Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board Audit Committee

Date: Wednesday, 20 June 2018

Time: 14:00

Venue: Civic Space,
Council Offices, 16 Church Street, Dumbarton

Contact: Nuala Quinn-Ross, Committee Officer
Tel: 01389 737210 Email: nuala.quinn-ross@west-dunbarton.gov.uk

Dear Member

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

The business is shown on the attached agenda.

Yours faithfully

JULIE SLAVIN

Chief Financial Officer of the
Health & Social Care Partnership

Distribution:-

Voting Members
Allan Macleod (Chair)
Marie McNair (Vice Chair)
Denis Agnew
John Mooney
Rona Sweeney
Audrey Thompson

Senior Management Team – Health & Social Care Partnership
Mr C. McDougall
Ms Z. Mahmood

Date of issue: 7 June 2018

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE

WDNESDAY, 20 JUNE 2018

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 MINUTES OF PREVIOUS MEETING **7 - 18**

Submit for approval as a correct record, the Minutes of Meeting of the Health & Social Care Partnership Board Audit Committee held on 14 March 2018.

4 COMMITTEE ACTION LIST **19 - 24**

Submit a note of the Audit Committee's Action List for information.

5 UNAUDITED ANNUAL REPORT AND ACCOUNTS 2017/18 **To Follow**

Submit report by the Chief Financial Officer providing an overview of the unaudited annual report and accounts for the HSCP Board for the period 1 April 2017 to 31 March 2018 and outline the legislative requirements

6 INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018 **25 - 54**

Submit report by the Chief Internal Auditor Annual providing an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health and Social Care Partnership Board's internal control environment that can be used to inform its Governance Statement.

7/

7 AUDIT PLAN PROGRESS REPORT **55 - 94**

Submit report by the Chief Internal Auditor advising on progress made in relation to the Audit Plan for 2017/18 and in progressing other action plans.

8 LOCAL CODE OF GOOD GOVERNANCE REVIEW **95 - 101**

Submit report by the Chief Financial Officer advising on the outcome of the annual self-evaluation exercise on the Board's compliance with its Code of Good Governance.

9 CARE INSPECTORATE REPORT FOR CHILDREN & YOUNG PEOPLE'S SERVICES OPERATED BY WEST DUNBARTONSHIRE HSCP **103 - 115**

Submit report by the Chief Officer highlighting the recent excellent inspection results which our Throughcare and Aftercare Housing Support Service, has achieved.

10 CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WEST DUNBARTONSHIRE HSCP **117 - 122**

Submit report by the Integrated Operations Manager providing information on the most recent inspection reports for one of the Council's Older People's Residential Care Home Services.

11 CARE INSPECTORATE REPORTS FOR HOME CARE AND SHELTERED HOUSING SERVICES PROVIDED BY WEST DUNBARTONSHIRE HSCP **123 - 127**

Submit report by the Head of Health and Community Care providing information on recent inspection reports for Home Care and Sheltered Housing Services.

12 CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S CARE HOMES OPERATED BY INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE **129 - 132**

Submit report by the Interim Head of Strategy, Planning & Health Improvement providing a routine up-date on the most recent Care Inspectorate inspection report for one independent sector residential older peoples' Care Home located within West Dunbartonshire.

19 ORAL HEALTH UPDATE **179 - 183**

Submit report by the Health Improvement and Inequalities Manager providing an update following previous March Audit Committee on local oral health improvement activities contributing to the ongoing collaborative work between the HSCP, WDC and NHSGGC Oral Health Directorate (OHD)

20 UPDATE REPORT ON INDEPENDENT SECTOR PROVIDER SENSE **To Follow**

Submit report by the Interim Head of Strategy, Planning & Health Improvement providing an update on the Care Inspectorate Grade "Adequate", and outlining the current status and any actions or activities in place to address this grading.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD AUDIT COMMITTEE

At a Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit Committee held in the Council Chamber, Clydebank Town Hall, Dumbarton Road, Clydebank, on Wednesday 14 March 2018 at 2.00 p.m.

Present: Allan MacLeod (Chair), Councillor Marie McNair (Vice Chair), Baillie Denis Agnew, Councillor John Mooney and Rona Sweeney.

Attending: Beth Culshaw, Chief Officer of the Health & Social Care Partnership; Julie Slavin, Chief Financial Officer; Jo Gibson, Head of Community Health and Care; Jackie Irvine, Head of Children's Health, Care and Criminal Justice Services; Wendy Jack, Interim Head of Strategy, Planning and Health Improvement; Julie Lusk, Head of Mental Health, Addictions and Learning Disability; Colin McDougall, Chief Internal Auditor; Serena Barnatt, Head of People and Change and Nuala Quinn-Ross, Committee Officer.

Also Attending: Carol Hislop, Senior Audit Manager; Zahrah Mahmood, Senior Auditor; Audit Scotland and Frances McLinden, General Manager and Lead Officer for Dental Services NHS GG&C Oral Health Directorate.

Apologies: An apology for absence was intimated on behalf of Audrey Thompson.

Allan MacLeod in the Chair

DECLARATIONS OF INTEREST

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

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the Health & Social Care Partnership Board Audit Committee held on 20 September 2017 were submitted and approved as a correct record.

PRESENTATION BY THE GENERAL MANAGER AND LEAD OFFICER FOR DENTAL SERVICES NHS GG&C ORAL HEALTH DIRECTORATE

A presentation was provided by Frances McLinden, General Manager and Lead Officer for Dental Services NHS GG&C Oral Health Directorate on the measures to tackle the current oral health picture locally.

Ms McLinden highlighted areas where progress had been made and where challenges remain to improve oral health and reduce inequalities for the population of West Dunbartonshire.

Ms McLinden advised that oral health in West Dunbartonshire remained poor and year on year improvements had not been at a level found elsewhere in the NHS GG&C. It was noted that registration of very young children (0-2 years) with an NHS dentist remained low within West Dunbartonshire and that this needed to be addressed.

Ms McLinden advised that to meet oral health targets would require continued partnership working and community development with colleagues in WD HSCP and elsewhere.

Ms McLinden highlighted some of the services available throughout the area, including a fluoride varnishing programme and the out of hours provision, and spoke about the many initiatives which were already being carried out within West Dunbartonshire including the Childsmile campaign.

Ms McLinden also advised that the Scottish Government would be launching a Challenge Fund, where local authority areas could bid for funding for initiatives to help improve oral health in their area, and offered to assist in completing bid funding applications.

The Chair, thanked Ms McLinden for her very informative presentation and the Committee agreed that the Interim Head of Strategy, Planning and Health Improvement would devise an action plan for the consideration of the WD HSCP Board to identify possible initiatives and best practices from other local authorities.

ADJOURNMENT

Having heard the Chair, Allan MacLeod, the Committee agreed to a short adjournment.

The meeting resumed at 2.57 p.m. with all those Members noted in the sederunt being present.

CHAIR'S REMARKS

The Chair, Allan MacLeod, invited the Chief Officer and the Chief Financial Officer to address the Committee to provide an update on the potential budget position for 2018/19.

The Chief Officer advised that:-

- West Dunbartonshire Council, at its budget meeting on 5 March 2018, withdrew its £1.6 million saving option for the WD HSCP.

- The WD HSCP consultation had gone live on 6 March 2018 as a web based consultation, for a period of 4 weeks. Groups wishing to discuss the consultation were offered the opportunity to meet and discuss.

- There were still challenges to the budget, including prescribing costs and work was ongoing with GPs and Prescribing Support Pharmacists to proactively address both current and future pressures. .

The Chief Financial Officer advised that:-

- It was anticipated that the financial offer from the Health Board would be received in the next few days.

- Prescribing costs would continue to be an issue due to manufacture short supply problems.

- The initial projected 2018/19 Prescribing pressure of approximately of £1 million for HSCP Health Care Budget, predicted in February 2018, had reduced significantly in the last few weeks and is now anticipated to likely be in the region of between £600,000 to £700,000 and she would be in a position to provide an update on this in August 2018.

- A detailed report on the budget for 2018/19 would be presented to the WD HSCP at its meeting in May 2018.

COMMITTEE ACTION LIST

Having heard the chair, the Committee agreed to the circulation of an updated Committee Action List, which was then provided to those members present as is shown as Appendix 1 to these minutes.

The Chief Financial Officer advised that on 6 March the Keeper of Records for Scotland had advised that they would be requesting the submission of a Records Management Plan, to be submitted in January 2019.

AUDIT PLAN 2017/18 PROGRESS REPORT AND AUDIT PLAN 2018/19

A report was submitted by the Chief Internal Auditor:-

(a) providing an update on the planned programme of audit work for the year 2017/18;

(b) advising on the progress on the agreed actions from the audit of the Partnership Board's Governance, Performance and Financial Management arrangements;

(c) advising on the progress on the agreed actions arising from the Annual report to the IJB and the Controller of Audit for the financial year ended 31 March 2017 from the External Auditors, Audit Scotland; and

(d) providing details of the planned programme of work for 2018/19.

After discussion and having heard the Chief Internal Auditor and the Senior Audit Manager, Audit Scotland in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the progress made in relation to the Audit Plan for 2017/18; and

(2) to approve the Audit Plan for 2018/19.

2017/18 ANNUAL ACCOUNTS AUDIT PROCESS

A report was submitted by the Chief Financial Officer providing an overview of the preparation of the 2017/18 Annual Accounts of the HSCP Board identifying legislative requirements and key stages.

The Chief Financial Officer was heard in further explanation of the report. Thereafter the Committee agreed:-

(1) to note the contents of the report; and

(2) that a report be presented to the HSCP Board on 2 May 2018, seeking delegated authority for the Audit Committee to approve the unaudited annual accounts, including the annual governance statement for submission to the HSCP Board's external auditors, Audit Scotland, by 30 June 2018.

AUDIT SCOTLAND: WEST DUNBARTONSHIRE INTEGRATED JOINT BOARD ANNUAL AUDIT PLAN 2017/18

A report was submitted by the Chief Financial Officer presenting the Annual Audit Plan produced by the IJB's external auditors, Audit Scotland, for the audit of the financial year ending 31 March 2018.

After discussion and having heard the Chief Financial Officer and the Senior Auditor, Audit Scotland in further explanation of the report and in answer to Members' questions, the Committee agreed to note the Audit Scotland's 2017/18 draft Audit Plan.

AUDIT SCOTLAND REPORT ON NHS IN SCOTLAND 2017

A report was submitted by the Interim Head of Strategy, Planning Health & Improvement advising on the recently published Audit Scotland report on the NHS in Scotland 2017.

The Interim Head of Strategy, Planning & Health Improvement was heard in further explanation of the report. Thereafter the Committee agreed to note the findings of the Audit Scotland report.

COMPLAINTS HANDLING PROCEDURES - CONFIRMATION OF COMPLIANCE

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement presenting confirmation from the Scottish Public Services Ombudsman that the approved Health & Social Care Partnership Board Complaints Handling Procedure is fully compliant with the Requirements of the Scottish Government and Associated Public Authorities Model CHP.

After discussion and having heard the Interim Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to a Members' question, the Committee agreed to note the Scottish Public Services Ombudsman's confirmation of compliance.

CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

A report was submitted by the Head of Community Health and Care Services providing information regarding the most recent inspection reports for the Council's Older People's Residential Care Home Services.

After discussion and having heard the Head of Community Health and Care Services in further explanation of the report and in answer to a Member's question, the Committee agreed to note the contents of the report and the work undertaken to ensure grades awarded reflect the quality levels expected.

CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S CARE HOMES OPERATED BY INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE

A report was submitted by the Contracts & Commissioning Officer providing a routine update on the most recent Care Inspectorate assessments for one independent sector residential older people's Care Home located within West Dunbartonshire.

The Committee agreed to note the contents of the report.

CARE INSPECTORATE REPORT FOR CHILDREN & YOUNG PEOPLE'S SERVICES OPERATED BY WEST DUNBARTONSHIRE HSCP

A report was submitted by the Head of Children's Health, Care and Criminal Justice providing information on the most recent inspection report for Craigellachie Residential Children's House.

Having heard the Head of Children's Health, Care and Criminal Justice in further explanation of the report, the Committee agreed to note the contents of the report and the work undertaken to ensure grades awarded reflect the high quality levels expected by the HSCP.

CHAIR'S REMARKS

The Chair, Allan MacLeod, invited the Chief Officer to address the Committee on staffing during the recent Red Weather Warning.

The Chief Officer advised:-

- That many staff stayed at their workplace after their shift had ended to assist where colleagues were unable to attend.
- Many staff had gone above and beyond the call of duty to help residents.
- Partnership working was invaluable, in particular working with colleagues within the Roads Department.
- Senior Managers had been asked to provide names of individuals and the Chief Officer would write to them personally to thank them.
- A debriefing session would be held with Senior Managers to assess the situation.
- Business Continuity plans would be reviewed.

Thereafter, the Committee agreed to acknowledge the commitment and dedication to continue providing services in such exceptional circumstance by HSCP staff and third parties.

CARE INSPECTORATE REPORTS FOR SUPPORT SERVICES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE

A report was submitted by the Contracts & Commissioning Officer providing a routine update on the most recent Care Inspectorate assessments for seven independent sector support services operating within the West Dunbartonshire area.

The Committee agreed to note the contents of the report.

WORK UNDERTAKEN TO IMPROVE GRADES AT DUNN STREET RESPITE SERVICE

A report was submitted by the Head of Mental Health, Addictions and Learning Disability providing an update of the work being undertaken to support the improvement of Care Inspectorate Grades of Dunn Street Respite Care Unit Clydebank.

After discussion and having heard the Head of Mental Health, Addictions and Learning Disability in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the work being undertaken to support Quarriers to make improvements with their clinical and care governance processes and standards of care delivery; and

(2) that a further report, providing an update on progress be submitted to the next meeting of the Committee.

ARE THEY INVOLVING US? INTEGRATION AUTHORITIES' ENGAGEMENT WITH STAKEHOLDERS - A REPORT BY THE SCOTTISH PARLIAMENT HEALTH AND SPORT COMMITTEE REPORT

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement advising on a recent report published by the Scottish Parliament Health and Sport Committee, and the Cabinet Secretary's formal response to it.

The Interim Head of Strategy, Planning & Health Improvement was heard in further explanation of the report. Thereafter, the Committee agreed to note the contents of the report.

LOOKING AHEAD TO THE SCOTTISH GOVERNMENT HEALTH AND SPORT DRAFT BUDGET 2018-19: A CALL FOR GREATER TRANSPARENCY

A report was submitted by the Chief Financial Officer advising on a report published by the Scottish Parliament Health and Sport Committee on 13 November 2017 and the Cabinet Secretary for Health and Sport related responses.

The Chief Financial Officer was heard in further explanation of the report and in answer to a Member's question. Thereafter, the Committee agreed:-

(1) to note the contents of the report; and

(2) the commitment made to work together with Integration Authorities (IAs) and their partners to increase transparency around budgets and financial performance.

PROVISION OF TAXI SERVICES FOR NON-SCHEDULED AND SCHEDULED TAXI JOURNEYS FOR THE HEALTH AND SOCIAL CARE PARTNERSHIP

A report was submitted by the Contracts & Commissioning Officer seeking approval to proceed to a re-tendering process to secure Taxi Services for non-scheduled and scheduled taxi journeys to predominately support the Health and Social Care Partnership services, as part of a co-ordinated arrangement between West Dunbartonshire Council and the Health Board.

After discussion and having heard officers in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) that a tender exercise in line with European legislation and Council Standing Orders involving a Dynamic Purchasing System (DPS) be advertised in the Official Journal of the European Union (OJEU) and Public Contracts Scotland to obtain non-scheduled and scheduled taxi journeys for Council and Health Board premises located in the West Dunbartonshire area, for an initial fixed 5 year period with a further potential 5 years agreed on a year by year decision;

(2) that authority be delegated to the Chief Officer of the Health and Social Care Partnership, to accept the most economically advantageous tender/s received and appoint a successful tenderer or tenderers; and

(3) that at the end of the fixed agreement period, the Chief Officer of the Health and Social Care Partnership should review the position and consider whether to extend the contract for a maximum of a further additional 5 year period on a year by year decision.

The meeting closed at 4.24 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
AUDIT COMMITTEE
COMMITTEE ACTION LIST- updated 28 February 2018

Meeting Date - 23 March 2016					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
1.	**Equality Act 2010 Mainstreaming Report** A report on the range of vulnerable and socio-economic groups as well as protected characteristics be provided to the next meeting of the Audit Committee to enable members to consider marginalised groups other than those required by the Equality Act 2010. Public Health and Health Inequalities Report – will address socio-ecomonic factors .	HSCP Board – 2nd May 2018	Head of Strategy, Planning and Health Improvement /	Update February 2018 HSCP has a statutory duty to publish an update to the Mainstream report by 30 April 2018. A paper will be presented to the 2 May 2018 HSCP Board. The National Public Health Priorities and NHS Health Scotland Publication were postponed nationally and have not been published as yet. New timescales from Scottish Government for the National Public Health priorities are to be published by Spring 2018. NHS Health Scotland document is planned to be published next month. The new NHSGGC Public Health Strategy is planned to go to the NHSGGC Board March 2018. A paper on the NHSGGC Public Health Strategy will be presented to the 2 May 2018 HSCP Board incorporating any published national reports (as above) within this paper.	

Meeting Date – 7 December 2016					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
2.	**Audit Scotland Reports on Local Government in Scotland 2016**	June 2018	Head of Strategy, Planning and Health Improvement	Update – June 2017 Officers prioritised development of the local Code of Good Governance to HSCP Board, as that	

	It was agreed that the Senior Audit Manager, Audit Scotland and the Head of Strategy, Planning and Health Improvement should collaborate to develop a checklist specific to Members of the integration authorities, to enable Members to reflect upon the questions posed in respect of the totality of the Partnership Board's resources and arrangements for health and social care.		/ Audit Scotland	would usefully provide logical parameters for this work with external auditors. Also, felt prudent not to initiate this development prior to changes to the Audit Scotland team assigned to the HSCP Board. Now that HSCP Board local Code of Good Governance approved and new external audit team in place, developmental discussions will now be taken forward with respect to a potential IJB governance checklist. Update September 2017 Developing a checklist for members of IJB - to be discussed with Audit Scotland after completion of annual audit. Update March 2017 Initial meeting with Head of Strategy took place in December and Audit Scotland. Audit Scotland updated that they have not been asked by any other IJB to develop a checklist. Members could consider developing one at a forthcoming board information/development session?	
Meeting Date – 22 June 2017					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
3.	**RECORDS MANAGEMENT PLAN – UPDATE**	2018	Head of Strategy, Planning and Health Improvement	An invitation has yet to be received from the Keeper of the Records of Scotland requesting the submission of a Records Management Plan. East Dunbartonshire IJB are working with KRS on a template that should be applicable to all partnerships. Updated March 2018.	
4.	**CLIMATE CHANGE REPORTING AND INTEGRATION JOINT BOARDS**	22 November 2017	Head of Strategy, Planning and Health Improvement	It was agreed that the Head of Strategy, Planning and Health Improvement would prepare a Climate Change Report for presentation and approval at a future meeting of the Partnership Board. Climate Change Report submitted to 22 November HSCP Board for approval and submission to SG.	**22/11/2017**

No.	Action required	Date to be completed	Responsible Officer	Comments	Completed
5.	**NHS GGC ORAL HEALTH DIRECTORATE REPORT FOR WEST DUNBARTONSHIRE**	14 March 2018	Head of Strategy, Planning and Health Improvement	It was agreed to invite the General Manager, Oral Health Directorate to a future meeting of the Audit Committee to discuss the performance report generally and measures to tackle the current oral health picture locally. Update February 2018 – the General Manager, Oral Health Directorate will attend and present to the 14 March 2018 Audit Committee and update with most up-to-date performance.	
6.	**LOCAL GOVERNMENT BENCHMARKING FRAMEWORK 2015/16** **AUDIT SCOTLAND – SELF DIRECTED SUPPORT 2017 PROGRESS REPORT (20 SEPTEMBER 2017)**	14 November 2018	Head of Strategy, Planning and Health Improvement	Update: March 2018 The new Carers' Act provides the local authority with the power to provide support to carers. After assessment of the carers needs the authority should consider the carer has needs in relation to their caring role and have the power to decide if they intend to meet these through funded support. If they decide the carer is eligible the carer should be offered access to the 4 SDS options and the duties apply. We have taken this an opportunity to strengthen the key components of our local arrangements for the delivery of self directed support within the context of the Audit Scotland Report; Self-directed Support 2017: Progress Report on National implementation of SDS as well as within the proposed inspection programme focusing on, amongst other topics, self directed support. Working with the Audit Scotland Report, we will refresh our approach and consider the key messages from the report within our planned response and create revised SDS Guidance for front line staff across services.	

Meeting Date – 20 September 2017					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
7.	**LOCAL CODE OF GOOD GOVERNANCE REVIEW**	20 June 2018	Chief Financial Officer	That an additional column be added to the Annual Review of Code of Good Governance – Summary, to include the total number of criteria per subsection for future reporting.	
8.	**KEY SOURCES OF ASSURANCE FOR INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2017**	14 March 2018	Chief Financial Officer	The Committee agreed to propose to NHS GGC that a clause relating to information sharing be written into future procurement agreements with providers of audit services. Update February 2018 – Chief Financial Officer has written to James Hobson, copy included within Item 6 of 14 March 2018 agenda.	
9.	**CARE INSPECTORATE REPORTS FOR SUPPORT SERVICES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE**	14 March 2018	Head of Community Health & Care Services/Head of Mental Health, Addictions and Learning Disability	It was agreed that a report would be submitted to the next meeting, following engagement with the newly appointed Link Care Inspector, to provide re-assurance to Members on work being undertaken to improve grades at the independent sector support services, Dunn Street Respite Service and Sense Scotland. Update February 2018 – Report for Dunn Street is Item 16 14 March 2018 agenda.	
10.	**CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WD HSCP**	14 March 2018	Head of Community Health & Care Services	It was agreed that a report with an action plan to improve Care Inspectorate grades at Mount Pleasant House would be presented to the next meeting of the Committee. Update February 2018 - Report is Item 15 of 14 March 2018 agenda.	
11.	**DRAFT STRATEGIC RISK REGISTER**	22 November 2017	Head of Strategy, Planning and Health Improvement	It was agreed to endorse the updated draft Strategic Risk Register for onward recommendation to the WD HSCP Board at its next meeting on 22 November 2017.	**22/11/2017**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
AUDIT COMMITTEE
COMMITTEE ACTION LIST- updated 28 May 2018

Meeting Date - 23 March 2016					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
1.	**Equality Act 2010 Mainstreaming Report** A report on the range of vulnerable and socio-economic groups as well as protected characteristics be provided to the next meeting of the Audit Committee to enable members to consider marginalised groups other than those required by the Equality Act 2010. Public Health and Health Inequalities Report – will address socio-economic factors .	HSCP Board – 2nd May 2018	Head of Strategy, Planning and Health Improvement /	Update May 2018 HSCP Board approved the publication of the mainstreaming report. Update February 2018 HSCP has a statutory duty to publish an update to the Mainstream report by 30 April 2018. A paper will be presented to the 2 May 2018 HSCP Board.	**02/05/18**

ITEM 5

Meeting Date – 7 December 2016					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
2.	**Audit Scotland Reports on Local Government in Scotland 2016** It was agreed that the Senior Audit Manager, Audit Scotland and the Head of Strategy, Planning and Health Improvement should collaborate to develop a checklist specific to Members of the integration authorities, to enable Members to reflect upon the questions posed in respect of the totality of the Partnership Board's resources and arrangements for health and social care.	June 2018	Head of Strategy, Planning and Health Improvement **/** Audit Scotland	Update May 2018 Report being presented to HSCP Board Audit Committee on 20 June 2018, on the review of the Local Code of Good Governance. Update June 2017 Officers prioritised development of the local Code of Good Governance to HSCP Board, as that would usefully provide logical parameters for this work with external auditors. Also, felt prudent not to initiate this development prior to changes to the Audit Scotland team assigned to the HSCP Board. Now that HSCP Board local Code of Good Governance approved and new external audit team in place, developmental discussions will now be taken forward with respect to a potential IJB governance checklist. Update September 2017 Developing a checklist for members of IJB - to be discussed with Audit Scotland after completion of annual audit. Update March 2017 Initial meeting with Head of Strategy took place in December and Audit Scotland. Audit Scotland updated that they have not been asked by any other IJB to develop a checklist. Members could consider developing one at a forthcoming board information/development session?	

