted there is a waiting list for this service, C McNeill agreed to discuss with Julie Lusk, Head of Mental Health, Learning Disability and Addictions to query if they have resource to invest in additional time to reduce waiting list. **CMcN**
- The group were informed that the West Dunbartonshire Dementia friendly drive has won an award in Japan.

10. Date of Next Meeting

25th April, 2017.

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West Dunbartonshire Local Engagement Network

Open Forum Discussion: Adult Carers

16 May 2017 in the Carers of West Dunbartonshire Centre, Clydebank

The session began with an introduction and scene setting by Soumen Sengupta, Head of Strategy, Planning and Health Improvement with the Health & Social Care Partnership. The caring responsibilities of workshop attendees spanned dementia, learning disabilities, long term conditions and mental health.

The workshop discussion, chaired by Barbara Barnes highlighted the following key points:

- The group had mixed experiences around accessing information and advice on their respective caring roles
- Managing information and service access across geographical boundaries was problematic (e.g. where the carer lives in West Dunbartonshire and the cared for person in Glasgow) with carers feeling that they often lost out by 'falling through the gap'
- Information relatively easy to find on the internet but need to know it is from a trusted source
- Pathways through and across services not clear
- Transition points are problematic – into school, primary to high school, children to adult services etc
- Can be difficult to gain appropriate information when the cared form person moves within the system eg. during hospital admission
- Access to services is needed outwith office hours (9-5)
- Carers of West Dunbartonshire services are good
- Social work support can be patchy depending on the worker involved and the level of knowledge the worker has about the cared for person
- More befriending support is needed for young adults with complex needs
- Increase awareness and support around Power of Attorney and mandates would be helpful
- Levels of support are better for older people than adults in general

- Too much emphasis is put on crisis point activity and not enough on anticipatory planning
- Need to improve awareness of carer support at points of diagnosis
- Increase the opportunities for carers to network and share experiences
- Focus on recruitment and training of paid carers to ensure they better understand the nature of the caring relationship and how their role fits within it
- Need to improve opportunities for condition-specific carers groups to develop
- Consideration of positively managing any ending of a caring relationships
- Increase awareness of the choice of service providers available for people needing support

Main Feedback

Generally participants felt that more could be done to help support the caring role. In particular, those attending felt that the focus should be on:

- Clear information and support at points of transition
- More anticipatory planning and less reliance on crisis support
- Improved cross-boundary partnership working with the cared for person and carer at its heart
- Better service availability outwith office hours
- Increase staff knowledge of the role of carers to help develop better partnerships
- Better promotion of mandates and power of attorney
- Faster appointment of key workers
- Broader access to Carers Centre information

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West Dunbartonshire Local Engagement Network

Open Forum Discussion: Young Carers

16 May 2017 in Y-Sort It offices, Clydebank

The session began with an introduction and scene setting by Anne MacDougall, Clydebank LENS Chairperson. The young carers present included both child and young adult carers.

The workshop discussion, chaired by Anne MacDougall highlighted the following key points:

- The group had mixed experiences around accessing information and advice on their respective caring roles
- Strong reliance on Y-Sort It workers to get information needed, including internet searches and supporting engagement and liaison with services
- Perceived gap between the definition of a young carer and how young carers perceive themselves
- Pathways through and across services not clear
- Transition points are problematic – primary to high school, children to adult services etc
- Before Y-Sort It there was nothing for young carers to do
- Raising awareness in schools has been positive but still much to do to identify young carers
- Social networks are useful for information and also getting in touch with workers quickly
- Perceived lack of understanding from teachers around impact of caring on school work/submission of homework
- Two main sources of information and support are Y-Sort It workers and Pastoral care teachers at school
- Perception that social work support is not flexible or consistent enough (infrequent connections and changes in staff)
- Relationship building is important to understand the young carers life – barrier to engagement is having to retell the story to someone new every time

- Every young carer is different – the group agreed that it might be useful to have a similar discussion session directly with social work to talk through how they feel services work for young carers
- Issues can arise when the cared for person needs/receives GP or hospital treatment with the young carers feeling they are not taken seriously or informed appropriately

Main Feedback

Generally participants felt that more could be done to help support understanding of their caring role.
In particular, those attending felt that the focus should be on:

- Increasing awareness in schools – both for teachers and staff and also to help reach more young carers
- Make services more accessible to young carers
- Greater number of young carer activity groups and fun things to do
- Build better relationships between young carers and social work service
- Raise awareness of the carer recognition card
- Better transport to get young carers to and from school
- Better use of social media across all services to share information with young carers

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