Meeting Date – 22 June 2017					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
3.	**RECORDS MANAGEMENT PLAN – UPDATE**	2018	Head of Strategy, Planning and Health Improvement	Update May 2018 Report on the Records Management Plan being presented to the HSCP Board Audit Committee on 20 June 2018. Update 14 March 2018 The Keeper of Records for Scotland had advised that they would be requesting the submission of the records Management Plan, to be submitted in January 2019. East Dunbartonshire IJB are working with the KRS on a template that should be applicable to all partnerships.	
4.	**NHS GGC ORAL HEALTH DIRECTORATE REPORT FOR WEST DUNBARTONSHIRE**	14 March 2018	Head of Strategy, Planning and Health Improvement	Update May 2018 Frances McLinden attended and provided a presentation on Oral health to the HSCP Board Audit Committee on 14 March 2018.	**14/03/18**

5.	**LOCAL GOVERNMENT BENCHMARKING FRAMEWORK 2015/16** **AUDIT SCOTLAND – SELF DIRECTED SUPPORT 2017 PROGRESS REPORT (20 SEPTEMBER 2017)**	14 November 2018	Head of Strategy, Planning and Health Improvement	Update: June 2018 See Agenda for SDS Update report Update: March 2018 The new Carers' Act provides the local authority with the power to provide support to carers. After assessment of the carers needs the authority should consider the carer has needs in relation to their caring role and have the power to decide if they intend to meet these through funded support. If they decide the carer is eligible the carer should be offered access to the 4 SDS options and the duties apply. We have taken this an opportunity to strengthen the key components of our local arrangements for the delivery of self directed support within the context of the Audit Scotland Report; Self-directed Support 2017: Progress Report on National implementation of SDS as well as within the proposed inspection programme focusing on, amongst other topics, self directed support. Working with the Audit Scotland Report, we will refresh our approach and consider the key messages from the report within our planned response and create revised SDS Guidance for front line staff across services.	

Meeting Date – 20 September 2017					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
6.	**LOCAL CODE OF GOOD GOVERNANCE REVIEW**	20 June 2018	Chief Financial Officer	Update June 2018: See Agenda for Local Code Review and Action Plan Update May 2018 Report being presented to HSCP Board Audit Committee on 20 June 2018. That an additional column be added to the Annual Review of Code of Good Governance – Summary, to include the total number of criteria per subsection for future reporting.	
7.	**KEY SOURCES OF ASSURANCE FOR INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2017**	14 March 2018	Chief Financial Officer	Update June 2018: NHSGGC have appointed new internal auditors for 2018 and the CIS for HSCP Board has asked that a meeting be arranged in the near future to discuss new protocol. Update February 2018 – Chief Financial Officer has written to James Hobson, copy included within Item 6 of 14 March 2018 agenda. The Committee agreed to propose to NHS GGC that a clause relating to information sharing be written into future procurement agreements with providers of audit services	

8.	**CARE INSPECTORATE REPORTS FOR SUPPORT SERVICES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE**	14 March 2018	Head of Community Health & Care Services/Head of Mental Health, Addictions and Learning Disability	Update June 2018: See Agenda for Update Report Update March 2018 It was agreed at the HSCP Board Audit Committee on 14 March 2018 that a further report would be presented to the next Committee. Report on the agenda for 20 March HSCP Board Audit Committee meeting. Update February 2018 – Report for Dunn Street is Item 16 14 March 2018 agenda.	
9.	**CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WD HSCP**	14 March 2018	Head of Community Health & Care Services	It was agreed that a report with an action plan to improve Care Inspectorate grades at Mount Pleasant House would be presented to the next meeting of the Committee. Update March 2018 Report to be presented to HSCP Board 14 March 2018 – Item 10 Update February 2018 - Report is Item 15 of 14 March 2018 agenda.	**14/03/18**
Meeting Date – 14 March 2018					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
10.	**DUNN STREET RESPITE SERVICE**	**20 June 2018**	Head of Community Health & Care Services/Head of Mental Health, Addictions and Learning Disability	Update June 2018: See Agenda for Update Report	

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Internal Audit Annual Report for the year ended 31 March 2018

1. Purpose

1.1 To submit the Chief Internal Auditor's Annual Report for 2017/18 based on the internal audit work carried out for the year ended 31 March 2018, which contains an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health and Social Care Partnership Board's internal control environment that can be used to inform its Governance Statement.

2. Recommendations

2.1 It is recommended that the Audit Committee note the contents of this report.

3. Background

3.1 The Public Sector Internal Audit Standards (PSIAS) became effective on 1st April 2013 and require that:

"The chief audit executive [for WDC: Audit and Risk Manager] *must deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement*

The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The annual report must incorporate:

- *The opinion;*
- *A summary of the work that supports the opinion; and*
- *A statement on conformance with the Public Sector Internal Audit Standards and the results of the quality assurance and improvement programme"*

3.2 For the purposes of providing an annual opinion, reliance will be placed on the work of NHS Greater Glasgow and Clyde internal auditors and West Dunbartonshire Council internal auditors and any other work carried out by other external assessors, for example Audit Scotland and Care Inspectorate.

3.3 In order to ensure proper coverage and avoid duplication of effort, the internal auditors of NHSGGC and all local authorities operating within this Health Board area meet periodically.

4. Main Issues

4.1 The Internal Audit Annual Report for 2017/18 included at Appendix 1 concludes with the Chief Internal Auditor's independent and objective opinion that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2018 that the Health & Social Care Partnership Board requires to rely upon within both the Council the Health Board. This opinion has informed the Health & Social Care Partnership Board's Governance Statement.

4.2 The basis of the audit opinion includes taking reliance from:

- The Assurance Statement for the year ended 31 March 2018 from the Chief Internal Auditor of West Dunbartonshire Council (as attached at Appendix 2); and
- The Internal Audit Annual Report for 2017/18 provided by PWC, the Internal Auditors of NHS Greater Glasgow and Clyde (as attached at Appendix 3).

4.3 We hope to strengthen the information sharing protocol with NHSGGC in 2018/19 after them acknowledging the HSCP Audit Committee's concerns in relation to NHSGGC's internal auditors being required to provide assurances to IJB Chief Auditors on HSCP related matters. In this respect, a sentence was added to the tender document for the provision of internal audit services for NHSGGC.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 There is a risk that failure to deliver the Internal Audit Plan would result in an inability to provide assurances to those charged with governance over which the Health & Social Care Partnership Board is required to rely upon within both the Council's and Health Board's system of internal financial control.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 This report has been agreed with the Health Board's Director of Finance and Council's Section 95 Officer.

12. Strategic Assessment

12.1 The establishment of a robust audit plan will assist in assessing whether the Partnership Board and Officers have established proper governance and control arrangements which contribute to the achievement of the strategic priorities of the HSCP Strategic Plan.

Author: **Colin McDougall – Chief Internal Auditor for West Dunbartonshire Health and Social Care Partnership Board.**

Date: **6 June 2018**

Person to Contact: Colin McDougall, Audit and Risk Manager
West Dunbartonshire Council
Telephone 01389 737436
E-mail – colin.mcdougall@west-dunbarton.gov.uk

Appendices:
1 - Internal Annual Audit Report for the year ended 31 March 2018 from the Chief Internal Auditor
2 - Assurance Statement for the year ended 31 March 2018 from the Audit and Risk Manager of West Dunbartonshire Council
3 - Internal Audit Annual Report 2017/18 provided by PWC, the Internal Auditors of NHS Greater Glasgow and Clyde

Background Papers: None

Wards Affected: All Wards

APPENDIX 1

Internal Audit Annual Report for the year ended 31 March 2018 from the Chief Internal Auditor

To the Members of West Dunbartonshire Health & Social Care Partnership Board, the Chief Officer and the Section 95 Officer (Chief Financial Officer)

As the appointed Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board, I am pleased to present my annual statement on the adequacy and effectiveness of the internal financial control system of the Partnership Board for the year ended 31 March 2018.

Respective responsibilities of management and internal auditors in relation to internal control

It is the responsibility of senior management of the Health and Social Care Partnership to establish an appropriate and sound system of internal financial control and to monitor the continuing effectiveness of that system. It is the responsibility of the Chief Internal Auditor to provide an annual overall assessment of the robustness of the internal financial control system.

The Health & Social Care Partnership Board's framework of governance, risk management and internal controls

The Partnership Board has a responsibility to ensure that its business is conducted in accordance with legislation and proper standards.

The governance framework comprises the systems and processes, culture and values by which the Partnership Board IJB is directed and controlled and how it accounts to communities. It enables the Partnership Board to monitor the achievement of its strategic priorities and to consider whether those objectives have led to the delivery of appropriate services and value for money.

The system of internal control is a significant element of the governance framework. Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. Accordingly, the Partnership Board is continually seeking to improve the effectiveness of its systems of internal control in order to identify and prioritise the risks that would prevent the achievement of the Health & Social Care Partnership Board's strategic objectives as set out within its Strategic Plan.

The work of internal audit

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

The operational delivery of services with WDC and NHSGGC on behalf of the WD HSCP will be covered by their respective internal audit arrangements.

Both the Council's Internal Audit Section and the Health Board's internal audit function operate in accordance with the *Public Sector Internal Audit Standards* (PSIAS) which have been agreed to be adopted from 1st April 2013 by the relevant public sector Internal Audit Standard setters. PSIAS applies the Institute of Internal Auditors International Standards to the UK Public Sector.

Planned work for 2018/19

Following a risk based assessment of the activities of IJB and consultation with the Chief Officer and the Chief Financial Officer the Internal Audit Plan for 2018/19 provides for 20 days of Internal Audit resource drawn from the Internal Audit Service of West Dunbartonshire Council. This will be used to service this audit committee and carry out a review the Local Code of Good Governance.

The Internal Audit Plan for 2018/19 was approved by the Health & Social Care Partnership Board on 14th March 2018.

Basis of Opinion

My evaluation of the control environment is informed by a number of sources:

- The audit work undertaken by Internal Audit within the Council and the Health Board and also for the Partnership Board during the year to 31 March 2018;
- The Assurance Statement for the year ended 31 March 2018 from the Chief Internal Auditor of West Dunbartonshire Council (as attached at Appendix 2);
- The Internal Audit Annual Report 2017/18 provided by PWC, the Internal Auditors of NHS Greater Glasgow and Clyde (as attached at Appendix 3);
- The review of the Local Code of Good Governance and the identified improvement actions;
- The assurance statement signed by the Chief Officer on the operation of the internal financial controls for the services for which she was responsible during the year to 31 March 2018;
- Reports issued by the External Auditors of the Council and the Health Board and other review agencies; and

- My knowledge of the Partnership Board's governance, risk management and performance monitoring arrangements.

Opinion

It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2018 within the Council and the Health Board over which the Partnership Board requires to receive assurances and within the Health & Social Care Partnership Board itself.

Signature: 

Title: Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board

Date: 6 June 2018

APPENDIX 2

Assurance Statement for the year ended 31 March 2018 from the Audit and Risk Manager

To the Members of West Dunbartonshire Council, the Chief Executive and the Section 95 Officer (Strategic Lead - Resources)

As Audit and Risk Manager of West Dunbartonshire Council, I am pleased to present my annual statement on the adequacy and effectiveness of the internal financial control system of the Group Accounts prepared by the Council for the year ended 31 March 2018.

Respective responsibilities of management and internal auditors in relation to internal control

It is the responsibility of the Council's senior management to establish an appropriate and sound system of internal financial control and to monitor the continuing effectiveness of that system. It is the responsibility of the Audit and Risk Manager to provide an annual overall assessment of the robustness of the internal financial control system.

The Council's framework of governance, risk management and internal control

The Council has a responsibility to ensure that its business is conducted in accordance with legislation and proper standards.

The governance framework comprises the systems and processes, culture and values by which the Council is directed and controlled and how it accounts to communities. It enables the Council to monitor the achievement of its strategic priorities and to consider whether those objectives have led to the delivery of appropriate services and value for money.

The main objectives of the Council's internal control systems are to ensure:

- Adherence to management policies and directives in order to achieve the organisation's objectives;
- Economic, efficient, effective and safe use of resources and assets;
- The relevance, reliability and integrity of information, so ensuring as far as possible the completeness and accuracy of records; and
- Compliance with statutory requirements.

The system of internal control is a significant element of the governance framework. Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. Accordingly, the Council is continually seeking to improve the effectiveness of its systems of internal control in order to identify and prioritise

the risks that would prevent the achievement of the Council's strategic objectives

The work of internal audit

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

The Council's Internal Audit Section operates in accordance with the *Public Sector Internal Audit Standards* (PSIAS) which have been agreed to be adopted from 1st April 2013 by the relevant public sector Internal Audit Standard setters. PSIAS applies the Institute of Internal Auditors International Standards to the UK Public Sector.

PSIAS requires that a Quality Assurance and Improvement Programme (QAIP) is developed in order to provide assurance that internal audit activity:

- Is conducted in accordance with an Internal Audit Charter;
- Operates in an efficient and effective manner; and
- Is perceived to be adding value and improving operations.

An internal self-assessment of internal audit practices has been carried out by the Audit and Risk Manager every year since PSIAS became effective on 1st April 2013, with improvements identified and implemented as appropriate. PSIAS also requires, as outlined in Standard 1300 "QAIP", that:

"External assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation. External assessments can be in the form of a full external assessment or a self-assessment with independent external validation".

To meet this requirement, a reciprocal arrangement to complete a programme of inspections has been developed by the Scottish Local Authorities Chief Internal Auditors Group (SLACIAG). This process identified South Lanarkshire Council as the Authority to undertake the independent review of WDC's Internal Audit function's level of compliance with PSIAS and the external review was carried out during 2015/16. The next external review is due to be carried out in the next two to three years.

The Internal Audit Section undertakes an annual programme of work based on a risk assessment process which is revised on an ongoing basis to reflect evolving risks and changes within the Council. All Internal Audit reports identifying system weaknesses and / or non-compliance with expected controls are brought to the attention of management and the Audit and Performance Review Committee together with appropriate recommendations and agreed action plans. It is management's responsibility to ensure that proper consideration is given to Internal Audit reports and that appropriate action is taken on audit recommendations. The internal auditor is required to

ensure that appropriate arrangements are made to determine whether action has been taken on internal audit recommendations or that management has understood and assumed the risk of not taking action. A programme of follow-up on assignment findings and recommendations provides assurance on the complete and timeous implementation of both internal Audit and External Audit recommendations.

Internal Audit and Corporate Fraud staff regularly attended the following external user group meetings:

- SLACIAG, the purpose of which is to develop and improve the practice of internal audit activity with Scottish local authorities. It achieves this by meeting to discuss issues of common concern, commissioning work to develop ideas, sharing good practice, working in partnership with other professional / governing bodies and promoting SLACIAG as the representative body for internal audit in local authorities. The Council's Audit and Risk Manager attended three out of four of the quarterly meetings of SLACIAG during 2017/18 (the remaining one was cancelled in March due to adverse weather conditions) and also further meetings in his role as a member of the SLACIAG management committee;

- SLACIAG Computer Audit sub group: either an Auditor or the ICT Security Officer attends this forum which has the aim of ensuring that audit teams are better equipped to perform technical Information Systems auditing; and

- The Scottish Local Authority Investigators Group (SLAIG): This group consists of fraud practitioners from local authorities in Scotland, with the objectives of:

    - Raising the profile of the counter fraud agenda;
    - Sharing good practice;
    - Raising awareness of the risk of fraud; and
    - Ensuring that fraud is investigated in a professional manner.

Basis of Opinion

My evaluation of the control environment is informed by a number of sources:

- The audit work undertaken by Internal Audit during the year to 31 March 2018, including risk based systems audits, ICT audits, investigations, follow-up reviews and one-off exercises;
- The assessment of risk completed during reviews of the annual audit plan;
- The assurance statements signed by the Strategic Directors and Strategic Leads on the operation of the internal financial controls for the services for which they were responsible during the year to 31 March 2018;
- The assurance statement signed by the Chief Executive for the overall Council for the year ended 31 March 2018;

- Reports issued by the Council's External Auditors, Audit Scotland, and other review agencies; and
- My knowledge of the Council's governance, risk management and performance monitoring arrangements.

Limitation to Resources or Scope of Internal Audit Work

There were sufficient resources available to deliver the programme of audit assignments contained within the 2017/18 Audit Plan and no significant threats emerged to the independence of the internal audit activity such as inappropriate scope or resource limitations.

Opinion

It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of West Dunbartonshire Council's systems of governance, risk management and internal control in the year to 31 March 2018.

Signature: 

Title: Audit and Risk Manager

Date: 31 May 2018

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Internal audit annual report 2017/2018

NHS Greater Glasgow & Clyde

29 May 2018

Final

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Contents

Distribution list

For action: Mark White, Director of Finance

For information: Audit and Risk Committee

Executive summary

Introduction

This report outlines the internal audit work we have carried out for the year ended 31 March 2018.

The Public Sector Internal Audit Standards require the Head of Internal Audit to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit and Risk Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below and set out in Appendix 1. The opinion does not imply that Internal Audit has reviewed all risks relating to the organisation.

The Audit and Risk Committee agreed to a level of internal audit input of 525 days, of which 505 days were delivered. The plan was revised during the year following discussions with management and approval from the Audit and Risk Committee. Internal audit delivered all work in accordance with the revised plan.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is in conformance with the Public Sector Internal Audit Standards.

Head of internal audit opinion

We are satisfied that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, it should be noted that assurance can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

Opinion

Our opinion is as follows:

Generally satisfactory with some improvements required

Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk.

Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control. Please see our Summary of Findings from page 5.

Executive summary continued

An explanation of the types of opinion that may be given can be found in Appendix 2.

Basis of opinion

Our opinion is based on all audits undertaken during the year and follow up action taken in respect of audits from previous periods.

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Commentary

The key factors that contributed to our opinion are summarised as follows:

- A high risk finding was raised in the 'Achieving Financial Balance' internal audit report around the Board's increasing reliance on non-recurring funding. Whilst the Board successfully achieved financial balance in the year, this relied heavily on an increasing level of non recurring funding, which has a potential impact on the ability of the Board to be financially sustainable. It presents an increasing financial challenge to achieve financial balance in future years as the Board has to 'start again' to achieve in-year balance.
- As highlighted within the 'Financial Planning 2018/19' internal audit report, the 2018/19 planning process was undertaken with an objective of transparency: however, the Board has a significant challenge to reduce the underlying recurring deficit going forward. The Board enters the 2018/19 financial year with an overall cash releasing efficiency challenge in excess of £100m. Transformational change is being driven through the recently instigated Financial Improvement Programme Moving Forward Together programmes. However, the ability and timeliness of these programmes to deliver the transformational change and recurring savings required is not yet clear. It is critical that these programmes can deliver the required savings on a recurring basis and there is strong governance and control around these programmes to ensure they deliver.
- Two of the 18 internal audit reports issued in the year were classified as high risk. These related to Mental Health: Crisis Management and Waiting Times Management. The Mental Health: Crisis Management review identified that in a significant number of instances, risk assessments were not completed in accordance with the governing policies in place. The Waiting Times Management report highlighted that there should be greater project management arrangements around demand and capacity gap assessment exercises to ensure there is clarity on project objectives and benefits, timescales and milestones, resource inputs and monitoring arrangements. Management has accepted our findings in these areas and action plans are in place to address the issues raised.
- Six reports were classified as medium risk and relate to a number of pervasive areas within the Board. These relate to Achieving Financial Balance, Financial Planning 2018/19, Gifts and Hospitality Compliance, Health and Safety Compliance, Delayed Discharges and Premium Rate Agency Use.
- Of the 45 high and medium audit actions due for implementation by 31 March 2018, 41 actions have been implemented and 4 actions remain ongoing.

Acknowledgement

We would like to take this opportunity to thank NHS Greater Glasgow & Clyde staff, for their co-operation and assistance provided during the year.

Summary of findings

Our annual internal audit report is timed to inform the organisation's Annual Governance Statement.

A summary of key findings from our programme of internal audit work for the year work is recorded in the table below:

Description	Detail
Overview We completed 18 internal audit reviews. This resulted in the identification of **3 high, 22 medium and 16 low** risk findings to improve weaknesses in the design of controls and/or operating effectiveness.	• Our work has been delivered in accordance with the 2017/18 internal audit plan approved by the Audit and Risk Committee. There were some changes to the internal audit plan which were approved by the Audit and Risk Committee throughout the year. Two reviews were not undertaken; Scottish Medical Training Requirements and H&SCI – Managing Directions from IJBs. An additional review on Financial Planning 2018/19 was undertaken. • Our findings have allowed management to identify specific control weaknesses within their current systems and processes, and to agree actions that will promptly address these weaknesses and improve the efficiency and effectiveness of the controls. • In August 2017 we hosted a roundtable discussion led by PwC's national health industries leader and involving the internal audit team and key members of our specialist health team with experience in clinical, financial and strategic change to consider the challenges of delivering NHS services sustainably. This was also attended by representatives from other NHS Boards in Scotland and representation from the Scottish Government. This was a useful session to facilitate information sharing and generate discussion on key sector issues.

Summary of findings continued

Description	Detail
Internal control issues During the course of our work we identified a number of weaknesses that we consider should be reported in your Annual Governance Statement.	• Three high risk recommendations were identified through internal audit's work in respect of the following reports: **Achieving Financial Balance** The Board successfully achieved financial balance in the year, however, this relied heavily on the use of non-recurring support. The percentage of total savings achieved which were on a non-recurring basis was circa 70% in 2017/18, an increase from 40% in 2015/16. While non-recurring savings will always form part of a Board's savings, the lack of enduring savings increases future financial challenges and risks its financial sustainability. It is critical that the Board puts in place a transformation plan that will delivers recurring savings and provides financially sustainability for the future. **Waiting times management** In order to address the deteriorating performance against the Treatment Time Guarantee, management implemented a programme of demand and capacity gap assessment and improvement. The demand and capacity gap assessment exercise is of significant strategic and clinical importance to NHSGGC and its delivery is both complex and multi-faceted. However, we found that the exercise, despite its complexity and scale, has been initiated and partly executed without any formal project management discipline. **Mental Health: Crisis Management** We performed sample testing over the execution of the three risk assessment tools operating across NHSGGC and found that in a significant number of instances, across all three tools, risk assessments were not completed in accordance with the governing policies in place.

Summary of findings

Description	Detail
Other weaknesses Other weaknesses were identified within the organisation's governance, risk management and control.	• These weaknesses relate to a variety of areas across the Health Board, including governance, risk management, clinical, financial and operational areas. We have not identified any common themes or common root causes for these findings.
Follow up During the year we have undertaken follow up work on previously agreed actions.	• We have followed up on all high risk recommendations and a sample of medium risk recommendations. Of the 45 recommendations due to be implemented by 31 March 2018 41 had been implemented and four were in progress.
Good practice We also identified a number of areas where few weaknesses were identified and/or areas of good practice.	We have identified a number of areas of good practice in all of the reviews we have undertaken and these have been detailed in the reports issued for each of these reviews. Strong controls are in place within the areas sampled as part of Key Financial Control Reviews (Fixed Assets, Accounts Payable and Payroll). Additionally, the review of Property Transaction Monitoring found that there was a high standard of documentation stored as back-up for these transactions, with all stages of the property transactions evidenced sufficiently.

Internal audit work conducted

Introduction

The table below sets out the results of our internal audit work. The following page shows direction of control travel and a comparison of planned and actual internal audit activity.

Results of individual assignments

Review	Report classification	Number of findings			
		Critical	High	Medium	Low
Property Transactions Monitoring	N/a	-	-	-	-
Waiting times management	High	-	1	3	1
Mental Health: Crisis Management	High	-	1	2	1
Delayed discharge	Medium	-	-	4	-
Premium rate agency use	Medium	-	-	2	1
Cyber security maturity: Phase 2	N/a	-	-	-	-
Key financial controls: Accounts Payable	Low	-	-	-	-
Key Financial Controls: Fixed Assets	Low	-	-	-	3
Key Financial Controls: Payroll	Low	-	-	-	-
Clinical and Care Governance	Low	-	-	-	2
Information Governance - Information Asset Register	Low	-	-	2	1
Public health screening programmes	Low	-	-	-	2
Gifts and hospitality compliance	Medium	-	-	3	1

Internal audit work conducted (continued)

Results of individual assignments

Review	Report classification	Number of findings			
		Critical	High	Medium	Low
Programme management – Moving Forward Together	Low	-	-	-	1
Health and safety compliance	Medium	-	-	3	-
Corporate risk management	Low	-	-	1	2
Achieving Financial Balance	High	-	1	-	-
Financial Planning 2018/19	Medium	-	-	2	1
	Total	-	3	22	16

Internal audit work conducted

Direction of control travel

Finding rating	Trend between current and prior year	Number of findings		
		2017/18	2016/17	2015/16
Critical	⟷	0	0	0
High	⟷	3	3	1
Medium	↓	22	32	33
Low	↓	16	21	48
Total	↓	41	56	82

Whilst we have noted the overall number of findings has reduced, the number of audit days delivered was reduced in 2017/18 to 505 day. In 2016/17, 665 days were delivered.

Implications for management

Management should continue to track and report progress against outstanding audit findings with a focus on those rated as high risk.

The extent of the financial challenges to reduce the recurring deficit and reliance on non-recurring savings is known by the Board. The Board should continue to focus in this area as it is an area of high risk for the Board.

Internal audit work conducted

Comparison of planned and actual activity

Audit unit	Budgeted days	Actual days
Property Transactions Monitoring	10	10
Waiting times management	20	20
Suicide risk management	35	35
Delayed discharge	30	30
Temporary staffing: nursing	35	35
Cyber security: Phase 2	35	35
Key Financial Controls: Accounts Payable, fixed assets, payroll	75	75
Scottish medical training requirements	25	0
Public health screening programmes	25	25
Gifts and hospitality compliance	25	25
Programme management	25	25
Health and safety compliance	35	35
Corporate risk management	15	15
Financial efficiency savings (Achieving Financial Balance)	30	30

Audit unit	Budgeted days	Actual days
Managing directions from IJBs	25	0
Information Governance - IAR	25	25
Financial Planning 2018/19	0	30
Annual Report	5	5
Contract Management and A&RC Attendance	40	40
Contingency	10	10
	525	**505**

Follow up work conducted

Introduction

In order for the organisation to derive maximum benefit from internal audit, agreed actions should be implemented. In accordance with our internal audit plan, we followed up on all high risk and a sample of medium risk recommendations made in prior years that were due for implementation by 31 March 2018 to ascertain whether action had been taken. The table below summarises the follow up work performed.

Results of Internal Audit follow up work undertaken

Audit Report	Report classification	No. of findings followed up	Status of agreed actions	
			Implemented	Ongoing
Capacity Planning - Cancer Services	Medium	3 Medium	3	-
Performance Monitoring and Reporting in Acute Services	Low	1 Medium	1	-
Repairs and Maintenance Spend Data	Medium	1 Medium	1	-
IT Resilience	Medium	1 High	1	-
Significant Capital Projects Governance & PPE	Medium	1 Medium	1	-
Estates – Backlog & Operational Maintenance	Medium	2 Medium	1	2
Waiting times management	High	1 High 1 Medium	2	-
Business Continuity Management 2015/16	High	1 High	1	-
IT Project Governance	Medium	2 Medium	2	-
Reporting and monitoring arrangements for efficiency savings	High	1 High	1	-
Embedding Risk Management Arrangements	Medium	1 Medium	1	-

Management's overall assessment of audit actions

In addition to the work performed by Internal Audit, Management perform follow up of all outstanding Internal Audit actions on an ongoing basis and report progress to the Audit and Risk Committee. The table below sets out the status of outstanding audit findings as reported by management as at May 2018.

Audit Report	Report classification	*Actions Due for Implementation*	Status of agreed actions	
			Implemented	Ongoing
Central decontamination unit arrangements	Medium	1 Medium	1	-
Capacity Planning – Cancer Services	Medium	3 Medium	3	-
Performance Monitoring and Reporting in Acute Services	Low	2 Medium	2	-
Repairs and Maintenance Spend Data	Medium	3 Medium	3	-
IT Resilience	Medium	1 High 1 Medium	2	
Significant Capital Projects Governance & PPE	Medium	5 Medium	5	-
Estates – Backlog & Operational Maintenance	Medium	3 Medium	1	2
Waiting times management	High	1 High 3 Medium	4	-
Suicide risk assessment	High	1 High 2 Medium	3	-
Delayed discharge	Medium	4 Medium	3	1
Temporary staffing: nursing	Medium	3 Medium	3	1
Business Continuity Management 2015/16	High	1 High 1 Medium	2	-
Embedding Risk Management Arrangements	Medium	3 Medium	3	-
IT Project Governance	Medium	2 Medium	2	-
Reporting and monitoring arrangements for efficiency savings	High	1 High 4 Medium	5	-

Appendices

Appendix 1: Limitations and responsibilities

Limitations inherent to the internal auditor's work

Our work has been performed subject to the limitations outlined below.

Opinion

The opinion is based solely on the work undertaken as part of the agreed internal audit plan. There might be weaknesses in the system of internal control that we are not aware of because they did not form part of our programme of work, were excluded from the scope of individual internal audit assignments or were not brought to our attention. As a consequence management and the Audit Committee should be aware that our opinion may have differed if our programme of work or scope for individual reviews was extended or other relevant matters were brought to our attention.

Internal control

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

Our assessment of controls relating to NHS Greater Glasgow & Clyde is for the period 1 April 2017 to 31 March 2018. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that:

- The design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
- The degree of compliance with policies and procedures may deteriorate.

The specific time period for each individual internal audit is recorded within section3 of this report.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected, and our examinations as internal auditors should not be relied upon to disclose all fraud, defalcations or other irregularities which may exist.

Appendix 2: Opinion types

The table below sets out the four types of opinion that we use, along with an indication of the types of findings that may determine the opinion given. The Head of Internal Audit will apply his judgement when determining the appropriate opinion so the guide given below is indicative rather than definitive.

Type of opinion	Indication of when this type of opinion may be given
Satisfactory	• A limited number of medium risk rated weaknesses may have been identified, but generally only low risk rated weaknesses have been found in individual assignments; and • None of the individual assignment reports have an overall report classification of either high or critical risk.
Generally satisfactory with some improvements required	• Medium risk rated weaknesses identified in individual assignments that are **not significant in aggregate** to the system of internal control; and/or • High risk rated weaknesses identified in individual assignments that are **isolated** to specific systems or processes; and • None of the individual assignment reports have an overall classification of critical risk.
Major improvement required	• Medium risk rated weaknesses identified in individual assignments that are **significant in aggregate but discrete parts** of the system of internal control remain unaffected; and/or • High risk rated weaknesses identified in individual assignments that are **significant in aggregate but discrete parts** of the system of internal control remain unaffected; and/or • Critical risk rated weaknesses identified in individual assignments that are **not pervasive** to the system of internal control; and • A **minority** of the individual assignment reports may have an overall report classification of either high or critical risk.
Unsatisfactory	• High risk rated weaknesses identified in individual assignments that **in aggregate are pervasive** to the system of internal control; and/or • Critical risk rated weaknesses identified in individual assignments that are **pervasive** to the system of internal control; and/or • **More than a minority** of the individual assignment reports have an overall report classification of either high or critical risk.
Disclaimer opinion	• An opinion cannot be issued because insufficient internal audit work has been completed. This may be due to either: - Restrictions in the audit programme agreed with the Audit Committee, which meant that our planned work would not allow us to gather sufficient evidence to conclude on the adequacy and effectiveness of governance, risk management and control; or - We were unable to complete enough reviews and gather sufficient information to conclude on the adequacy and effectiveness of arrangements for governance, risk management and control.

Appendix 3: Basis of our classifications

Report classifications

The report classification is determined by allocating points to each of the findings included in the report.

Findings rating	Points
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	Points
Critical risk	40 points and over
High risk	16–39 points
Medium risk	7–15 points
Low risk	6 points or less

Appendix 3: Basis of our classifications

Individual finding ratings

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences; or • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** or • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Audit Plan Progress Report

1. Purpose

1.1 The purpose of this report is to provide an update to members on:

- The planned programme of audit work for the year 2017/18 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 Board;
- The agreed actions from the audit of the Partnership Board's Governance, Performance and Financial Management Arrangements; and
- The agreed actions arising from the Annual Report to the IJB and the Controller of Audit for the financial year ended 31 March 2017 from the External Auditors.

2. Recommendations

2.1 It is recommended that the Audit Committee note the progress made in relation to the Audit Plan for 2017/18 and in progressing other action plans.

3. Background

3.1 This report provides a summary to the Partnership Board of recent Internal Audit activity, within the 2017/18 Audit Plan at the Council and the Health Board which may have an impact upon the delivery of the strategic plan.

3.2 This report details progress in addressing actions arising from a recent audit of the Partnership Board's Governance, Performance and Financial Management Arrangements and also the External Auditors Annual Report for 2016/17.

4. Main Issues

Progress on Audit Plan 2017/18

West Dunbartonshire Council

4.1 Since 1st April 2017, the following Internal Audit reports have been issued to the Council, which are relevant to the Partnership Board:

Audit Title	**Number and Priority of Recommendations**		
	High	Medium	Low
Social Care Services reports:			
Fostering and adoption payments / allowances (from 2016/17 Audit Plan)	1	0	0
Guardianship Cases (Mental Health Officer [MHO] Involvement	0	3	2
Employment Support (Social Work initiative for vulnerable people)	1	5	3
Scottish Social Services Council Registration (from 2016/17 Audit Plan)	0	1	1
Use of Care First Functionality for Financial Management	0	7	0
Corporate Reports:			
Capital Expenditure / Capital Programme	0	0	1
ICT Disaster Recovery/Business Continuity Controls	0	5	2
Purchasing Cards	0	1	6
Register of Gifts, Hospitality & Interests	0	4	2
Creditors	2	10	9
Payroll – Overtime	0	2	0
ICT Procurement Controls	0	0	1
ICT Remote Access Controls	0	1	1
ICT Service Desk Controls	0	0	1
Data and Information Security – Governance and Practice	0	5	4
Total	**4**	**44**	**33**

4.2 Recommendations have timescales for completion in line with the following categories:

Category	**Expected implementation timescale**
High Risk: Material observations requiring immediate action. These require to be added to the department's risk register	Generally, implementation of recommendations should start immediately and be fully completed within three months of action plan being agreed
Medium risk: Significant observations requiring reasonably urgent action.	Generally, complete implementation of recommendations within six months of action plan being agreed
Low risk: Minor observations which require action to improve the efficiency, effectiveness and economy of operations or which otherwise require to be brought to the attention of senior management.	Generally, complete implementation of recommendations within twelve months of action plan being agreed

4.3 For Social Care audit assignments outstanding actions from previously issued audit reports are included at Appendix 1, together with all actions from recently issued audit reports. These reports are:

- Fostering and adoption payments / allowances (all actions completed);
- Guardianship Cases (Mental Health Officer [MHO];
- Employment Support (Social Work initiative for vulnerable people);
- Scottish Social Services Council Registration; and
- Use of Care First Functionality for Financial Management.

4.4 In addition, Appendix 1 also contains information on actions arising from audits carried out within the WDC audit plan which have a potential impact on the HSCP as follows:

Recently completed audits (all actions):

- Payroll – Overtime;
- ICT Procurement Controls;
- ICT Remote Access Controls;
- ICT Service Desk Controls; and
- Data and Information Security – Governance and Practice.

Previously completed audits (outstanding actions):

- ICT Disaster Recovery/Business Continuity Controls;
- Purchasing Cards;

- Register of Gifts, Hospitality & Interests; and
- Creditors.

4.5 Internal Audit will undertake follow up work to confirm the implementation of the recommendations.

NHS Greater Glasgow and Clyde

4.6 The following Internal Audit reports have recently been issued to the NHS Greater Glasgow & Clyde, which are relevant to the Partnership Board:

Review	Report classification	Number of individual findings			
		High	Medium	Low	Total
Waiting times management	High	1	3	1	5
Suicide risk assessment	High	1	2	1	4
Delayed discharge	Medium	-	4	-	4
Temporary staffing: nursing	Medium	-	2	1	3
Key financial controls: accounts payable	Low	-	-	-	-
Key financial controls: fixed assets	Low	-	-	3	3
Total findings		**2**	**11**	**6**	**19**

4.7 Further information of these audit assignment is provided at Appendix 2.

4.8 These reports are all from the 2017/18 audit plan and are the most recently available.

Follow up work

4.9 Internal Audit undertakes follow up work to confirm the implementation of high risk and a sample of medium risk recommendations. The results of this follow up work are reported to the HSCP Audit Committee with any matters of concern being drawn to the attention of this Committee.

WD Health & Social Care Partnership Board

4.10 In addition to the reviews referred to above, an audit has been carried out in March 2017 on the West Dunbartonshire Governance, Performance and Financial Management arrangements of the Health & Social Care Partnership Board. The report and agreed actions were presented to the HSCP Board at its special meeting on 22 March 2017. Progress on the agreed actions from this report is provided in Appendix 3.

4.11 As a result of a significant amount of investigations work to which the Internal Audit team has had to respond it has not been possible to fully complete the risk based audit plan for 2017/18. As a result, three risk based audits from the overall Council audit plan have been rolled forward into 2018/19, including Social Work Tendering and Commissioning. This approach has been agreed in discussion with External Audit.

External Auditors Annual Report 2016/17

4.12 Progress on actions arising External Auditors Annual Report for 2016/17 is also included within Appendix 3.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Risk Analysis

7.1 The Plan has been constructed taking cognisance of the risks associated with major systems. Consultation with Senior Managers was carried out to ensure that risks associated with delivering strategic objectives have been considered.

8. Equalities Impact Assessment (EIA)

8.1 There are no issues.

9. Environmental Impact Assessment

9.1 There are no issues.

10. Consultation

10.1 This report has been prepared in consultation between the Partnership Board's Chief Internal Auditor, James Hobson, Assistant Director of Finance (NHS Greater Glasgow and Clyde), Julie Slavin (Chief Financial Officer, West Dunbartonshire Health and Social Care Partnership) and Stephen West (Strategic Lead – Resources, West Dunbartonshire Council.

11. Strategic Assessment

11.1 The establishment of a robust audit plan will assist in assessing whether the Partnership Board and Officers have established proper governance and control arrangements which contribute to the achievement of the strategic priorities of the HSCP Strategic Plan.

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Date: **7 June 2018**

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Appendices: Appendix 1: Internal Audit Reports – WDC Internal Audit Team

Appendix 2: Further information on NHSGGC Internal Audit Reports

Appendix 3: WDHSCP - Internal Audit Reports / External Audit Reports

Background Papers: None

Appendix 1
Internal Audit Reports – WDC Internal Audit Team

Generated on: 06 June 2018

Action Status	
	Cancelled
	Overdue; Neglected
	Unassigned; Check Progress
	Not Started; In Progress; Assigned
	Completed

Social Care Services Reports

Project 124. Guardianship Cases (MHO Involvement) (Report Issued November 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/558	4. Review of time taken to complete reports It is important that all AWI reports be completed as quickly as possible to ensure the welfare of the incapacitated adult. To achieve this it is vital to fully understand the reasons, in each case, as to why the recommended timescale for completing the AWI report was not met.	A quarterly internal audit will be undertaken in respect of all completed guardianship reports, and this will be distributed as appropriate. This will assist in highlighting performance and progress, but will also serve to indicate areas of resource pressure and other challenges encountered.		50%		31-Mar-2018	Drew Lyall	Population of the relevant data remains a bit inconsistent as MHOs acquaint themselves with the new system and work is underway to improve this. The routine population of data relating to local authority guardianship processes will have to be addressed and has been impacted upon by the lack of admin cover. This task will have

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	It is recommended that applications, once the report is finalised, be reviewed and the reasons for delays in the time taken to complete the report should be fully analysed and documented. This should be possible utilising the CareFirst System following implementation of recommendations 1 and 2 of this action plan. This will enable the MHO Team to understand the reasons for delays and find solutions to speed up the process. (Medium Risk)	It should be noted that at times the circumstances leading to the completion of reports are outwith the control of the assigned MHO. This can be due to factors such as delays with the family making contact or with legal processes surrounding the application						to be completed within the overall context of the service priorities – i.e.: discharging our primary statutory duties.
T&PSR/IAAP/559	5. Review of Guidelines A review of the Guidance Note on Applications for Welfare Guardianship should be carried out. Timescales should be set the match the increase in number of applications and legislation. (Low Risk)	A review of current guidance and policy will be undertaken, with amendments made as appropriate and required. This will reflect changes in practice, and the significantly increased demand for reports since the guidance was initially produced		20%		30-Sep-2018	Drew Lyall	Senior MHO will progress this task from early 2018 with a view to completing well within agreed timescale. It will be necessary to review, draft amendments, and submit to SMT for approval.

Project 127. Employment Support (Social Work initiative for vulnerable people) (Report Issued May 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/599	1. Performance of reconciliations It is a significant control weakness that a reconciliation between the ledger and the income/expenditure spreadsheet is not performed. A reconciliation needs to be performed for both T in the Park, Havoc and Slipway (a reconciliation is already performed for Cafe Connect). (High Risk)	Staff to be identified within team to undertake this duty in accordance with financial control procedures. Monthly reconciliations checks to be undertaken and audited by Manager. And following receipt of BCR reports. Any discrepancies discovered to be reported to finance department immediately. IOM to audit 3 monthly		100%		01-Apr-2018	Ingram Wilson	Slipway opened in April 2018. Staff identified and reconciliation taking place and BCR reports checked. Any discrepancies will be reported to finance. T in the Park have had 1 transaction and on the basis of this the decision has been made to change from a cafe to a social hub. Havoc not currently operational due to recent fire.
T&PSR/IAAP/600	2. Financial procedures It is recommended that the two policies be bought in line with each other and potentially combined to create one policy. A review of the policies to ensure they include all necessary detail and are correct should also be carried out. (Medium Risk)	Different procedures result of historic situation where Café Connect was managed by Dumbarton Centre manager IOM will meet with I Wilson to review both sets of procedures to ensure consistency.		100%		30-Apr-2018	Ingram Wilson	Café Connect has reviewed its procedures to bring them into line with the rest of Work Connect catering outlets, in particular with regard to reconciliation procedures and purchase card procedures.
T&PSR/IAAP/601	3. Adherence to Financial Controls for Income It is recommended that the employees performing these cash controls should be reminded of the importance of carrying out all of the controls properly and	Recorded Financial Control Procedure workshops will be undertaken 3 monthly by all staff involved. Staff member to be identified and trained to continue with this		100%		01-Apr-2018	Adrian McBride; Ingram Wilson	Workshops have taken place. Staff member identified and trained and Slipway inductions carried out. Monthly checks being undertaken. Triple signature being used and VAT being recorded to

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	promptly. (Medium Risk)	system Spreadsheets are Work Connect in house system and will continue to be used. Monthly checks to be undertaken. Triple signature sheet now introduced to ensure all correct paperwork is completed and monies (Z & X plus cash totals) are correct. This will be included in the Slipway Induction and be recorded. Please note that we amended daily cash sheets to include minus 20% VAT to enable easier recognition on finance ledgers IOM to audit.						ensure clear identification on the ledger.
T&PSR/IAAP/602	4. Approval of expenditure on RBS system Management need to ensure that they are authorising purchase card transactions in a timely manner, and uploading the receipts onto the RBS system. (Medium Risk)	All receipts to be scanned into RBS Smart Data and checked before approval. RBS approval dates to be flagged up in advance and staff to ensure timeous approval. Monitor compliance.		100%		26-Apr-2018	Ingram Wilson	All receipts being scanned and checked. Approval dates being flagged and approved timeously. Compliance being monitored.
T&PSR/IAAP/603	5. Authorisation authority A review should be carried out to determine who has a purchase card and to ensure only employees who should be making purchases hold cards. A review should also be carried out of the approvers for each card	Café Connect – review will be undertaken and approvers updated on system. Monitor		100%		30-Apr-2018	Ingram Wilson	The manager of Café Connect is the only person holding a purchase card.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	holder. (Medium Risk)							
T&PSR/IAAP/604	6. Review of Stockists It is recommended that the method for making purchases is reviewed to ensure best value is being obtained. (Medium Risk)	Work Connect – review of suppliers and awareness of purchasing from wholesale and best value. Change in practice highlighted in aforementioned workshops. Café Connect – A/A		100%		26-Apr-2018	Ingram Wilson	Review of suppliers carried out and reflected in practice.
T&PSR/IAAP/605	7. Food Hygiene A food hygiene inspection should be organised at TITP to ensure that the facility is covered even for the sporadic use for food purposes that is happening currently. Copies of all the food hygiene certificates are kept on file. (Low Risk)	Environmental health inspection has already been requested. SESW to inform manager when this is undertaken. Current certificate to be displayed. Monitor routine that all requirements are being adhered too. 2018 certificates copied and kept alongside client training records. Annual training record audit		100%		30-Apr-2018	Adrian McBride; Ingram Wilson	Environmental Health inspection of T in the Park carried out. All clients who have started at Slipway have food hygiene certificates and copies have been retained and included in our training record.
T&PSR/IAAP/606	8. General Management of Facilities It is recommended that an induction process is developed ahead of the opening of Slipway, for the 2018 season. (Low Risk)	All areas have Induction in line with WDC plus Work Connect has further in house induction. New recording methods to be introduced and kept on record. Reviewed annually		100%		30-Apr-2018	Ingram Wilson	Re Slipway - Induction completed for new staff and clients, Clients all completed Elementary Food hygiene prior to commencing. Awaiting dates for further one session for staff member. This year Work Connect included an information session and site visit for all clients prior to induction day.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/607	9. Procedures Manual There needs to be a review of the manuals, and update for the missing sections, correcting the few issues as necessary. (Low Risk)	All manuals to be reviewed and refreshed as recommended. Final inspection by A McBride. RPO to be clarified and confirmed		95%		30-Jun-2018	Adrian McBride; Ingram Wilson	Timescale has slipped due to recent events at Havoc and staffing changes. T in the Park manual at final stages. Slipway manual completed and draft for Café Connect near completion.

Project 129. Scottish Social Services Council Registration (Report Issued May 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/610	1. Monitoring Staff Registration with Scottish Social Services Council All service managers are required to monitor their staff's SSSC registration proactively. Each manager should manage the registration list for their staff in a manner that ensures that all changes are updated on a timely basis. (Medium Risk)	All service managers monitor the registration of their SSSC registered staff and ensure the list is updated regularly.		100%		08-May-2018	All service managers	This is an ongoing action and management have been advised of the requirement to monitor SSSC registrations.
T&PSR/IAAP/611	2. Updates to SSC Register Managers should request staff identified, whose SSSC registration requires updating, to ensure that their registration is updated. (Low Risk))	Early Learning and Childcare information has been updated.		100%		11-May-2018	Kathy Morrison	Managers have requested that staff whose SSSC registration requires updating, ensure that their registration is updated.

Project 134. Use of Care First Functionality for Financial Management (Report Issued May 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/624	1. System Functionality A review should be undertaken to determine if the personal budgeting screen could be utilised by other client teams and if it can't whether from a cost benefit analysis it is worth maintaining the functionality. In addition an analysis should be done by the teams on what information they currently use and need and whether the use of business objects could assist with this. (Medium Risk)	The Self Directed Support (SDS) policy is currently under review, in preparation for potential inspection. Terms of review maybe extended to consider the appropriateness of using CareFirst to assess client packages.		0%	31-Mar-2019	31-Mar-2019	Wendy Jack	
T&PSR/IAAP/625	2. Training Serious consideration should be given to obtaining training from the Care First providers to: - Ensure we are: using all of the functionality across all service areas that we are currently paying for; and - Determine how to eliminate some of the inefficiencies found when using the system by ensuring users are using the system properly. (Medium Risk)	The Self Directed Support (SDS) policy is currently under review, in preparation for potential inspection. Terms of review maybe extended to consider the appropriateness of using CareFirst to assess client packages. We would expect that there will be initial concerns/teething problems when setting up any new processes. Approaches had been made and will continue to be made, if we feel this will assist, to our neighbouring Health and		0%	31-Jul-2018	31-Jul-2018	Jacqueline Pender	

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
		Social Care Partnerships who also use Care First for client care package management. Two days a week were allocated to the Learning Disability process by a member of the Information Team and this will continue if required. Olm have also been involved in the process. Going forward the responsibility for maintenance of care packages will be part of an ongoing review of the HSCP staffing structure.						
T&PSR/IAAP/626	3. Ensure sign off of Contribution Calculations in Care Contracts All of the contributions need to be signed off. (Medium Risk)	Agreed. All calculations will in future be signed off.		0%	31-Jul-2018	31-Jul-2018	Jacqueline Pender	
T&PSR/IAAP/627	4. Upgrade to Civica Thought should be given to upgrading Civica to enable edits to be made to documents in the system. Alternatively thought should be given to how to improve the calculations produced by Care First to completely avoid the duplication of files. (Medium Risk)	Consideration will be given to upgrade, in the climate of competing budget priorities. Civica is used throughout the council. Consideration will be given again to check if other services out-with the HSCP are now in a position where they would find the package useful. An assessment will be carried out to assess use of staff time, to determine if this would be cost effective to purchase.		0%	31-Dec-2018	31-Dec-2018	Jacqueline Pender	

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/628	5. Sharing of information Social Workers should be encouraged to share any information with the finance team they have for a client which may have a financial effect. Consideration should be given to how sharing of information with other client teams could help streamline processes and avoid duplication of work, this will become more critical when other teams start to use the finance functions of Care First. (Medium Risk)	Consideration will be given to the possibility of creating a regular report on Business Objects which provides details of deceased clients. We currently have access to "Tell us Once" and when we are notified, then the Care Contracts Team are advised. A letter will be sent to the Providers advising them of our recent audit inspection and remind them of their responsibility to contact the Care Contracts Team when a resident is deceased.		0%	31-Aug-2018	31-Aug-2018	Jacqueline Pender	
T&PSR/IAAP/629	6. Segregation of Duties in Learning Disabilities There should be appropriate segregation of duties; the permissions of individuals within Care First should be looked at to ensure that no one is allowed to perform all functions. (Medium Risk)	This will be reviewed.		0%	30-Jun-2018	30-Jun-2018	Robert MacFarlane; Adrian McBride	
T&PSR/IAAP/630	7. Differences between agreed care and actual care in Learning Disabilities If the client's needs have changed then this needs to be documented in an	This will be reviewed.		0%	30-Jun-2018	30-Jun-2018	Robert MacFarlane; Adrian McBride	

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	updated IRF2 as well as changing the service package. (Medium Risk)							

Corporate Reports

Project 120. ICT Disaster Recovery/Business Continuity Controls (Report Issued August 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
CS/IAAP/520	2. DR Plans for the main telephony delivery systems have yet to be implemented/tested Management must set in place plans and timescales to effectively test DR arrangements for the main telephony systems. (Medium Risk)	ICT will develop the implementation plan for this test by the end of October		33%	31-Oct-2017	30-Mar-2018	Brian Miller	May 18 - Lines still to be fully commissioned and then handed over to Capita. This is being hastened on a daily basis but BT do not give commissioning or installation dates for new lines and therefore there is no timescale for delivery. There has been progress on some of the installation but overall it still remains outstanding.
CS/IAAP/521	3. Systems without parallel DR arrangements are not fully tested Management must put in place effective plans and timescales to effectively test DR arrangements for large departmental and corporate systems. (Medium Risk)	ICT Management will deliver a testing schedule for these systems by 30th Nov 2017 ICT will implement the above testing schedule by 30th June 2018		75%	30-Jun-2018	30-Jun-2018	James Gallacher	May 18 - On target to complete. Full DR testing schedule implemented with Email & Citrix applications identified as the first critical applications to be DR tested. Both systems are complex in terms of configuration and server requirements and DR planning has been in progress. By mid-June both systems will be fully DR tested and signed off. The remaining list of applications will continue to be tested with the aim of testing a minimum of two applications per month. Client department liaison is continuing to

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
								agree dates and test plans for DR testing of all applications as per schedule. As and when any systems encounter issues we will take the opportunity to DR test if possible and the schedule will be updated accordingly. Data Centre move completed in January 18 and all systems partly DR tested with server hardware & storage move to Aurora site.

Project 121. Purchasing Card Audit (Report Issued August 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
CS/IAAP/528	2b. Terminating Purchase Cards when employees leave As part of the employee leaving process a procedure should be added to ensure that any purchase cards an employee holds are terminated. (Low risk)	Further development required with Workforce Management System to identify staff with CPC to have automated notifications where staff move location, section or terminate employment to ensure robust management of CPC distribution and manager notifications.		33%	30-May-2018	30-May-2018	Stella Kinloch	Development of new functions will be carried forward following the Version 8 upgrade for completion by end of year.

Project 122. Register of Gifts, Hospitality & Interests (Report Issued November 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/536	3. Guidance & Declaration Form In relation to the Register of Gifts & Hospitality and Declaring Interests, the following is recommended: • The title of the guidance be renamed which covers both offers and acceptance of Gifts, Hospitality & Interests e.g. 'Guidance of Acceptance & Offers of Gifts, Hospitality & Declaring Interests. • The Guidance should be revised and updated particularly in relation to the Register of Interests. This should include the requirement for Senior Officers i.e. Strategic Leads and above to make an annual return which would be either confirming all/any interests already declared or making a nil return. • A separate declaration form should be established for declaring private interests which may result in a conflict or conflict of interests with the work of Officers and not incorporated with Gifts & Hospitality. (Medium Risk)	Agreed, relatively minor changes to be made.		95%		31-Mar-2018	Peter Hessett	Drafts completed on time. As ELG has not met it will be discussed with Trade Union Conveners on 13 June.

T&PSR/IAAP/539	6. Date Guidance Prepared As the guidance document relating to the Register of Gifts, Hospitality and Declaring Interests was updated in March 2017, the date should be recorded on the guidance to ensure that staff are making reference to the correct and most up to date version. In addition, the retention periods for the register and declaration forms should also be documented within the guidance i.e. current plus five years. (Low Risk)	Agreed		95%		31-Mar-2018	Peter Hessett	Drafts completed on time. As ELG has not met it will be discussed with Trade Union Conveners on 13 June.

Project 125. Creditors (Report Issued February 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/580	5. Agresso Payments - Insufficient checking of authorised signatories when processing batches for payment CAS should consider implementation of alternative automated process to confirm batches are appropriately authorised. In the interim CAS should ensure sufficient manual checking is undertaken to reduce risk of unauthorised payments to acceptable level.	Project to be undertaken to streamline online transactional processing, including implementation of online approval process Council wide incorporating post specific financial responsibilities with relevant limits. In the interim checking process will be reinforced with CAS staff.		10%	30-Jun-2018	30-Jun-2018	Graham Hawthorn; Stella Kinloch	Development within Workforce Management System requires to be carried forward to 18/19 following Version 8 upgrade.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	(Low Risk)							
T&PSR/IAAP/582	7. Agresso Payments - Comino authorised signatory listing is not accurate Signatory list should be updated to ensure it is accurate and procedures should be implemented to ensure the signatory list is kept up to date. (Low risk)	Project to be undertaken to streamline online transactional processing, including implementation of online approval process Council wide incorporating post specific financial responsibilities with relevant limits. In the interim checking process will be reinforced with CAS staff.		10%		30-Jun-2018	Stella Kinloch	Development within Workforce Management System to be carried forward to 18/19 following Version 8 upgrade.

Project 128. Payroll - Overtime (Report Issued May 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/608	1. Overtime - Building Services/Repairs & Maintenance In relation to Building Services / Repairs & Maintenance, in order to continue to manage the level of overtime, it is recommended that consideration be given to: - Adopting a more flexible approach to working; and - Employing more personnel, paid at plain time, to cover the anticipated demand for services rather than paying some existing staff at enhanced rates.	Negotiations with TU's to introduce more flexibility into working patterns within service provision commenced in 2017 and it is hoped a positive outcome will be achieved in 2018/2019. This may introduce seasonal working, extended hours Mondays to Thursdays and Saturday mornings would be considered part of the standard week with all paid as standard time. If agreed it could mean a reduction in overtime		0%		31-Mar-2019	Martin Feeney	This action has 7 milestones none of which have been completed; the first is due for completion on 20 July 2018. Although no milestones have been completed to date, good progress has been made with much of the analysis completed, negotiations with TU's have commenced, flexible work patterns developed and outline workforce planning is well advanced. It is anticipated significant progress will be made in

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	(Medium Risk)	costs for emergency repairs and overtime to complete projects and void house repairs. It would also allow better utilisation of resources for external project works with extended hours in Spring / Summer / Autumn and reduced hours in the Winter months (seasonal working). In addition, we will analyse if there are any benefits in employing additional staff to reduce expenditure on overtime as part of our regular workforce planning meetings where Building Services review resource requirements.						coming months and although benefits of all proposed changes may not be fully realised until 2019/2020, good progress will be evident in 2018/2019.
T&PSR/IAAP/609	2. Overtime - Homecare Whilst it is accepted that some action has been/is being taken to address some of the issues relating to the management of overtime, it is apparent that a lot of the issues which were highlighted in the previous audit still exist e.g. historical contracts, excessive overtime hours being worked by some staff, absence management etc. It is therefore recommended that a detailed review of the service including compliance of CM2000 is undertaken in	Further commitment to developing a supply list of staff who can provide service based on peaks of activity and cover for absence / annual leave / training / team briefings. Speed of recruitment turnaround to be scrutinised to ensure length of time from vacancy to trained staff is minimised. Continued effort to ensure most economic cover i.e. additional		62%		30-Jun-2018	Jo Gibson	Compliance reports are being produced on a weekly basis and discussed with the relevant staff. First response continues to be identifying and using any gaps/availability within scheduled staff hours before resorting to additional cover and the first option is always to look at the most economic option while providing continuity of care. Authorisation must be given for any overtime at premium rates. The

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	order to ensure that overtime is being managed in a more efficient manner. (Medium Risk)	basic hours from part time staff also provides continuity of care for individual clients. Service operates in a rapidly changing environment e.g., hospital admissions / discharges requiring flexibility and responsiveness. As staff provide service on an 1:1 or 2:1 basis the implication of ensuring clients receive a service at the appropriate time results in firstly identifying whether there is availability within staff scheduled to work, before having to provide additional cover, resulting in additional hours worked either at plain time or at premium rates. Co-ordinators will monitor hours worked on a weekly basis in conjunction with organisers. Every effort will be made to limit overtime at premium rates, with authorisation required from Service Manager if cover will result in double time. Compliance reports for						recruitment process has been scrutinised.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
		CM2000 are being produced weekly and are discussed initially with Organisers, and also with staff teams to improve increase levels of compliance. Additional prompts are being established to assist staff in identifying that their swipe has registered with the system for entering and exiting the client's home.						

Project 130. ICT Procurement Controls (Report Issued May 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/612	1. Review authorisation hierarchy of ICT staff in WeBuy Management should review the setup of users within the WeBuy system to take into account any moves and changes and new structures. (Low Risk)	An updated list of ICT requisitioners, approvers and locations is required to allow the We Buy system to be updated.		1%	28-Dec-2018	28-Dec-2018	Patricia Kerr; Derek McLean	May 18. Draft of the ICT proposed purchasing authorisation levels supplied to Procurement.

Project 131. ICT Remote Access Controls (Report Issued May 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/613	1. Data handling Terms and Conditions required for 3rd party access to WDC information Management should develop a standard 3rd party suite of data handling terms and conditions to protect WDC information whilst 3rd party vendors carry out support activities. (Medium Risk)	ICT will assist Legal Services in the development data handling terms and conditions.		16%	30-Sep-2018	30-Sep-2018	Alan Douglas; James Gallacher; Iain Kerr; Patricia Kerr	May 18. Work has started on establishing the working group.
T&PSR/IAAP/614	2. Central log detailing 3rd party support activity Management should maintain a central report of which 3rd party accessed which system and when. (Low Risk)	ICT will provide Service Desk reports and remote access logs to the data/system owner to allow an assessment of whether the access is proportionate. Initial test reports to be produced.		100%	30-Jun-2018	30-Jun-2018	James Gallacher	June 6th 2018. Following workshop with EDC on June 6th a third party access report is available and will be issued at the end of every month starting June.

Project 132. ICT Service Desk Controls (Report Issued May 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/615	1. A Sharing agreement specific to the Service Desk software and platform does not exist Whilst there is a Service Level Agreement (SLA) document covering the general sharing arrangements between EDC and WDC, as part of the SLA annual review it may be	This will form part of the annual review to ensure data sharing responsibilities are fit for purpose.		66%	30-Jun-2018	30-Jun-2018	Patricia Kerr	May 18. On target for completion by end June. WDC changes incorporated. Network design diagram to be added following data centre relocation to Aurora. Draft issued to EDC and meeting with EDC scheduled for 7 June.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	beneficial to make additional references to the sharing arrangement for the ICT service desk. (Low Risk)							

Project 133. Data and Information Security – Governance and Practice (Report Issued May 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/616	1. Business as Usual Patching Regime for Devices In order to comply with both PSN and Cyber Essentials requirements, a Business as Usual (BAU) position, whereby all identified vulnerabilities are resolved within 60 days of the patch released needs to be fully established, as supported by: - Resources (both personnel and technology) to detect and implement; - Structured scanning processes to detect vulnerabilities and then demonstrate that patches have been successfully applied; and - Investing in technology to add automation and reporting functionality in order to enhance this process to increase its effectiveness. (Medium Risk)	Processes and resources (personnel and budget) are in place and will continue to be improved, refined and automated to ensure compliance with the 60-day patching requirements. Planned improvement for 2018-19 includes patching tool.		20%	30-Sep-2018	30-Sep-2018	John Martin; Brian Miller	May 18. Device patching for Microsoft products already automated. Routine programme of device scanning in place. product testing started.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/617	2. Automation of vulnerability detection / resolution / reporting In order to enhance both the PSN and Cyber Essentials accreditation processes, an automated tool identifying, resolving and reporting on vulnerabilities should be acquired for implementation during the current financial year. (Low Risk)	Funding has been approved to acquire an enterprise level vulnerability scanning/discovery tool for a period of one year initially. A draft specification paper will be drawn up for review by the ICT board and subsequently published on PCS for quick quotes, and for implementation thereafter.		0%	31-Jul-2018	31-Jul-2018	Iain Kerr	There are 6 milestones for this action the first of which is underway and on target
T&PSR/IAAP/618	3. Attainment of Payment Card Industry (PCI) Data Security Standard The remaining specific actions, as detailed below, require to be completed so that WDC can achieve PCI compliance: 1. Provision and deployment of tablet devices for the receiving and processing of card payments; 2. Completion of Self-Assessment Questionnaire and submission thereafter to PCI DSS authorising body; and 3. Establishment of quarterly scans by an external provider. (Medium Risk)	Pilot devices are currently at testing stage and full deployment will take place when user sign off is received. Items 2 and 3 will be carried out once item 1 has been completed.		33%	30-Sep-2018	30-Sep-2018	Iain Kerr; John Martin; Brian Miller	May 18. Receipt printing issue identified during user test. Solution identified and will be offered to user to consider
T&PSR/IAAP/619	4. Cyber Essentials In preparation for the Council achieving Cyber Essentials plus by October 2019, steps should continue within the	An exercise to self-assess for Cyber Essentials will be carried out in keeping with timescales outlined in		0%	30-Sep-2018	30-Sep-2018	Iain Kerr	There are 3 milestones to this action with target dates expected to be met

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	project work to deliver the Cyber Essentials process in accordance with the plan with a view to achieving Cyber Essentials Plus by October 2019. (Medium Risk)	the Scottish Government Public Sector Action Plan on Cyber Security.						
T&PSR/IAAP/620	5. Combined procurement approach for PSN / PCI / Cyber Essentials A coordinated procurement approach covering the compliance requirements for PSN, PCI and Cyber Essentials should be progressed. (Low Risk)	Although an exercise to carry out the PSN IT Health Check will progress this year, a regulated procurement exercise will follow for subsequent years to combine tests for each of the compliance regimes, initially over a three year period.		0%	31-Mar-2019	31-Mar-2019	Iain Kerr	There are 7 milestones to this action with initial launch expected to meet target dates
T&PSR/IAAP/621	6. Supply Chain Cyber Security Policy Once the final Supply Chain Cyber Security Policy is issued by the Scottish Government, a process needs to be established to implement the laid down requirements. (Medium Risk)	Meetings will take place between Annabel Travers, Iain Kerr and Patricia Kerr to determine how the *Supply Chain Cyber Security Policy* will be processed and implemented. The process will be captured in a guidance document and published on the intranet with an email sent out to the CPU and ICT staff.		0%	31-Dec-2018	31-Dec-2018	Iain Kerr; Patricia Kerr; Annabel Travers	Milestones with timescales will be firmed up on publication of the new guidance
T&PSR/IAAP/622	7. Update required to Acceptable Use Policy The Council's Acceptable Use Policy (AUP) should be reviewed and updated. (Low Risk)	The AUP will be reviewed as an Information Security policy, taking into account changes in working practices and legislation since the last		0%	31-Mar-2019	31-Mar-2019	Iain Kerr	There are 6 milestones for this action the first of which is underway and on target

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
		review, input will be required from ICT, Legal and possibly procurement.						
T&PSR/IAAP/622	8. GDPR Awareness A list of staff with access to a PC or laptop who do not complete the GDPR e-learn module by 27th July 2018 should be prepared by service area and reported to PAMG for appropriate action by Strategic Leads (HSCP – Heads of Service). A similar reporting process should be adopted for staff without access to a PC or Laptop, in terms of any such staff not confirming that they have read the 'GDPR Employees' staff booklet by 31st August 2018. (Medium Risk)	The action proposed is considered to be a proportionate first step to ensure that all staff handling Personal Data are sufficiently aware of their obligations under GDPR. Further steps required to ensure awareness will be considered upon monitoring of the take up rate and will be agreed through senior management structures if necessary.		80%	31-Aug-2018	31-Aug-2018	Michael Butler	The rollout of the online GDPR module for corporate staff in ongoing and to date over 1200 employees have completed the course. In addition to this, over 900 educational establishment staff have acknowledged that they have received and understood the online access to the GDPR Employee booklet. HSCP staff are publishing the GDPR employee booklet on their intranet and sending a link to over 500 Homecare staff. Over 700 GDPR employee booklets has been distributed for staff who do not have access to PCs. Work on this is ongoing and future updates will be provided.
T&PSR/IAAP/623	9. Information Governance Scheme An Information Governance Scheme should be developed, approved and introduced. (Low Risk)	Whilst the relevant information exists on the Records Management page of the Staff Intranet, it is believed that such an Information Governance Scheme will assist employees to understand the inter-relationships between various governance documents and internal and external requirements.		0%	31-Mar-2019	31-Mar-2019	Alan Douglas	

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
		The scheme will form a useful first port of call for Employees seeking to understand how information should be dealt with across the Council. It will require significant input from colleagues across the Council.						

Appendix 2

NHS Greater Glasgow and Clyde
Internal Audit Activity Report for Integration Joint Boards – December 2017

Background

Integration Joint Boards direct both NHS Greater Glasgow and Clyde and the local authority to deliver services that enable the Integration Joint Board to deliver on its strategic plan.

Both NHS Greater Glasgow and Clyde and the local authority have internal audit functions that conduct audits across each organisation and report the findings of these to the respective audit committees.

Members of the Integration Joint Board have an interest in the outcomes of audits at both NHS Greater Glasgow and Clyde and the local authority that have an impact upon the Integration Joint Board's ability to deliver the strategic plan.

This report provides a summary for the Integration Joint Board of the internal audit activity within NHSGGC which has an impact upon the delivery of the strategic plan.

NHS Greater Glasgow and Clyde Internal Audit Activity

At the NHSGGC Audit and Risk Committee meeting on 12th December 2017, the Board's internal auditors, PwC, reported on the following:

Review	Report classification	Number of individual findings			
		High	Medium	Low	Total
1. Waiting times management	High	1	3	1	5
2. Suicide risk assessment	High	1	2	1	4
3. Delayed discharge	Medium	-	4	-	4
4. Temporary staffing: nursing	Medium	-	2	1	3
5. Key financial controls: accounts payable	Low	-	-	-	-
6. Key financial controls: fixed assets	Low	-	-	3	3
Total findings		**2**	**11**	**6**	**19**

High risk indicates findings that could have a significant:
impact on operational performance; or
monetary or financial statement impact or
breach in laws and regulations resulting in significant fines and consequences; or
impact on the reputation or brand of the organisation.

Medium risk indicates findings that could have a moderate:
impact on operational performance; or
monetary or financial statement impact; or
breach in laws and regulations resulting in fines and consequences; or
impact on the reputation or brand of the organisation.

Low risk indicates findings that could have a minor:
impact on the organisation's operational performance; or
monetary or financial statement impact; or
breach in laws and regulations with limited consequences; or
impact on the reputation of the organisation.

1. **Waiting times management - high risk**
   Following the findings of a previous audit report, a new corporate capacity planning exercise was undertaken. The programme of demand and capacity gap assessment and improvement was intended to provide a consistent approach to addressing the deteriorating performance against waiting times targets. Workshops have taken place in order to aid the Acute Directors in identifying potential efficiency drivers which can be implemented in order to increase productivity and capacity across the board. Whilst a significant level of time and resource has been expended to date on implementing the programme of demand and capacity gap assessment and improvement, there is a risk that this exercise will not deliver its key objectives due to the current lack of project management discipline and the absence of a capacity planning approach that considers actual available resource. As such, without refining the programme further to address the issues raised within this report, there is a risk that management's response to the deteriorating performance against waiting time targets will be insufficient. For this reason this report was classified as overall high risk.

2. **Suicide risk assessment – high risk**
   NHS Greater Glasgow and Clyde has a series of risk assessment protocols in place, which address numerous mental health risk factors including suicide. At present there are three key risk assessment tools in place across Mental Health services, Child and Adolescent Mental Health Services and Emergency Departments.
   Whilst patient safety is dependent on effective clinical process and judgement, the risk assessment process is important to ensuring that at risk patients are identified and managed through the appropriate pathways and acts as an important aid to clinical judgement. PwC acknowledged that clinical research indicates that the positive predictive value of suicide risk assessment tools can be as low as 5%, and that there is consequently no direct correlation between completion of a tool and a reduction in suicide rates.
   Overall PwC found that whilst there are risk assessment tools in place which have been tailored for specific service needs, these are not being completed in practice in accordance with the requirements of the Board's policies. Whilst the appropriate clinical care may have been provided in these cases, in numerous instances there was a lack of evidence that the appropriate considerations were made.
   Whilst they acknowledged the continued clinical debate on the extent to which suicide risk assessment tools have an impact on suicide rates, they expected that staff within NHSGGC would follow the Board's policies in relation to use of the tools.
   They also found that there are gaps in the coordination of suicide risk assessment across service areas in NHS Greater Glasgow and Clyde. At the time of the report, Board suicide prevention guidelines covered adult mental health services only, rather than including CAMHS, Acute and Primary Care services.
   A revised risk management policy has been developed after extensive consultation. It introduced a new risk management tool which includes user and carer input, is embedded in the electronic care record, and links directly to care planning and is accompanied by five new auditable standards. Implementation will be supported by SPSP and a new Quality Improvement hub in Mental Health. The data provided in this report will form a useful baseline to assess the effectiveness of this new suite of measures in adult, LD, addictions and older peoples' mental health services.
   Management recognise that the use of risk assessment tools was not fully compliant with policy in the audits conducted in CAMHS and ED, two areas that have not so far had the benefit of SPSP support. Performance needs to be improved, and a suite of measures including training, prompts to policy awareness and audit will be introduced.

As part of the revision of risk management policy, management has recognised that an overarching framework of Suicide Prevention Guidance needed to be developed to bring together all relevant policies into one coherent document. That is now available online through Staffnet. The document did not expressly reference risk management in CAMHS and Acute settings, and that oversight will be corrected.

Management accepted the criticism of suicide prevention training (as distinct from risk management training) made in this audit. This was previously subject to a HEAT target and Scottish Government support for training materials, both of which have now lapsed. A working group to reinstate appropriate training has been established.

It is the Board's view that pathways are in place to guide the management of suicidal behaviour in ED, but it is accepted there is scope to improve the clarity and availability of that guidance.

3. Delayed discharge – medium risk

In 2015/16 NHS Greater Glasgow and Clyde received additional funding from the Scottish Government of £23.66m allocated across the Board's six Health and Social Care Partnerships (HSCPs) over a period of three years. This funding came from the national Integration Fund and was designed to support reduced numbers of delayed discharges.

The key finding of this report is that, in order to drive tangible and sustainable improvement against delayed discharge targets, a more detailed, data-driven and targeted approach must be taken in order to identify and change underlying root causes at a granular, departmental and patient-pathway level. This approach should be based on available delayed discharge data, lost bed days data and any additional understanding that can be gained on detailed underlying root causes for delay. Actions should then be targeted towards the areas which present the poorest performance. By doing this, the Board will be better equipped to create and prioritise meaningful actions.

The Board has reported the risk of an increase in delayed discharges and increased bed days due to pressures on local authority funding as the highest scored risk in their corporate risk register. This risk does have a financial implication, however, the other risk relates to the wellbeing of patients due to the deterioration caused by each subsequent day spent in an acute hospital bed. Whilst this is clearly a risk being faced by the Board, the findings of this report do not support the assertion that it is the most significant corporate risk being faced by NHSGGC.

PwC acknowledged that the challenges in improving delayed discharge performance are complex, multi-faceted and variable across the different HSCPs. Differences in patient populations, demographics, the number of stakeholders involved, and other external factors render a single, consistent approach ineffective.

This review, and the patient case studies conducted, has identified a number of underlying causes for delay. Whilst there are numerous others, these included:

- patient and family choice;
- availability of care homes;
- social work referral/SMAT process;
- slow email communication between healthcare providers; and
- restrictive and inflexible patient pathways.

4. Temporary staffing: nursing – medium risk

In the last 12 months the Board has initiated a series of actions to consider the use of temporary staffing across nursing and midwifery. At present the focus is on reducing the level of agency use. Whilst in the longer term it is the objective that reliance on bank staff will be reduced, it has been acknowledged that bank staff will always be required as a contingency across the health service.

The Board has in place policies and processes to manage the use of temporary staff. The Board follows national guidelines when it comes to workforce planning. Work has been done over the last six months by management to examine rostering and the underlying factors that impact the use of temporary staffing. A number of initiatives are underway to improve and help teams with rostering, sickness absence, enhanced observations and recruitment. The findings and recommendations raised within this report demonstrate that the root cause of the issues is the need to set consistent minimum standards for approving the use of agency requests, for managing and monitoring complaints and to ensure proper on-boarding of agency staff.

NHSGGC accepts the findings of the review and will progress associated actions where practical and reasonable to do so, specifically in relation to the on boarding of agency staff.

5. **Key financial controls: accounts payable – low risk**

NHSGGC spends around £1.5bn per annum on non-pay related costs. These cover areas of core expenditure including prescribing, estates, suppliers, and service costs. The accounts payable process is critical to ensuring that goods and services are only paid for when they have been appropriately received and that payment processing is controlled. The controls within the accounts payable process are important in ensuring the accuracy and completeness of financial information, that suppliers are paid accurately and on a timely basis and also that the risk of fraud is managed.

In the current year PwC had no new findings to report and have concluded that, in line with prior years, the control environment for accounts payable remains strong. Overall controls were found to be well designed and sample testing of their operation noted no exceptions. This report has therefore been classified as low risk.

6. **Key financial controls: fixed assets – low risk**

The fixed asset portfolio of NHS Greater Glasgow and Clyde (NHSGGC) represents a balance of £2.1 billion on the Board's balance sheet. This is comprised of £1.7 billion of buildings representing the large and complex estate of NHSGGC. The size and diversity of the fixed asset balance of NHSGGC can present risks associated with ensuring that all assets are captured and held at an appropriate value within the financial statements. Key financial controls are critical to ensuring that the fixed asset balance is reflected accurately within the accounts.

Overall, PwC found that controls are in place to ensure fixed assets are accounted for appropriately, but identified some minor areas for improvement to ensure that processes are suitably formalised and consistently operating as expected.

Management accepts the findings within this report and has an action plan in place to address them.

Appendix 3
WDHSCP - Internal Audit Reports / External Audit Reports

Generated on: 06 June 2018

Action Status	
	Cancelled
	Overdue; Neglected
	Unassigned; Check Progress
	Not Started; In Progress; Assigned
	Completed

Project 1. WDHSCP Governance, Performance & Financial Management (Report Issued March 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
WDHSCP-001	It is recommended that when a model plan is completed and published a Records Management Plan prepared for local approval by the Partnership Board in order to comply with the statutory requirement. (Low Risk)	This will be completed at the earliest opportunity, with WDHSCP officers having already engaged with Scottish Government officials on the drafting of the model Records Management Plan.		60%	31-Oct-2017	31-Jan-2019	Wendy Jack	We have been advise that in September 2018 the Keeper intends to invite WDHSCP to submit their plan. Although September 2018 is the month the invitation will be issued, the plan will not be expected until January 2019.
WDHSCP-002	2. Partnership governance arrangements It is recommended that management within WDC and WDHSCP should, as part of their regular management meetings, identify any issues in relation to partnership	Preliminary discussions have already taken place, and initial scoping begun with respect to partnership governance arrangements as relates to the WDHSCP Board.		100%	31-Aug-2017	31-Aug-2017	Wendy Jack; Julie Slavin	Chief Financial Officer and Head of Strategy, Planning & Health Improvement have prepared a local Code of Good Governance (as per CIPFA Guidance), which has been approved by the HSCP Board. A

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	governance arrangements and agree any resultant improvement actions in order comply with the best practice. (Low Risk)							compliance self-assessment has been completed in accordance with CIPFA recommendations, with ongoing engagement of Chief Internal Auditor and external auditor. This self-assessment has identified a number of improvement actions and has been used to develop an improvement action plan. This will be presented to the September 2017 meeting of the HSCP Audit Committee for approval.

Project 2. WDHSCP External Audit Annual Report 2016/17

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
WDHSCP-003	1. Hospital Acute Services (Set Aside) Arrangements for the sum set aside for hospital acute services under the control of WDIJB are not yet operating as required by legislation and statutory guidance. A notional figure was included in the accounts under a transitional arrangement agreed by the Scottish Government. Risk: In future years the sum set aside recorded in the annual accounts will not reflect actual hospital use.	A working group has been formed with NHSGGC finance colleagues, CFOs and the Scottish Government to establish processes for planning, quantifying and performance management of delegated hospital functions and associated resources in 2017/18.		40%	30-Jun-2018	30-Jun-2018	Wendy Jack; Julie Slavin	On 18/05/18 the CFOs from the 6 Glasgow group IJBs and the Assistant Director of Finance for NHSGGC submitted a joint response to Scottish Government on the progress, timescales and risk factors around the ongoing work.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	Recommendation: NHSGGC and WDIJB should establish processes for planning and performance management of delegated hospital functions and associated resources in 2017/18.							
WDHSCP-004	2. Budget Monitoring There were differences in the figures reported to the Board in May and the surplus in the draft accounts reported to the Audit Committee in June. Risk: Budget reports may not provide sufficient information to enable members to review performance and make the necessary decisions. Recommendation: A report which reconciles any movements from the final outturn report to the accounts should be provided to the Board and Audit Committee.	Going forward, a year end summary report will be provided for the Board and Audit Committee.		100%	30-Jun-2018	30-Jun-2018	Wendy Jack; Julie Slavin	The 2017/18 Draft Unaudited Accounts Report contains the relevant data.
WDHSCP-005	3. 2017/18 Budget The budget for 2017/18 was not approved till 23 August 2017, which means that the Board was operating without a fully approved budget for almost six months of the financial year. Risk: Operating without a fully approved budget makes financial management and decision making more difficult and may negatively affect the quality of service	2017/18 Budget has been approved at the August 2017 Board Meeting. We will continue to ensure future budgets are agreed as a matter of priority.		95%	30-Jun-2018	30-Jun-2018	Wendy Jack; Julie Slavin	The 2018/19 Annual Revenue Budget was approved by the HSCP Board on 2nd May 2018, including savings options required to close the funding gap. The Set Aside remains a notional budget at this time.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	delivery. Recommendation: The Board should continue to ensure that budgets for future years are approved as a matter of urgency.							
WDHSCP-006	4. Medium to Long term Financial Plans There are no medium to long term financial plans in place. This is increasingly important as demand pressures increase, financial settlements continue to reduce and fundamental service redesign over a longer time frame becomes necessary. Risk: WDIJB is not planning adequately over the medium to long term to manage or respond to significant financial risks. Services may be affected if their sustainability is not planned. Recommendation: A long term financial strategy (5 years +) supported by clear and detailed financial plans (3 years +) should be prepared Plans should set out scenario plans (best, worst, most likely).	This has been committed through further actions in our Annual Governance Statement and is now also included in our Improvement Action Plan as part of our review of the Local Code of Governance.		40%	28-Feb-2018	30-Nov-2018	Wendy Jack; Julie Slavin	The delay in approving the 2018/19 budget, including savings options until 2 May 2018, coupled with significant uncertainty around significant funding streams from the Scottish Government for Primary Care Transformation, ADP and Mental Health Services has led to a delay. However scenario planning is underway and the work undertaken by the new Strategic Planning Group will also require to be reflected.
WDHSCP-007	5. Local Code Good Governance Arrangements The requirement in 2016/17 for the IJB to publicly report on their compliance with their Local Governance Code	This has been included as part of the agenda for the September Audit Committee for approval from the Board. Going forward the annual		100%	30-Jun-2018	30-Jun-2018	Wendy Jack; Julie Slavin	The new local code of good governance was approved at the Sept 2017 Audit Committee and can therefore apply to 2017/18 Governance

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	was not met. Risk: WDIJB did not adopt the requirements of the Delivering Good Governance Framework in 2016/17. Recommendation: WDIJB should review compliance against their Local Code and publicly report on this for 2017/18.	review will form part of our draft annual accounts timetable						Statement for Annual Accounts, with a "light touch" review undertaken.
WDHSCP-008	6. Internal Audit The internal auditors of NHSGGC do not share copies of individual internal audit reports with the IJB or attend meetings of the IJB's Audit Committee. Risk: Officers and Board members may be unable properly discharge their scrutiny and governance responsibilities. Recommendation: The WDIJB should develop a protocol with the auditors to facilitate for all internal audit reports that affect the IJB are made available to its Audit Committee.	Discussions have commenced with the NSGGC Assistant Director of Finance. We will work to develop an agreement, if possible within the existing terms of contract between HNSGGC and PwC.		50%	30-Jun-2018	30-Jun-2018	Wendy Jack; Colin McDougall; Julie Slavin	NHSGGC included a clause in the new contract that the successful organisation would have to work with IJBs on developing an information sharing protocol. Now that the contract has been awarded this work will commence.
WDHSCP-009	7. Value for Money While there is evidence of elements of Best Value being demonstrated by the joint board, there is no mechanism for formal review.	Work on developing links with Annual Performance Reporting to demonstrate that in a climate of financial austerity targets are on track.		15%	31-Jul-2018	31-Jul-2018	Wendy Jack; Julie Slavin	The HSCP will consider the outcomes of the recent WDC Best Value Review.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	Risk: Opportunities for continuous improvement are missed. Recommendation: The IJB should undertake a periodic and evidenced formal review of its performance against the Scottish Government Best Value framework							
WDHSCP-010	8. Annual Performance Report The 2014 Regulations require that an Annual Performance Report be approved and submitted within four months of the financial year end this was not achieved for 2016/17 with the report being submitted on 23 August. Risk: Non compliance with statutory regulations which is required to be reported by auditors. In addition, late submission delays the ability of Board members to review performance and progress improvement actions Recommendation: The WDIJB should ensure the Annual Performance Report is approved and submitted within the deadline	To seek approval from the Board to publish a draft of the Annual Performance Report by 31 July subject to Board approval at the next available meeting.		35%	31-Jul-2018	31-Jul-2018	Wendy Jack	The Annual Performance Report is underway and will be completed by 31st July for the August IJB in line with requirements, making use of full year data.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

Audit Committee: 20 June 2018

Subject: Local Code of Good Governance Review

1. Purpose

1.1 To advise to the Audit Committee the outcome of the annual self-evaluation exercise on the Health and Social Care Partnership Board's compliance with its Code of Good Governance.

2. Recommendations

2.1 The Audit Committee is asked to:

- Note the outcomes of the recent self-evaluation process undertaken and the updated Improvement Action Plan; and
- Approve the new improvement actions identified to strength compliance with the adopted Governance Framework principles.

3. Background

3.1 *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.

3.2 While the Framework is written in a local authority context, most of the principles are applicable to the HSCP Board, particularly as legislation recognises Integrated Joint Board's 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.

3.3 The concept underpinning the Framework is that it is helping local government bodies in taking responsibility for developing and shaping an informed approach to governance, aimed at achieving the highest standards in a measured and proportionate way. The Framework is intended to assist organisations individually in reviewing and accounting for their own unique approach. The overall aim is to ensure that:

- resources are directed in accordance with agreed policy and according to priorities;
- there is sound and inclusive decision making; and

- there is clear accountability for the use of those resources in order to achieve desired outcomes for service users and communities.

4. Main Issues

4.1 The HSCP Board at 31 May 2017 approved the Local Code of Good Governance and on 20 September 2017 noted the outcome of the self-evaluation process, and the improvement actions identified to strength compliance with the adopted Governance Framework principles.

4.2 The Governance Statement included in the 2017/18 draft Annual Accounts reflects the local code (and sources of assurance) as adopted in September 2017 and the June 2018 annual review, including updated and new improvement actions.

4.3 The annual self-evaluation review process for 2017/18 included a review by the Chief Financial Officer and the Chief Internal Auditor of the principles and the evidence underpinning them, i.e. systems, processes and practice. This review was considered by the Chief Officer and the Senior Management Team and used to update the progress of the September 2017 improvement actions and identify new actions for ongoing improvement.

4.4 No areas of non-compliance were identified and the compliance rating improved from “Amber” to “Green” in 6 sub-principles (Appendix 1) reflecting new policies and procedures such as the Freedom of Information Policy and annual compliance checks, including the review of the local code.

4.5 For those areas remaining unchanged from Amber, there has been progress and improvement (Appendix 2) such as: the formation of a Strategic Planning Group (sub-committee of the HSCP Board; members’ information sessions and progress on the methodology on quantifying “Set Aside” resources. The expectation being that these areas will be assessed as being fully compliant in next year’s annual review.

4.6 The review also identified new improvement actions for 2018/19 (Appendix 2), that are reflective of improvements to best practice and legislative requirements. These include an assessment of the effectiveness of the new Strategic Planning Group, given that it has a multi-stakeholder membership with a range of priorities that will have to be considered in a climate of financial constraint.

5. People Implications

5.1 None.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Risk Analysis

8.1 The risk of failure of not annually reviewing the local code and sources of assurance for governance arrangements could impact on the HSCP Board's ability to produce a meaningful Governance Statement.

9. Impact Assessments

9.1 None. .

10. Consultation

10.1 This report was prepared in conjunction with the Chief Officer and Senior Management Team.

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
4 June 2018

Person to Contact:	Julie Slavin – Chief Financial Officer, Hartfield, Dumbarton, G82 2DS, Telephone: 01389 812350 E-mail julie.slavin@ggc.scot.nhs.uk
Appendices:	Appendix 1 – Local Code Review Summary of Compliance Appendix 2 - Improvement Action Plan
Background Papers:	Delivering Good Governance Framework June 2018 WDHSCP detail of review at sub-principles
Wards Affected:	All

APPENDIX 1

Annual Review of Code of Good Governance - Summary

West Dunbartonshire
Health & Social Care Partnership

No. of sub-principles	A. Behaving with integrity, demonstrating strong commitment to ethical values, and respecting the rule of law			
		Fully Compliant	Generally Compliant	Non Compliant
4	Behaving with Integrity	3	1	0
4	Demonstrating strong commitment to ethical values	3	1	0
5	Respecting the rule of law	5	0	0
	B. Ensuring openness and comprehensive stakeholder engagement			
4	Openness	3	1	0
3	Engaging comprehensively with institutional stakeholders	2	1	0
6	Engaging stakeholders effectively, including individual citizens and service users	3	3	0
	C. Defining outcomes in terms of sustainable economic, social, and environmental benefits			
5	Defining outcomes	2	3	0
4	Sustainable economic, social and environmental benefits	0	4	0
	D. Determining the interventions necessary to optimise the achievement of the intended			
2	Determining interventions	0	2	0
8	Planning interventions	3	5	0
4	Optimising achievement of intended outcomes	0	4	0
	E. Developing the entity's capacity, including the capability of its leadership and the individuals within it			
4	Developing the entity's capacity	2	2	0
7	Developing the capability of the entity's leadership and other individuals	5	2	0
	F. Managing risks and performance through robust internal control and strong public financial management			
3	Managing Risk	3	0	0
5	Managing performance	3	2	0
5	Robust internal control	4	1	0
3	Managing Data	1	2	0
2	Strong public financial management	0	2	0
	G. Implementing good practices in transparency, reporting, and audit to deliver effective accountability			
2	Implementing good practice in transparency	2	0	0
5	Implementing good practices in reporting	4	1	0
5	Assurance and effective accountability	5	0	0
90	**TOTAL**	**53**	**37**	**0**

90	**TOTAL - 2017/18 September Review**	**47**	**43**	**0**

West Dunbartonshire

Health & Social Care Partnership

Annual Review of Code of Good Governance
Improvement Action Plan (September 2017) – REVIEWED June 2018

Improvement Action	Lead Officer	Due Date	Review June 2018
Introduce annual compliance check of code of conduct sign off by individual members as part of annual accounts process.	Chief Financial Officer	April 2018	Complete May 2018
Implement approved Partnership Board and Board Member Development Programme.	Head of People & Change	February 2018	Underway – full programme to be agreed
Work with WDC and NHSGGC to continue to implement approved Workforce and Organisational Development Strategy and Support Plan.	Head of People & Change	February 2018	Complete Revised Support Plan approved by HSCP Board Feb 2018
Introduce annual compliance check of register of interests and hospitality by individual members as part of annual accounts process.	Chief Financial Officer	April 2018	Complete May 2018
Develop and approve a FOI policy specific to the Partnership Board.	Head of Strategy, Planning & Health Improvement	November 2017	Complete Approved by HSCP Board Nov 2017
Complete Records Management Plan.	Head of Strategy, Planning & Health Improvement	June 2018	Invitation received by Keeper of Records Scotland - Mar 2018 for completion Jan 2019
Strengthening strategic planning process in light of Audit Scotland recommendations and local learning.	Chief Financial Officer and Head of Strategy, Planning & Health Improvement	July 2018	New Strategic Planning Group (sub-committee of HSCP Board) Feb 2018
Refresh and update local Self Directed Support arrangements.	Head of Strategy, Planning & Health Improvement	March 2018	Update Report to June 2018 HSCP Board
Develop medium term financial plan.	Chief Financial Officer	February 2018	Revised to Nov 2018. Scenario planning underway – must reflect priorities of new Strategic Planning Group and be reflective of Scottish Govt funding streams.

Improvement Action	Lead Officer	Due Date	Review June 2018
Strengthening performance reports against the Scottish Government's Best Value framework.	Chief Financial Officer and Head of Strategy, Planning & Health Improvement	March 2018	New performance report format adopted for July 2018. Will work with WDC and consider the outcomes of the recent Best Value Review by Audit Scotland.
In partnership with NHSGGC, Scottish Government and GGC IJBs agree on methodology that allows Set Aside resources to be quantified and reflect actual activity to comply with legislation on the use of this resource in shifting the balance of care.	Chief Financial Officer	June 2018	Data sets have been agreed and progress reported to the Scottish Government June 2018. Impact of set-aside funding must be considered from 2019/20.
Develop a protocol with NHSGGC auditors to share internal audit report findings with Chief Financial Officer and Chief Internal Auditor.	Chief Internal Auditor	December 2017	Chief Financial Officer formally wrote to NHSGGC and clause on information sharing included in tender to appoint new auditors from April 2018.
Present annual update on compliance of Local Code to Audit Committee alongside draft unaudited annual accounts.	Chief Financial Officer	June 2018	Presented to HSCP Audit Committee June 2018

Improvement Action Plan – NEW ACTIONS (June 2018)

Improvement Action	Lead Officer	Due Date
Review the effectiveness of the Audit Committee and the Terms of Reference	Chief Internal Auditor	December 2018
Review the effectiveness of the new Strategic Planning Group	Chief Officer & Head of Strategy, Planning and Health Improvement	March 2019
Consider long term financial planning in the context of projections and assumptions made by HSCP Board's funding partners.	Chief Financial Officer	June 2019

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Care Inspectorate Report for Children & Young People's Services Operated by West Dunbartonshire HSCP

1. Purpose

1.1 The purpose of the report is to highlight the recent excellent inspection results which our Throughcare and Aftercare Housing Support Service, has achieved.

2. Recommendations

2.1 There were no requirements or recommendations from this inspection with the service managing to improve its previously very good grades to excellent ones.

2.2 It was noted at the time of the previous validation inspection (March 2016) that the inspection at that time, only allowed the service to retain its previous grades of "very good" (Fives) but did not allow the opportunity for those grades to be improved on at that point.

3. Background

3.1 The Throughcare and Aftercare Housing Support Service had an announced inspection on the 27th of February 2018 which took place over a full day, the Inspector met with the service Manager, individual Staff and a group of Young People. She then followed up the inspection with telephone interviews held with other Staff and Partner agencies. The final report was published on the27th of March 2018.

The grades awarded for each of the two themes inspected are as follows:

- Quality of Care and support **6** **Excellent**
- Quality of Staffing **6** **Excellent**
- Quality of Management and Leadership **Not assessed**

4. Main issues

4.1 In respect to quality of care and support the inspection report highlighted the excellent quality of care and support provided to young people using the service. The inspector noted that young people spoke highly of the excellent

support they received and of the very positive working relationships they enjoyed with staff members.

4.2 The Inspector found “risk assessments and robust support plans” were in place for each young person. She noted from reading electronic files, “that there was an excellent standard of record keeping which helped to ensure that support provided was informed and up to date”.

4.3 The inspector said, “The service has established an impressive range of networks to ensure the needs of the young people they supported were being prioritised”. The team worked closely with other departments within the authority including the Department of work and Pensions, Young people in Mind and Housing. Having spoken to staff from these agencies, the Inspector mentioned the following:

- “*We spoke with a professional from the DWP who told us that recent shadowing opportunities had been extremely useful and increased her staff understanding of the challenges faced by the young people being supported”.*

- *“Work with the Housing department drew up procedures (Care Leavers Housing Protocol) tailored specifically for people leaving care, these procedures had impacted positively”.*

- *Another professional from a partner agency said, “The team help build a young people’s resilience and help build up their life skills. They are attachment figures. They persist and build relationships with young people, I feel re-assured when my young people are with Throughcare, I am reassured that they will be looked after”.*

4.4 The inspector noted, “There is a robust supervision framework in place which helped to maintain the excellent quality of service being delivered by staff”.

4.5 “Staff in the service are committed to supporting and advocating for the young people to achieve the best outcomes for them.” The following comment made by a young person who the inspector met reflected comments she heard about the relationships between staff and young people they support. “At first I was resistant to working with them. Since I got to know my worker, I`ve built up a good bond. I trust her; she’s always fighting my corner”.

4.6 The inspector stated that “all the young people being supported were extremely positive about the standard of care and support they had received from the service.” “All spoke about the very positive impact on their lives” and how they “valued the quality relationships.” She went on to note the following comments made to her by the young people:

- *"They helped me cope with crisis."*

- *“They supported me to go to college. They helped me get my accommodation.”*

- *"I’ve not looked back since I was allocated a Throughcare worker. She helped me apply to college. She knew how to put a smile on my face."*

- *"My worker goes above and beyond, she is like my Mum."*

- *“The manager – he cares. He wants to get to know you, he wants you to do well and you can talk to him.”*

4.7 The table below shows the consistency in very good grades and increase to excellent over the past two inspections**:**

Throughcare & Aftercare Adult Placement Service	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
	Mar 2016						Feb 2018					
Care & support					X							X
Staffing					X							X
Management & Leadership					X							N/A

4.8 It should be commented on that The Throughcare service has two registered services with the Care Inspectorate. The Housing Support Service has now achieved sixes and The Adult Placement service maintained Sixes at its last inspection in February 2017. For a service two have two registrations, both on Sixes is very unusual and is testament to the hard work of a long serving team.

5. People Implications

5.1 There are no personnel issues.

6 Financial and Procurement Implications

6.1 There are no financial and/or procurement implications.

7. Risk Analysis

7.1 Risk assessment was not required.

8. Equalities Impact Assessment (EIA)

8.1 Not required for this report.

9. Consultation

9.1 Not required for this report.

10. Strategic Assessment

10.1 The Council's Strategic Plan 2012-17 identifies "improve life chances for children and young people" as one of the authority's five strategic priorities.

10.2 The Councils Housing Protocol for Care Leavers along with significant changes to the councils Housing Allocations Policy, recognises that Care Leavers as a group, will be given reasonable preference.

10.3 The provision of Throughcare and Aftercare is a statutory requirement.

10.4 Many of the Young People who work with Throughcare and Aftercare, have went on to be involved in the Councils Champions Board and have already been involved in reviewing the Councils Corporate Parenting Strategy.

Beth Culshaw
Chief Officer
Health & Social Care Partnership
Date: April 2018

Person to Contact:
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West Dunbartonshire HSCP
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Appendices: a. Care Inspectorate Report 27th March 2018

Background Papers:	The information provided in Care Inspectorate Inspection Reports Web-site address: - http://www.careinspectorate.com/
Wards Affected:	All

West Dunbartonshire CHCP, Throughcare/ Aftercare Team
Housing Support Service

West Dunbartonshire Council
Health and Social Care Partnership
Council Offices
Garshake Road
Dumbarton
G82 3PU

Telephone: 01389 776301

Type of inspection: Announced (short notice)
Inspection completed on: 27 March 2018

Service provided by:
West Dunbartonshire Council

Service provider number:
SP2003003383

Care service number:
CS2004063275

About the service

West Dunbartonshire Throughcare was registered with the Care Inspectorate in November 2004. The service is a housing support service and it's aim is to offer support, advice and guidance to young people who have been looked after and accommodated in the West Dunbartonshire area. Attendance by the young people is voluntary and contact can be open ended. At the time of the inspection visit the service was supporting 36 young people.

The service's objectives are to:

Identify those young people who will not be returning to the family home.

Be involved in the preparation of an appropriate plan for young people who have been accommodated/looked after by West Dunbartonshire Council.

Offer appropriate preparation to enable young people to progress to some form of supported accommodation.

Provide an agreed level of on-going support and to offer suitable preparation to enable young people to move to their own tenancy when appropriate and provide ongoing support.

What people told us

We visited the service on the 27 February 2018. During our inspection visit we met with a group of six young people who were supported by the service. We sent eight Care Standards Questionnaires (CSQs) to people who used the service and five of these were completed and returned to us.

All of the people being supported were extremely positive about the standard of care and support they had received from West Dunbartonshire Throughcare. The young people told us how much they valued the quality relationships they had with their keyworker and with the other staff in the service, including the manager. We found the staff had built up strong working relationships with the young people being supported. We heard that staff had persevered in working with people who admitted that initially they had been hesitant to engage. We heard that staff were flexible when making arrangements and worked round young people's commitments and time tables. All the young people we spoke with talked about the very positive impact on their lives in relation to the support they had received from the service.

Young people we spoke with made the following comments:

'They supported me to go to college. They helped me get my accommodation. She phoned me and she helped me financially'.

'They have helped me cope with crisis, they helped me to get a house. They try their hardest. They tell agencies about your situation'.

'As soon as I lost my job my keyworker was looking for jobs for me'.

'I've not looked back since I was allocated a through care worker. She helped me to apply to college. She knew how to put a smile on my face'.

'The manager brings us together, he organises events, he organised go karting - he cares. He wants to get to know you, he's keen to see you, he wants you to do well and you can talk to him. They share information so they can all help you. The office worker - she helps you too'.

'You never feel they won't make time for you. They get back to you as quickly as possible'.

'My keyworker asks me about my family. My keyworker goes above and beyond. My keyworker is like my mum, she cares about everyone'.

'They help you to do everything by the book so nothing comes back to bite you'.

'They make you a priority'.

'I feel the staff enjoy their job, they have a laugh. They're like a pal, not a worker'.

Self assessment

A self assessment was not requested prior to this inspection.

From this inspection we graded this service as:

Quality of care and support	6 - Excellent
Quality of staffing	6 - Excellent
Quality of management and leadership	not assessed

What the service does well

The staff at the West Dunbartonshire Throughcare provided an excellent quality of care and support to vulnerable individuals to prevent homelessness and to establish stable independent lives. Young people we met with spoke highly of the excellent support they received and of the very positive working relationships they enjoyed with staff members. The following comment made by a young person we met reflected the comments we heard about the relationships between staff and the young people they supported: 'At first I was resistant to working with them. Since I got to know my keyworker I've built up a good bond. I trust her, she's always fighting my corner'. The service made contact with young people while they were living in care placements and continued to build up relationships from that point.

Staff were committed to supporting and advocating for the young people to achieve the best possible outcomes. We found that risk assessments and robust support plans were in place for each young person. This helped to contribute to the achievement of excellent outcomes for young people. We noted, from reading electronic files, that there was an excellent standard of record keeping which helped to ensure that support provided was informed and up to date. A nurse therapist worked closely with the staff team to provide advice and guidance on how best to tailor support to each young person in order to maximise their wellbeing and mental health. The service accessed a personal development programme for young people which they told us helped them to significantly develop their self-awareness and their confidence.

We found that staff worked proactively with relevant local partner agencies to ensure that information was shared effectively between the agencies supporting people who used the service. An example of this partnership

included work with the local job centre. We spoke with a professional based within a local job centre who told us this opportunity had been extremely useful and had increased her understanding of the challenges faced by young people being supported by West Dunbartonshire Throughcare. This increased understanding had improved how her agency had engaged with the young people being supported. The local housing department had worked with the service to draw up procedures tailored specifically for people leaving care and these procedures had positively impacted in terms of helping young people to secure suitable accommodation.

A professional in a local partner agency told us: 'The young people would be at higher risk of mental health problems if this project wasn't there. They help to build young people's resilience and help to build up their life skills. They are attachment figures ... staff are thoughtful and caring and they seek advice and information when they need to. They communicate very well and they share the right information. I can't fault them ... They persist and build relationships with young people. I enjoy working with them. I feel re-assured when my young people are with Throughcare, I'm reassured that they'll be looked after'. Another local professional told us that the staff team helped young people to realise their potential.

This joint working with other agencies helped to ensure that supports delivered across agencies were informed by up to date information of individual's needs and to maximise positive outcomes for the young people being supported. We heard that staff within West Dunbartonshire Throughcare Team had inspired staff with whom they had worked in partnership and that the service was sector leading.

We found the service had established an impressive range of networks to ensure the needs of the young people they supported were prioritised. The staff team worked closely with other departments within the local authority area which helped to ensure that strategic developments were designed so that they could meet the needs of West Dunbartonshire Throughcare service's user group. This included the service contributing to the local authority's strategic group on child sexual exploitation. The service was involved in securing funding which allowed the local authority to set up a care leavers champions board. This board allowed the young people who used the service, as care leavers, to meet with council officials to discuss and agree how the council can effectively fulfil its corporate parenting responsibilities.

Staff within the service whom we spoke with told us they had access to a wide range of training and professional development opportunities. Recent training completed by staff included child protection, child sexual exploitation, therapeutic crisis intervention, self harm, the impact of trauma and of adverse childhood experiences and mental health training. Staff within West Dunbartonshire Throughcare Team had delivered training to multi agency groups from across the local authority area. All staff within West Dunbartonshire Throughcare Team who had not yet registered with the Scottish Social Services council (SSSC) held the qualifications to do so and were on course to register within the required timeframes.

We found that staff morale across the team was high and staff demonstrated a strong care ethic. Staff told us that they enjoyed their work and they gained satisfaction in witnessing the young people reaching their goals. Staff told us they felt fully supported within their roles and as members of their team. We found there was a robust supervision framework in place which helped to maintain the excellent quality of service being delivered by staff.

What the service could do better

The service should continue to develop their service in order to maintain the excellent standard that has been achieved.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 0

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Inspection and grading history

Date	Type	Gradings	
30 Mar 2016	Announced (short notice)	Care and support Environment Staffing Management and leadership	Not assessed Not assessed Not assessed Not assessed
27 Feb 2014	Announced (short notice)	Care and support Environment Staffing Management and leadership	5 - Very good Not assessed 5 - Very good 5 - Very good
17 Jan 2013	Announced (short notice)	Care and support Environment Staffing Management and leadership	5 - Very good Not assessed 5 - Very good 5 - Very good
30 Mar 2010	Announced	Care and support Environment Staffing Management and leadership	4 - Good Not assessed 4 - Good Not assessed
		Care and support Environment	4 - Good Not assessed

Date	Type	Gradings	
		Staffing	3 - Adequate
		Management and leadership	4 - Good

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Care Inspectorate Reports for Older People's Residential Care Services Operated by West Dunbartonshire Health and Social Care Partnership

1. Purpose

1.1 To provide the Audit Committee with information regarding the most recent inspection reports for one of the Council's Older People's Residential Care Home Services.

2. Recommendations

2.1 The Audit Committee is asked to note the content of this report and the work undertaken to ensure grades awarded reflect the quality levels expected.

3. Background

3.1 Care Inspectorate inspections focus on any combination of four thematic areas. These themes are: quality of care and support, environment, staffing and management and leadership.

3.2 The services covered in this Audit Committee report are :

- Frank Downie Day Centre
- Mount Pleasant Care Home

3.3 Copies of inspection reports for all services can be accessed on the Care Inspectorate website: www.scswis.com

4. Main Issues

4.1 Frank Downie Day Centre was inspected on 28th February 2018.

The inspector commented that staff training had taken place and My Home Life philosophy continued to underpin how staff engaged with people attending the centre and their relatives.

They observed very good interaction between staff and people using the centre and people were encouraged to be as independent as possible and fully participate in designing and deciding each day's activities and outings. Regular physical activity within the centre included; vitality classes, local walks, walking football, gardening, Boccia and Funky Boxing, helping people improve their mobility, strength and stamina.

Regular auditing of all key aspects of the service helped the service identify any areas for improvement and there was a continuous improvement plan in place to chart progress.

4.2 The inspection awarded the following grades:

- Quality of Care and Support - **Grade 5 – Very good**
- Quality of Environment - **Not Assessed**
- Quality of Staffing - **Not Assessed**
- Quality of Management & Leadership - **Grade 5 – Very Good**

4.3 There were no requirements from the February 2018 inspection.

4.4 The tables below sets out the grades for this care home over the last two full inspections.

Frank Downie Day Centre: Previous Grades 5th November 2014	
Care & Support	**4**
Environment	**5**
Staffing	**Not Assessed**
Management & Leadership	**4**

Frank Downie Day Centre: Current Grades 28th February 2018	
Care & Support	**5**
Environment	**Not Assessed**
Staffing	**Not Assessed**
Management & Leadership	**5**

4.5 The table below summarises the movement in grades for the service over their last two inspections.

	5th November 2014						**28th February 2018**					
Frank Downie Day Centre	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
• Care & Support				✓							✓	
• Environment					✓							
• Staff												
• Management & Leadership				✓							✓	

4.6 Mount Pleasant House was inspected on 21st December 2017

4.7 The inspector commented that the service was making good progress since the last inspection. They observed very good staff interaction with resident's and had a very good knowledge of each resident's care and support needs. On the whole, resident's care plans were of a good standard, but they could see areas where they could improve. Good team working was observed throughout the visit and there was a very pleasant atmosphere in the home.

4.8 The inspection awarded the following grades:

- Quality of Care and Support - **Grade 4 Good**
- Quality of Environment - **Grade 4 Good**
- Quality of Staffing - **Grade 4 Good**
- Quality of Management & Leadership - **Grade 4 Good**

4.9 There was one requirement from the inspection on 21st December 2017.

The provider must ensure that all care plans and related documentation is accurate, up-to-date, signed and dated, and reflective of the care needs and outcomes to be achieved for each resident.

This requirement was carried forward from the previous inspection report. The inspector states Care Plans had improved but more remains to be done.

4.10 An Action Plan relating to this requirement is attached.

4.11 The tables below set out the grades for this care home over the last two full inspections.

Mount Pleasant House : 19th July 2017	
Care & Support	**3**
Environment	**3**
Staffing	**3**
Management & Leadership	**3**

Mount Pleasant House : 21st December 2017	
Care & Support	**4**
Environment	**4**
Staffing	**4**
Management & Leadership	**4**

4.12 The table below summaries the movement in grades for the service over their last two inspections.

	19th July 2017						**21st December 2017**					
Insert Care Home	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
• Care & Support			✓							✓		
• Environment			✓							✓		
• Staff			✓							✓		
• Management & Leadership			✓							✓		

5. Options Appraisal

5.1 No options appraisal required for this report.

6. People Implications

6.1 There are no people implications associated with this report.

7. Financial and Procurement Implications

7.1 There are no financial implications associated with this report.

8. Risk Analysis

8.1 For any services inspected, failure to meet requirements within the time-scales set out in their inspection report could result in a reduction in grading or enforcement action. This may have an impact on our ability to continue to deliver the service.

9. Equalities Impact Assessment (EIA)

9.1 Equalities impact assessment has been undertaken for this service and is reviewed on the basis of the change process being undertaken. The assessment has determined there is no discrimination against any group within the service, or redesign process, nor equalities impact of any sort.

10. Environmental Sustainability

10.1 Not required for this report

11. Consultation

11.1 No consultation required for this report.

12. Strategic Assessment

12.1 No Strategic Assessment required for this report.

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Appendices:	Mount Pleasant House: Audit Committee Action Plan Update February 2018
Background Papers:	None
Wards Affected:	All

Mount Pleasant House: Audit Committee Action Plan Update February 2018			
Requirement (1)	**The provider must ensure that all internal areas of the home are maintained to a good standard at all times.**		**Date of Completion**
Action	Programme of works to be undertaken in respect of following: - Painting to walls in common areas - Painting to walls in bedrooms - Replacement of floor coverings in some bathroom areas - Replacement of some furnishings in common areas		October 2017
Progress	This requirement was met at the December 2017 visit		December 2017
Requirement (repeat) (2)	**The provider must ensure that all care plans and related documentation is accurate, up-to-date, signed and dated, and reflective of the care needs and outcomes to be achieved for each resident.**		
Action		**By Whom**	
	Further training and development sessions have been arranged to ensure staff have relevant knowledge and appropriate skill levels are developed to ensure accurate recording of care needs and outcomes for each resident.	Care Home and Quality & Service Development Managers	ongoing
Progress	Improvement was noted at the recent inspection, however, this requirement has been continued. The inspector felt some further improvements were needed to ensure support was provided consistently.		

APPENDIX 1

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Care Inspectorate Reports for Home Care and Sheltered Housing Services provided by West Dunbartonshire Health and Social Care Partnership

1. Purpose

1.1 To provide the Audit Committee with information regarding the recent inspection reports for Home Care and Sheltered Housing Services.

2. Recommendations

2.1 The Audit Committee is asked to note the content of this report and the work undertaken to ensure the grades awarded reflect the levels of quality expected.

3. Background

3.1 Care Inspectorate inspections focus on any combination of thematic areas. These inspections focussed on:

- Quality of care and support
- Quality of staffing

3.2 The services covered in this Audit Committee report are :

- Home Care
- Sheltered Housing

3.3 Copies of inspection reports for all services can be accessed on the Care Inspectorate website: www.careinspectorate.com

4. Main Issues

4.1 The unannounced inspection of the home care service took place between February and March 2018.

In conducting the inspection, over 100 completed client questionnaires were examined and the inspector subsequently met with a number of service users and their families. A series of focus groups took place with a variety of staff following the completion of staff questionnaires. The inspector described the staff as being passionate about their work, and genuinely caring about their clients.

It was noted that the service had introduced a "register of interest" and had encouraged service users and relatives to participate in areas of service development and recruitment.

The implementation of electronically held care plans to ensure that detailed changes in relation to individual support needs, routines and preferences could be easily updated was highlighted as an important development.

Clear evidence of the service working in partnership with health and care colleagues was identified by the inspector.

4.2 The inspection awarded the following grades:

- Quality of Care and Support - **Grade 5 – Very good**
- Quality of Environment - Not assessed
- Quality of Staffing - **Grade 5 – Very good**
- Quality of Management & Leadership - Not assessed

4.3 There were no requirements from the inspection.

4.4 The tables below set out the grades for home care over the last two full inspections.

Home Care: Previous Grades March 2017	
Care & Support	**5**
Environment	Not assessed
Staffing	Not assessed
Management & Leadership	**5**

Home Care: Current Grades March 2018	
Care & Support	**5**
Environment	Not assessed
Staffing	**5**
Management & Leadership	Not assessed

4.5 The table below summarises the movement in grades for the service over the last two inspections.

	March 2017						**March 2018**					
Home Care	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
• Care & Support					✓						✓	
• Environment												
• Staffing											✓	
• Management & Leadership					✓							

4.6 The unannounced inspection of the sheltered housing service took place between February and March 2018.

The inspector commented that service users were happy with the quality of the service and very complimentary about the staff. There was recognition that staff had established links with health and care colleagues resulting in a team approach to the delivery of care.

The opportunity for representative clients from different complexes to participate in regular sheltered housing forum meetings, to raise any issues and contribute to discussions about how the service is provided and developed, was viewed positively.

The inter-generational approach adopted at a sheltered housing complex where clients provided assistance with reading to primary school pupils was highlighted by the inspector and the potential to explore extending existing arrangements will be taken forward.

4.7 The inspection awarded the following grades:

- Quality of Care and Support - **Grade 5 – Very good**
- Quality of Environment - Not assessed
- Quality of Staffing - **Grade 5 – Very good**
- Quality of Management & Leadership - Not assessed

4.8 There were no requirements from the inspection.

4.9 The tables below set out the grades for home care over the last two full inspections.

Sheltered Housing: Previous Grades March 2017	
Care & Support	**5**
Environment	Not assessed
Staffing	Not assessed
Management & Leadership	**5**

Sheltered Housing: Current Grades March 2018	
Care & Support	**5**
Environment	Not assessed
Staffing	**5**
Management & Leadership	Not assessed

4.10 The table below summarises the movement in grades for the service over the last two inspections.

	March 2017						**March 2018**					
Sheltered Housing	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**

• Care & Support • Environment • Staff • Management & Leadership					✓ ✓						✓ ✓	

5. Options Appraisal

5.1 None required

6. People Implications

6.1 There are no people implications associated with this report.

7. Financial and Procurement Implications

7.1 There are no financial implications associated with this report.

8. Risk Analysis

8.1 For any services inspected, failure to meet requirements within the time-scales set out in their inspection report could result in a reduction in grading or enforcement action. This may have an impact on our ability to continue to deliver the service.

9. Equalities Impact Assessment (EIA)

9.1 There is no discrimination against any group within the service.

10. Environmental Sustainability

10.1 Not applicable

11. Consultation

11.1 None required

12. Strategic Assessment

12.1 Key strategic performance indicators in relation to the strategic priority of supporting older people focus on the provision of high quality, safe and person centred services. The inspection provides appropriate evidence.

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Background Papers: None

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Care Inspectorate Reports for Older People's Care Homes operated by Independent Sector in West Dunbartonshire

1. Purpose

1.1 To provide the Audit Committee with a routine up-date on the most recent Care Inspectorate inspection report for one independent sector residential older peoples' Care Home located within West Dunbartonshire.

2. Recommendations

2.1 The Audit Committee is asked to note the content of this report.

3. Background

3.1 The Care Inspectorate assesses registered providers of care services in relation to four quality themes: care & support; environment; staffing; and management & leadership.

3.2 If any residential care home is awarded Grade 2 - weak or less and/ or has requirements placed upon them following a full inspection then their next inspection may be a follow up inspection. This follow up inspection will only look at progress made in addressing the issues highlighted in the previous report allowing the Care Inspectorate to track improvement and gain assurance that services are making the right changes. The Care Inspectorate do not make further requirements or revise grades on these follow up visits, though Inspectors have some discretion to do so if they consider that sufficient evidence is evident.

3.3 The HSCP Quality Assurance Team monitor the independent sector care homes located within West Dunbartonshire in line with the terms of the National Care Home Contract; and arrange monitoring visits to ensure continued progress is being maintained in relation to agreed improvement plans. In addition, the HSCP Quality Assurance Team works with the independent sector providers to maintain their awareness of new developments and provide opportunities to share good practice/learning.

3.4 The independent sector Care Home reported within this report is:

- Sunningdale

Copies of inspection reports can be accessed on the Care Inspectorate web-site: www.scswis.com.

4. Main Issues

Sunningdale

4.1 Sunningdale is owned and managed by I & S Scotcare Ltd., who operate this single care home. The home is registered with the Care Inspectorate for a maximum of 17 Residential residents. As of 31 January 2018 there were 12 West Dunbartonshire residents supported within the care home.

4.2 The care home was inspected on 31 January 2018 and the report was published on the 27 February 2018. The table below summarises the movement in grades for each of the four themes awarded to Sunningdale over their last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
31.01.18	4 – Good	Not assessed	4 – Good	Not assessed
29.09.16	5 – Very Good	5 – Very Good	Not assessed	Not assessed
17.07.15	5 – Very Good	5 – Very Good	5 – Very Good	5 – Very Good

4.3 This has been the first reduction in grades awarded to Sunningdale since their inspection in 2014. There were no requirements detailed in the inspection report for remedial action by the care home.

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 The National Care Home Contract provides an additional quality payment, by the HSCP, to Care Homes if the Care Inspectorate Inspection report awards a grade of 5 - Very Good or 6 - Excellent for the theme of Quality of Care and Support. There is a second additional quality payment if the high grade in Quality of Care and Support is coupled with a grading of 5 - Very Good or 6 - Excellent in any of the other three thematic areas.

6.2 The National Care Home Contract also accounts for providers receiving low grades of 1/Unsatisfactory or 2/Weak in their Care Inspectorate Inspection report. If either of these grades are awarded it may trigger the withdrawal of the quality funding component, resulting in a reduction of £20 per resident per week from the weekly fee payable.

6.3 The Inspection Report for Sunningdale has financial implications for the HSCP. The grades awarded to them in this recent inspection may have resulted in the removal of the additional quality payment, as detailed in 6.1. However, in line with the National Care Home Contract, the care home has been given the opportunity to correct the grades awarded. If in their next

inspection the grades remain at the current level or lower, then the additional quality payment will be removed.

6.4 As detailed at point 6.3 above Sunningdale will continue to receive the enhanced weekly rate for Residential Homes of £2.50 per resident per week from the date of their inspection. The increase does not apply to residents who only receive a Free Personal and/or Nursing Care payment from the HSCP.

6.5 These additional payments will remain in place until either the National Care Home Contract terms are renegotiated or the Care Inspectorate reduces the grades awarded to Sunningdale following inspection.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no relevant locality implications associated with this report.

9. Risk Analysis

9.1 Grades awarded to a service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within the time-scales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any independent sector Care Home would be of concern to the Audit Committee, particularly in relation to the continued placement of older people in such establishments.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The Strategic Plan 2016 -19 emphasises the importance of quality assurance amongst independent sector providers of care; and the HSCP's commitment to work with independent sector providers within an agreed assurance framework.

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Date: 23rd May 2018

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Appendices:	None
Background Papers:	All the inspection reports can be accessed from http://www.scswis.com/index.php?option=com_content&task=view&id=7909&Itemid=727
Wards Affected:	All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTE: 20 JUNE 2018

Subject: Care Inspectorate Reports for Support Services Operated by the Independent Sector in West Dunbartonshire

1. Purpose

1.1 To provide the Audit Committee with a routine up-date on the most recent Care Inspectorate inspection reports for ten independent sector support services operating within the West Dunbartonshire area.

2. Recommendations

2.1 The Audit Committee is asked to note the content of this report.

3. Background

3.1 The Care Inspectorate assesses registered providers of care services in relation to four quality themes: quality of care and support; environment; staffing; and management & leadership.

3.2 If any service has been awarded a Grade 2 - weak or less and/ or has requirements placed upon them following a full inspection then their next inspection may be a follow up inspection. This follow up inspection will only look at progress made in addressing the issues highlighted in the previous report allowing the Care Inspectorate to track improvement and gain assurance that services are making the right changes. The Care Inspectorate do not make further requirements or revise grades on these follow up visits, though Inspectors have some discretion to do so if they consider that sufficient evidence is evident.

3.3 The independent sector support service inspections reported here are within the areas of Learning Disability, Care at Home, Sensory Impairment and Children & Young People's Services. The services are:

- Key Community Supports – Dunbartonshire – the service is provided is provided across West Dunbartonshire Council area.
- Carman Care – the service is provided in the Alexandria area.
- Joan's Carers Ltd. – the service is provided across West Dunbartonshire Council area.
- RNIB (West Dunbartonshire) Supported Tenancies and Alternative Day Opportunities – the service is provided throughout West Dunbartonshire Council area.
- Sense Scotland Supported Living Glasgow 1 & Surrounding Area - the service is provided in the Clydebank area.
- Cornerstone Baxter View - this service is located in Dumbarton.
- INCLUDEM (West) Intensive Support Service – the service is provided throughout West Dunbartonshire Council area.

- Up-2-Us Support Service – the service is provided throughout West Dunbartonshire Council area.
- Dalmuir Park Housing Association Sheltered Housing Service/Lynx Care – the service is provided in Dalmuir.
- Alltogether Care Services Ltd. – the service is provided across West Dunbartonshire Council area.

3.4 Some providers operate multiple services across Scotland and register groups of their services with the Care Inspectorate on a 'Branch' basis rather than as individual services. In this report Key Community Supports - Dunbartonshire, Sense Scotland Supported Living Glasgow 1 & Surrounding Area, INCLUDEM (West) Intensive Support Service and Up-2-Us Support Service operate in this manner.

3.5 Copies of inspection reports can be accessed on the Care Inspectorate web-site: www.scswis.com.

4. Main Issues

Learning Disability Services

Key Community Supports – Dunbartonshire

4.1 Key Community Supports - Dunbartonshire provides a combined housing support and care at home service to adults who have learning disabilities living in their own homes across both East and West Dunbartonshire. The service was inspected on 19 December 2017 and the report was published on 09 February 2018. The table below summarises the movement in grades for each of the four themes awarded to Key Community Supports - Dunbartonshire over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
19.12.17	4 – Good	Not assessed	4 – Good	4 – Good
31.01.17	3 – Adequate	Not assessed	4 – Good	3 – Adequate
23.03.16	4 – Good	Not assessed	4 – Good	4 – Good

4.2 This inspection shows an improvement in grades awarded to Key Community Supports – Dunbartonshire and takes them back up to that of their inspection in 2016. There were no requirements detailed in this inspection report for remedial action by the service.

RNIB (West Dunbartonshire) Supported Tenancies and Alternative Day Opportunities

4.3 RNIB (West Dunbartonshire) Supported Tenancies and Alternative Day Opportunities provide a combined Housing Support and Care at Home service. The service is offered to adults with learning disabilities and/or visual impairment who live independently at home. The service was inspected on 22 January 2018 and the report published on 03 April 2018. The table below summarises the

movement in grades for each of the four themes awarded to RNIB (West Dunbartonshire) Supported Tenancies and Alternative Day Opportunities over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
22.01.18	5 – Very Good	Not assessed	Not assessed	5 – Very Good
03.03.17	5 – Very Good	Not assessed	Not assessed	4 – Good
24.02.16	4 – Good	Not assessed	4 – Good	4 – Good

4.4 This is only the third inspection for the service and shows an incremental improvement in grades awarded to RNIB (West Dunbartonshire) Supported Tenancies and Alternative Day Opportunities in each of their inspections. There were no requirements detailed in the inspection report for remedial action.

Cornerstone Baxter View

4.5 Cornerstone Baxter View provides a combined Housing Support and Care at Home service. The service is offered to adults with learning disabilities, autism or acquired brain injury who have their own tenancy within Baxter View. The service was inspected on 27 February 2018 and the report published on 12 April 2018. The table below summarises the movement in grades for each of the four themes awarded to Cornerstone Baxter View over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
27.02.18	6 – Excellent	Not assessed	Not assessed	5 – Very Good
21.03.17	6 – Excellent	Not assessed	Not assessed	5 – Very Good
24.02.16	5 – Very Good	Not assessed	5 – Very Good	5 – Very Good

4.6 This is only the third inspection for the Cornerstone Baxter View service and they have been able to maintain the very high grades awarded to them in their last inspection which was an improvement on their first inspection by the Care Inspectorate. There were no requirements detailed in the inspection report for remedial action by the service.

Care at Home Services

Carman Care.

4.7 Carman Care is a combined Housing Support and Care at Home service. The service is offered to older people and people with medical conditions and more complex needs. The support is provided to people who live in Waterside View and in the local community. The service was inspected on 20 December 2017 and the report published on 27 March 2018. The table below summarises the movement in grades for each of the four themes awarded to Carman Care over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
20.12.17	5 – Very Good	Not assessed	5 – Very Good	Not assessed
17.11.16	5 – Very Good	Not assessed	Not assessed	4 – Good
24.02.16	5 – Very Good	Not assessed	5 – Very Good	5 – Very Good

4.8 The inspection grades awarded to Carman Care show that the service continues to maintain the high grades they have received since 2013. There were no requirements detailed in this inspection report for remedial action by the service.

Joan's Carers Ltd.

4.9 Joan's Carers Ltd. is a combined Housing Support and Care at Home service. The service is offered to a range of adults living in their own homes. The service was inspected on 12 January 2018 and the report published on 27 March 2018. The table below summarises the movement in grades for each of the four themes awarded to Carman Care over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
12.01.18	4 – Good	Not assessed	4 – Good	Not assessed
12.01.17	5 – Very Good	Not assessed	Not assessed	4 – Good
29.02.16	5 – Very Good	Not assessed	5 – Very Good	5 – Very Good

4.10 The inspection grades awarded to Carman Care show a slight dip from previous inspections. Both the Care Inspectorate and Provider put this down to a recent significant period of growth for the service. There were no requirements detailed in this inspection report for remedial action by the service.

Dalmuir Park Housing Association Sheltered Housing/Lynx Care Service

4.11 Dalmuir Park Housing Association Sheltered Housing/Lynx Care Service is a combined Housing Support and Care at Home service. The support is offered to people who live in in Dalmuir Park Housing Association Sheltered Housing properties. The service was inspected on 19 April 2018 and the report published on 01 May 2018. The table below summarises the movement in grades for each of the four themes awarded to Carman Care over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
19.04.18	5 – Very Good	Not assessed	Not assessed	5 – Very Good
04.05.17	5 – Very Good	Not assessed	Not assessed	5 – Very Good
18.05.16	5 – Very Good	Not assessed	Not assessed	5 – Very Good

4.12 The grades awarded to Dalmuir Park Housing Association Sheltered Housing/Lynx Care Service in this inspection show that the service is maintaining the high grades they have received since 2014. There were no requirements detailed in this inspection report for remedial action by the service.

Alltogether Care Services Ltd.

4.13 Alltogether Care Services Ltd. is a combined Housing Support and Care at Home service. The support is offered to older people living in their own homes. The service was inspected on 30 April 2018 and the report published on 16 May 2018. The table below summarises the movement in grades for each of the four themes awarded to Alltogether Care Services Ltd. over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
30.04.18	6 – Excellent	Not assessed	6 – Excellent	6 – Excellent
09.05.17	5 – Very Good	Not assessed	5 – Very Good	5 – Very Good
12.10.16	5 – Very Good	Not assessed	Not assessed	5 – Very Good

4.14 The grades awarded to Alltogether Care Services Ltd. in this inspection show that the service has improved on the high grades they have received since 2016. There were no requirements detailed in this inspection report for remedial action.

Sensory Impairment

Sense Scotland Supported Living Glasgow 1 & Surrounding Area

4.15 Sense Scotland Supported Living Glasgow 1 & Surrounding Area is a combined Housing Support and Care at Home service. The service supports people with sensory impairment and other disabilities living in their own homes. The service was inspected on 20 February 2018 and the report published on 28 March 2018. The table below summarises the movement in grades for each of the four themes awarded to Carman Care over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
20.02.18	3 – Adequate	Not assessed	3 – Adequate	3 – Adequate
11.05.17	3 – Adequate	Not assessed	3 – Adequate	3 – Adequate
27.06.16	3 – Adequate	Not assessed	3 – Adequate	3 – Adequate

4.16 The grades awarded to Sense Scotland Supported Living Glasgow 1 & Surrounding Area in this inspection have been the same from all their inspections since 2015. Their inspection report detailed the following requirement to be addressed:

- The Provider to ensure staff receive the support required to do their job safely. They must give staff the opportunity to reflect individually on their work

practice, staff supervision to be performed in accordance with the provider's policy and procedures and staff training to meet needs of the individuals they support.

Sense Scotland Supported Living Glasgow 1 & Surrounding Area was given to 30 April 2018 for the completion of this requirement. The provider has implemented the changes required within the timescale.

Children and Young People's Services

INCLUDEM (West) Intensive Support Service

4.17 INCLUDEM (West) Intensive Support Service provides a support service to young people and their families. The service was inspected on 9 March 2018 and the report published on 06 April 2018. The table below summarises the movement in grades for each of the four themes awarded to INCLUDEM (West) Intensive Support Service over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
09.03.18	6 – Excellent	Not assessed	6 – Excellent	Not assessed
09.03.17	6 – Excellent	Not assessed	6 – Excellent	Not assessed
21.12.16	5 – Very Good	Not assessed	6 – Excellent	6 – Excellent

4.18 The inspection grades awarded to INCLUDEM (West) Intensive Support Service confirms that the service continues to maintain the very high grades they have received since 2013. There were no requirements detailed in the inspection report for remedial action by the service.

Up-2-Us Support Service

4.19 Up-2-Us Support Service provides a combined Housing Support and Care at Home Service. The service is offered to young people, up to the age of 25, and their families across the west of Scotland. In West Dunbartonshire the service is based in Dumbarton and works with families and young people aged 10 to 18 years old. The service was inspected on 21 March 2018 and the report published on 8 May 2018. The table below summarises the movement in grades for each of the four themes awarded to Up-2-Us Support Service over the last 3 inspections:

Inspection date	Care and Support	Environment	Staffing	Management and Leadership
21.03.18	5 – Very Good	Not assessed	Not assessed	5 – Very Good
31.01.17	6 – Excellent	Not assessed	6 – Excellent	Not assessed
02.03.16	6 – Excellent	Not assessed	6 – Excellent	6 – Excellent

4.20 The inspection grades awarded to Up-2-Us Support Service show that the service continues to maintain high grades. However, it is the first time they have not

received 6 – Excellent in any theme since their inspection of October 2012 when they were awarded the grades of 5 – Very Good. There were no requirements detailed in this inspection report for remedial action by the service.

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 There are no financial implications associated with this report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no relevant locality implications associated with this report.

9. Risk Analysis

9.1 Grades awarded to a service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within the time-scales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any independent sector service would be of concern to the Audit Committee, particularly in relation to the continued referral of vulnerable people by the HSCP.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The Strategic Plan 2016 -19 emphasises the importance of quality assurance amongst independent sector providers of care; and the HSCP's commitment to work with independent sector providers within an agreed assurance framework.

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Date: 21st May 2018

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Appendices: None

Background Papers: All the inspection reports can be accessed from http://www.scswis.com/index.php?option=com_content&task=view&id=7909&Itemid=727

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: The New National Health and Social Care Standards

1. Purpose

1.1 To provide the Audit Committee with an overview of the new National Health and Social Care Standards implemented by the Scottish Government from 1st April 2018 and to highlight the preparatory work within the HSCP to prepare for the implementation of the new National Health and Social Care Standards.

2. Recommendations

2.1 Members are asked to:

- note the preparations made towards the implementation of the new National Health and Social Care Standards.
- seek a fuller report when the final quality framework is published by the Scottish Government.

3. Background

3.1 Scottish Ministers have a duty to prepare and publish standards and outcomes applicable to care services and social work services under Section 50 Public Services Reform (S) Act 2010. Scottish Ministers also have powers under Section 10H of the National Health Service (Scotland) Act 1978 to publish standards and outcomes for services provided under the health service and independent health care services.

3.2 A review of the previous national care standards was undertaken by the Scottish Government during the period 2015 to April 2018. Any new standards needed to reflect recent changes in policy and practice and also be fit for the future. There was a need for a single set of National Health and Social Care Standards that applied across all care services.

3.3 The purpose of the new National Health and Social Care Standards is to set out “what we can expect when we use health and social services in Scotland”. This includes a diverse range of services from childminding and day care for children in their early years, housing support and care at home for adults, to hospitals, clinics and care homes.

4. Main issues

4.3 The new National Health and Social Care Standards will be based on an EFQM (European Foundation for Quality Management) framework of self

evaluation for individually registered care and health services. There have been pilots however these have been based in care home settings and evaluation of the pilots have not yet been published.

4.4 Moving forward all services will be inspected using self assessment framework based on the 5 principles, as approved by Scottish Ministers in February 2016:

- Dignity and respect
- Compassion
- Be included
- Responsive care and support
- Wellbeing

4.5 The new National Health and Social Care Standards replace the 23 sets of standards produced for different types of registered care settings introduced in 2002. The new standards are designed under 5 principles with 5 over-arching outcomes linked to 146 standards/statements. One set of comprehensive standards across all care groups gives greater clarity, but it is necessary to ensure staff are aware of the new Standards and are replacing their old standards with the new ones.

4.6 The new National Health and Social Care Standards are based on a human rights approach. Human rights are the rights and freedoms that belong to every person, at every age. Looking at standards of care from a human rights perspective helps us identify what individuals using care services should be entitled to, as well as ensuring providers comply with legislation when providing care.

4.7 The new National Health and Social Care Standards are as follows:

- I experience high quality care and support that is right for me
- I am fully involved in all decisions about my care and support
- I have confidence in the people who support and care for me
- I have confidence in the organisation providing my care and support
- I experience a high quality environment if the organisation provides the premises I use

4.8 The new National Health and Social Care Standards will extend into areas of health and social care previously unaffected by the previous 23 sets of standards. There is a need for the HSCP to be clear on the change to a quality framework model based on self assessment.

4.9 The HSCP has been using Public Service Improvement Framework (PSIF) as a self evaluation tool for a number of years, PSIF is the public sector model of EFQM, as such, this is a familiar tool for operational managers and their teams.

4.10 It is likely that the new model will be published during the summer of 2018 and a further update will be provided to members at this point. However in anticipation of the introduction of the new National Health and Social Care

Standards, the HSCP and Scottish Care have been working with local external care home providers for the last six months to develop a methodology which details the requirements of the standards and providers have been evidencing how they meet the standards by mapping between and across the standards and current evidence linked to the principles.

4.11 This work continues within the HSCP and Scottish Care mapping the standards against existing evidence and identifying where perceived gaps may exist.

4.12 This work has been well received by local care home managers, as well as by other Partnership areas; independent care home providers have engaged well in this process ensuring that they are well versed in the new standards and what they mean for staff and residents alike. There will be a requirement to roll this out to all service areas in the months ahead.

5. People Implications

5.1 None.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 There could be organisational risk if professional staff do not work towards the new National Health and Social Care Standards.

7.2 The new National Health and Social Care Standards do not seek to replace detailed clinical standards about specific health interventions, or existing and future sector or professional guidance.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 Risk to the organisation if future inspections do not report that the HSCP is successfully working to the new National Health and Social Care Standards.

9.2 Risks to individual service areas if it is identified that their work is not underpinned by the new National Health and Social Care Standards.

9.3 Risk to service users if the HSCP is not able to evidence service delivery compliant with the new National Health and Social Care Standards.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The Strategic Plan lays out a commitment to self evaluation programme of work which will support the proposed new framework.

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Date: 28 May 2018

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Appendices: None

Background Papers: None

Wards Affected: All wards affected.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Self Directed Services

1. Purpose

1.1 To update members on progress to refresh Self Directed Services Guidance in terms of preparation for inspection and assurance of care and financial governance.

2. Recommendations

2.1 Members are asked

- to note the comments of the Report;
- to seek regular updates as to progress on the refreshed Guidance and assurance that care and financial governance is in place.

3. Background

3.1 The National Self-directed Support Strategy 2010 – 2020 is a joint Scottish Government and COSLA 10-year plan, dedicated to driving forward the personalisation of social care in Scotland.

3.2 All local authorities must enable people who receive social care to have choice and control over their care and support in line with the requirements of the Social Care (Self-directed Support) (Scotland) Act 2013. This includes availability of information, access to independent advice and promoting the availability of a variety of support within the locality (section 19).

3.3 There is an expectation that authorities are actively working to address the challenges laid out in the Implementation Plan:

- Commissioning**;** how to develop good flexible commissioning and procurement arrangements which place people at the heart of decision making.

- Risk enabling practice; how we better support people to achieve their agreed outcomes creatively whilst balancing the need for protection.

- Working with limited public resources; how we better manage demand and expectations through effective use of resources and develop a shared understanding of how this can be achieved in the context of reduced public funding.

- Knowledge and awareness; how we increase awareness and understanding of Self-directed Support amongst the workforce, supported people, carers and communities.
- Major system change; how we understand and work with other public sector reform agendas to ensure that Self-directed Support remains a high priority, particularly in the new integrated arrangements.

- Systems and processes; how we develop systems and processes for delivering Self-directed Support which are easy to navigate, transparent and focused on the person.

4. Main Issues

4.1 As with the new Health and Care Standards the inspection process for Self Directed Services will be based on a model of self evaluation. The Care Inspectorate is currently working with their partners at a national level to develop the new framework for publication later in the year.

4.2 Before the final roll out of the national framework for inspection of self directed services, the Care Inspectorate is seeking to pilot the framework in a small number of Partnership areas across Scotland towards the end of 2018.

4.3 The HSCP has been working for the past few months on refreshing the Guidance for SDS across all services; older people, adults, children and young people.

4.4 In order to ensure the new Guidance is fit for purpose a small working group has been established to test the Guidance within operational services before a final version. The HSCP is undertaking preparations in case it has been chosen as one of the inspection pilot areas as the areas have not yet been announced. There will be a twelve week letter of notification of any inspection.

4.5 Dedicated staff from within the Planning and Improvement Team and the Finance Team are reviewing current financial governance; current care governance and a full review of current staff guidance across all service areas.

5. Options Appraisal

5.1 None

6. People Implications

6.1 None

7. Financial and Procurement Implications

7.1 Moving forward there may be a need for a refreshed approach to financial management of case files however this will only be clear following the review process.

8. Risk Analysis

8.1 There is a risk to the organisation if the review process is not undertaken of the HSCP approach to SDS.

9. Equalities Impact Assessment (EIA)

9.1 An EIA is being completed on the new Guidance as it develops.

10. Environmental Sustainability

10.1 Not applicable

11. Consultation

11.1 None required

12. Strategic Assessment

12.1 The Strategic Plan commits to ensuring that people are offered SDS at the point of assessment.

Author: Wendy Jack Interim Head of Strategy, Planning & Health Improvement West Dunbartonshire Health & Care Partnership

Date: 22 May 2018

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Appendices: None

Background Papers: None

Wards Affected: All Wards

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Record Management Plan Update

1. Purpose

1.1 To present the Audit Committee with an update on the Partnership Board's requirement to prepare a Records Management Plan.

2. Recommendation

2.1 The Audit Committee is asked to note the report; and that the Interim Head of Strategy, Planning & Health Improvement will present a further update to a future meeting once an invitation has been received from the Keeper requesting the submission of a Records Management Plan.

3. Background

3.1 The Public Records (Scotland) Act 2011 (the PRSA) came into force on 1st January 2013.The primary aim of the Act is to improve the quality of record keeping by scheduled Scottish public authorities. Its intent is to help to develop a culture within authorities that prioritises public records and views record keeping as critical to guaranteeing the rights and privileges of all Scotland's citizens.

3.2 The Act requires named public authorities to prepare, implement and keep under review a records management plan (RMP) which clearly sets out the arrangements for the management of their records, either created or held by the authority. The RMP must be submitted to the Keeper of the Records of Scotland (the Keeper) for assessment within an agreed time frame.

3.3 Integration Joint Boards (IJB) will create new information and records as a consequence of strategic planning and the decision making process around the delivery of services. As designated Bodies Corporate, IJBs have been added to the Schedule of the PRSA; and so are obliged to comply fully with PRSA.

4. Main Issues

4.1 All bodies named under the Schedule to the PRSA must on invitation provide the Keeper with a RMP for their agreement. The Keeper has advised their intent to invite West Dunbartonshire IJB to submit their plan in September 2018. Although September 2018 is the month the invitation will be issued, the plan will not require to be submitted until January 2019.

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 Keeper requires to be satisfied that IJB records are being routinely managed in line with agreed operational records management policies and procedures before agreeing a plan. The Chief Officer's signature to the eventual RMP will provide the Keeper with an assurance that they are content for Partnership Board's records to be managed by another authority; and that its policies and procedures adequately safeguard the Partnership Board's records.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 None.

12. Strategic Assessment

12.1 The development of a RMP supports the commitment of the Partnership Board to good governance.

Author: Wendy Jack
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Date: 22nd May 2018

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Wards Affected: All

Appendices: None

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Dunn Street Update

1. Purpose

1.1 To present the Audit Committee with a further update of the work being undertaken to support the improvement of Care Inspectorate Grades at Dunn Street Respite Care Unit, Clydebank.

2. Recommendations

2.1 The Audit Committee is asked to note the work being undertaken to support Quarriers to make improvements with their clinical and care governance processes and standards of care delivery.

3. Background

3.1 Dunn Street is a 6 bed unit in Clydebank used to provide respite support for residents of West Dunbartonshire who have a Learning Disability.

The property at Dunn Street is leased by West Dunbartonshire from Knowes Housing Association. Quarriers are the service provider currently commissioned to deliver support services.

Discussion has been ongoing with the management team at Quarriers regarding several underpinning issues contributing to a lack of improvement in Care Inspection Grades over the past year. In order to support Quarriers with the improvement process, a multi-disciplinary care core group, comprising multi-agency professionals, was established by Learning Disability Services and has met monthly since March 2017 to identify key areas for improvement. An improvement work plan has been formulated in an attempt to support Quarriers raise their overall service standards.

4. Main Issues

4.1 The Care Inspectorate graded the service as 3 (adequate) in all four areas in 2017 and the grades have improved to Grade 4 (good) in all four areas during the inspection in April this year

Considerable effort has gone into improving the governance arrangements, particularly around medication error reporting and delivery of up to date support plans. The Prescribing Team from the HSCP has been involved in reviewing existing systems and processes. Staff medication workshops have been provided by Quarriers. Community Nurses continue to support staff. Staff de-briefing sessions following a medication error are carried out by

Quarriers Management, and the numbers of medication errors is monitored and fed back to our services on a monthly basis (see table 1for the last year's results).

Table 1:

	Months				
	Apr-June 2017	**Jul-Sept 2017**	**Oct-Dec 2017**	**Jan-Mar 2018**	**Apr-June 18 (so far)**
No. of Medications administered	774	1391	1132	2069	705
No. of errors	4	2	2	4	1
% of errors	0.51%	⬇0.14%	⬆0.17%	⬆0.19%	⬇0.14%

NB: Target is 1 medication error per 1000 administrations (0.1%).

The number of support plans that have been updated within the last 6 months to reflect changing needs is currently 63%, so there remains room for improvement. The number of adult support and protection referrals has significantly reduced from last year (see table 2).

Table 2:

	Months							
	Sept 17	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**	**Apr 18**
No. of ASP Referrals	2	3	2	0	1	0	0	1

5. People Implications

5.1 A requirement for Quarriers management and staff engagement in the improvement plan has been essential to ensure that the action points for improvement are implemented, with robust monitoring processes in place. The service still has one vacancy for a 39 hour Team Leader and a 34 hour Support Worker. The difficulties in recruiting to these posts are evident within broader recruitment challenges across the third sector at the moment. The absence of the above Team Leader is felt to have impacted on the speed of overall progress, with an increased expectation being placed on the local manager in the interim.

6. Financial Implications

6.1 The current commissioning contract between West Dunbartonshire HSCP and Quarriers is due for review. Although there has been improvement within the last few months, Quarriers management has informally been notified that the

procurement process may still be considered in terms of further raising the quality of the service.

7. Professional Implications

7.1 The Care Inspectorate continues to be fully involved in the improvement planning for Dunn Street. As indicated above, the HSCP Pharmacy team have also been involved in supporting staff with medication issues and their recommendations progressed.

8. Locality Implications

8.1 Dunn Street is the only learning disability respite resource available to residents of West Dunbartonshire and demand for the service is high. The HSCP expectation continues to be for Quarriers to make improvements across quality and care governance areas if the contract is to be continued.

9. Risk Analysis

9.1 Current risk issues are being managed through the improvement action plan.

10. Impact Assessments

10.1 None required

11. Consultation

11.1 Consultation with Quarriers remains ongoing.

12. Strategic Assessment

12.1 The Keys to Life Strategy (The Keys to Life – Improving quality of life for people with learning disabilities, June 2013) emphasises the requirement for care to be provided to the highest standards of quality and safety. The National Care Standards (published in June 2017 with implementation from April 2018) set out headline outcomes such as the requirement of high quality care and support and also having "confidence in the people who support and care for me". The West Dunbartonshire Strategic Plan 2016 – 2019 further recognises the importance of providing high quality Learning Disability services.

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Date: 21st May 2018

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Appendices: Copy of Dunn Street Work plan January 2018

Background Papers: None

Wards Affected: All

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
1	**Management and Leadership**					
1.1	Fully utilise quality assurance systems to assess and monitor the quality of service provision.	Brian Gardiner/ Sarah Perry/ Louise Fee		03/07/2017		**COMPLETED**
1.2	Policies and procedures on staff supervision, Team Meetings, PDP Planning are in place and are implemented.	Brian Gardiner/ Sarah Perry/ Louise Fee		13/04/2017		**COMPLETED**
1.3	Copies of policies and procedures on staff supervision, training, development available to the staff group.	Brian Gardiner/ Sarah Perry/ Louise Fee		04/04/2017		**COMPLETED**
1.4	There is a process for issues/concerns about staff skills to be recorded in supervision sessions and personal development plans.	Brian Gardiner/ Sarah Perry/ Louise Fee		30/05/2017		**COMPLETED**

APPENDIX 1

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
1.5	Evidence of information in relation to any changes in care needs being passed to staff.	Brian Gardiner/ Sarah Perry/ Louise Fee		ONGOING		**COMPLETED**
2	**Training provided for management team**					
2.1	All managers have undertaken leadership and management training.	Jude Grant	**Team Leader completed Qualification. Manager undertaking SSSC Management Qualification**	ONGOING		**GREEN**
3	**File Management**					
3.1	File management system to be implemented and up to date.	Brian Gardiner/ Sarah Perry/ Jude Grant	* New tracker in place to ensure target dates are met for auditing of files. *AWI Section 47 certificates required	ONGOING	Obtaining these from GP's is problematic due to the numbers required and GP's don't routinely ensure these are in place. **Some GP's refusing to share AWI documents.**	**RED**
3.2	Process to be put in place to ensure files are kept up to date by staff.	Brian Gardiner/ Sarah Perry/ Jude Grant	***Operational audit in place.** ***Internal audit every 2 months** ***Operational Manager implementing unannounced observation visits.** ***Quality clinics for manager & team leaders quarterly.**	30/06/2018		**GREEN**
4	**Staffing levels and staff turnover**					

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
4.1	Ensure all staff suitably qualified and registered with the SSSC. (This is cross referenced ensuring a review of training needs of staff).	Brian Gardiner/ Jude Grant	Usage of Outlook calendar to alert staff to renewal dates.	15/03/2018		**COMPLETED**

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
4.2	Ensure rota is set on a 4-6 weekly basis.	Brian Gardiner/ Jude Grant	***Staff Rota in place until 3/7/18** Manager periodically reviewing rota.	ONGOING		**GREEN**
4.3	Achieve a frequency of agency workers used within the service to below 7% of total staff.	Jude Grant	**Monthly Agency Staff Statistics April 34 shifts /May 20 shifts /June 0 shifts**	ONGOING		**GREEN**
4.4	Ensure agency staff are suitably qualified and registered with the SSSC?	Brian Gardiner/ Louise Fee	Profiles on all agency workers available which incorporates SSC registrations which Commissioning is satisfied with.	04/04/2017		**COMPLETED**
4.5	Establish the absence levels within the last year.	Brian Gardiner/ Jude Grant	**One long term absence Apr/May/Jun**	ONGOING		**GREEN**
4.6	Establish the turnover of staff within the last year, monthly vacancy list to be provided to this group.	Brian Gardiner/ Jude Grant	**1 X Team Leader vacancy =39 hours**	ONGOING	**Challenges with recruitment similar to other third sector agencies.**	**GREEN**
5						
5.1	There is a requirement for 4 to 6 weekly meetings to take place alongside Senior Staff at Dunn Street/Marie Malt/LD Staff? (This will facilitate supporting Dunn Street staff with the planning of respite.) To monitor the service user mix/dependency levels.	HSCP Staff/ Quarriers	**Dates arranged 4 x weekly**	ONGOING		**GREEN**

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
5.2	Face to face meetings with carers	Lorraine Bell	Carers being contacted by phone. Attendance at Social Work Reviews **Open Day planned for July.** **Individual Care Plan signatures being obtained from Carers.**	ONGOING		**AMBER**
5.3	Pre & Post visit questionnaires	MM/BG Quarriers		ONGOING		**GREEN**
6						
6.1	Undertake a review of the training needs of staff taking into account the health, welfare and safety needs of service users.	Brian Gardiner/ Louise Fee	**Medication and numerous health related training has taken place. Refresher training plan being implemented**	ONGOING		**GREEN**
6.2	The training provided by external agencies should be recorded and system to put in place to ensure this is implemented.	Brian Gardiner/ Louise Fee	Training Folder in place which is regularly updated.	ONGOING		**GREEN**
6.3	Issues in relation to staff training to be linked back to supervision.	Quarriers	Staff Supervision occurring 4-6 weekly Observations of staff practice by manager regularly occurring.	ONGOING		**GREEN**
7	**Skills and knowledge of how to communicate with individuals**					
7.1	Key worker system in place and monitored in order to ensure knowledge, consistency and communication with service users.	Nicola Wightman/ Brian Gardiner/ Louise Fee Quarriers	Project Manager continues to monitor.	ONGOING		**GREEN**

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
7.2	Systems put in place and monitored to ensure effective communication, with individuals, carers and external agencies.	Brian Gardiner/ Quarriers	New handover process implemented. Staff Communication Diary in use. Respite Users Questionnaire developed.	ONGOING		**GREEN**

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
7.3	Establish a process for recording and distributing information provided by external agencies.	Brian Gardiner/ Louise Fee Quarriers	There is a 'must read folder' which is discussed at all handover meetings. Any information discussed at Team Meetings	ONGOING		**GREEN**
7.4	Develop a system for updating service users care plans with any relevant changes or information.	Brian Gardiner/ Louise Fee Quarriers	**Action Plan developed by Quarriers Quality Assurance Dept. and Service Manager.**	ONGOING		**GREEN**
8						
8.1	Analyse how much time kitchen prep is taking away from care provision.	SP/NW	Analysis continues to be undertaken every 2 weeks Fri-Mon quarterly.	ONGOING		**GREEN**
8.2	Establish how often the training kitchen is being used as a meaningful activity for service users to participate in.	SP/NW	Refurbishment of kitchen required to ensure it's fit for purpose.	31/03/2018	**Delays to kitchen refurbishment due to discussions regarding source of funding.**	**AMBER**
8.3	Ensure staff are aware of the nutritional care of adults with a learning disability is being used.	SP/NW	Training provided at beginning of Jan 2018.	31/03/2018		**COMPLETED**
8.4	Review the food planner in place to evidence choice is being offered to guests at mealtime.	SP/NW		01/10/2017		**COMPLETED**

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
9	**Staff handover and planning meetings**					
9.1	Establish frequent staff meetings and ensure an action note is taken and distributed.	BG/ Quarriers	4 weekly Staff Team Meetings take place.	Ongoing		**GREEN**
9.2	A process in place to confirm staff not in attendance of the outcomes of staff meetings	BG/ Quarriers		01/11/2017		**COMPLETED**
9.3	Confirm communication methods in place for managers to pass information to the staff group.	BG/ Quarriers	*Staff must read folder in place.*	Ongoing		**GREEN**
10	**In house quality assurance for auditing care plans**					
10.1	Establish whether the staff group have easy access to pictorial information provided in current working care plan?	SP/NW/ BG		01/10/2017		**COMPLETED**
11	**Staff following external advice**					
11.1	A process is in place for recording all contact with external services.	BG/ Quarriers	**New IT Broadband lines installed by BT**	ONGOING	**Still waiting on Quarriers installing new phones**.	**GREEN**
12	**Clothing and belongings**					
12.1	Ensure there is a checklist of belongings at the start of respite and the checklist is signed off at the end of respite.	Quarriers	Existing checklist under review to try and identify a more efficient process.	31/05/2018	**Efficiency of existing process still being monitored to ensure improvements.**	**GREEN**
13	**Moving and Handling**					

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
13.1	There is a protocol in place to supervise any moving & handling procedures.	RU/ Quarriers		04/04/2017		**COMPLETED**
13.2	The staff group are fully trained and competent in relation to moving and handling procedures.	RU/ Quarriers	This is addressed through staff induction and monitored through supervision and mandatory (for all staff) training.	01/10/2017		**COMPLETED**

MULTI AGENCY ACTION PLAN (Version 22nd May 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
14	**Provision of medication**					
14.1	Review the medication recording system in place is safe, up to date and accurate. Review the record of medicines held on premises for use by service users.	DF /Quarriers	Prescribers Team completed assessment and report produced. **New "Share point" system implemented 14/5 and has identified significant efficiencies.**	15/01/2018		**COMPLETED**
14.2	Establish if there is a process in place when there is a medication discrepancy e.g. when care plan is different to medication labelling.	DF/RM Quarriers	Although completed this is monitored and reviewed on an ongoing basis with staff. **Mandatory notification of any discrepancies to Care Inspectorate, Quarriers Operational Manager and LDS .**	01/12/2017		**COMPLETED**
14.3	Ensure that there is a process in place for recording medication errors.	BG/RM Quarriers	Process recently reviewed by Prescribers Team. **Monthly medication report sent to LDS.**	01/12/2017		**COMPLETED**

Key to Risk Categories - 2012/13

		Green	Amber	Red
Status	Numerical targets	On target or better	Adverse variance of up to 10%	Adverse variance of 10% or more
	Non Numerical targets	On target	Achievement in doubt	Achievement at serious risk

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Community Connections

1. Purpose

1.1 To update the Audit Committee of the outcomes of the Care Inspectorate unannounced inspection to the Learning Disability Community Connections housing support service on 9 March 2018.

2. Recommendations

2.1 The Audit Committee is asked to note the outcome of the inspection report, the one outcome recommendation and the improvement in grade in relation of quality of staffing from grade 4 to grade 5.

3. Background

3.1 Community Connections is a West Dunbartonshire integrated service for care at home and housing support. The service is provided to adults with a learning disability who live in their own homes and the support teams' work from two office bases located in Alexandria and Dalmuir. 42 people are currently supported by the service.

4. Main Issues

4.1 There is one recommendation highlighted in the report relating to staff being able to access historical information regarding accidents and incidents noted on the Council FIGTREE system. The issue with this is that once staff had uploaded the incident form (HS1) to the Figtree system they were unable to go back into the system to access the form. During the recent inspection the Inspector requested evidence from the system that staff were compliant with health and safety processes. Staff were unable to fully evidence this due to being unable to access the form once it had been uploaded to the system. This matter has now been progressed by the management team in conjunction with Stevie Gallagher from the Health and Safety FIGTREE team.

5. People Implications

5.1 Staff will be required to undertake a briefing session on how to operate the new process once this is confirmed.

6. Financial Implications

6.1 There are no financial implications to this report.

7. Professional Implications

7.1 The Care Inspectorate will undertake checks at the next inspection as to whether this recommendation has been implemented.

8. Locality Implications

8.1 Staff regularly work across the two locality bases. Therefore the recommendation in this report applies to both locations.

9. Risk Analysis

9.1 The implementation of the new element to the current system will allow staff access to current and historical health and safety information. This will support the reduction of risk issues for staff and service users in the daily operation of their work.

10. Impact Assessments

10.1 None required

11. Consultation

11.1 The Community Connections management team will continue to work with the Health and Safety team to resolve this issue and report back on the progress of achieving this recommendation to the Care Inspectorate as part of the action planning process.

12. Strategic Assessment

12.1 The Keys to Life Strategy (The Keys to Life – Improving quality of life for people with learning disabilities, June 2013) emphasises the requirement for care to be provided to the highest standards of quality and safety. The National Care Standards (published in June 2017 with implementation from April 2018) set out headline outcomes such as the requirement of high quality care and support and also having “confidence in the people who support and care for me”. The West Dunbartonshire Strategic Plan 2016 – 2019 further recognises the importance of providing high quality Learning Disability services.

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Date: 21 May 2018

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Appendices: Copy of Community Connections Care Inspectorate report.

Background Papers: None

Wards Affected: All

West Dunbartonshire HSCP Learning Disability Service - Community Connections Housing Support Service

118 Dumbarton Road
Clydebank
G81 1UG

Telephone: 0141 562 2332

Type of inspection: Unannounced
Inspection completed on: 9 March 2018

Service provided by:
West Dunbartonshire Council

Service provider number:
SP2003003383

Care service number:
CS2015341708

About the service

West Dunbartonshire HSCP Learning Disability Service - Community Connections is an integrated service for Care at Home and Housing Support provided by West Dunbartonshire Council. The service registered with the Care Inspectorate on 5 January 2016.

The service is provided for adults with a learning disability who live in their own homes. The service operates from two office locations in Alexandria and Dalmuir. The service provides support to people living in their own tenancies and supports them to access resources in their local community. This includes access to clubs, support to learn independent living skills, help with developing relationships and to become active citizens.

At the time of the inspection 42 people were being supported by the service across both locations. The service aims include "to help you create a safe comfortable home" and to " help you use your local community resources and to be part of the community."

What people told us

For this inspection, we received views from 12 of the 42 people using the service. Four people shared their views by completing our care service questionnaires. We also spoke with eight people who were using the service when we inspected it.

Everyone who gave us their views said that they were very happy or happy with the quality of the service. People were consistent in their positive views about the quality of staff that supported them. Some people shared specific examples about how the service had helped make improvements in their lives. Comments from people who used the service included:

"It's great. I'm enjoying it."

"Staff are great. They support me to go to my classes. They are like friends"

"I like the cooking class. I've tried some cooking at home."

Self assessment

The service had not been asked to complete a self assessment in advance of the inspection. We looked at their own improvement plan and quality assurance paperwork. These demonstrated their priorities for development and how they were monitoring the quality of the provision within the service.

From this inspection we graded this service as:

Quality of care and support	5 - Very Good
Quality of staffing	5 - Very Good
Quality of management and leadership	not assessed

What the service does well

People who used the service were consistently very positive about what they got from it. We saw the service helped people to take part in a wide range of community based activities. Further, people told us that they led their own choice of activities rather than the staff who supported them. This allowed people to be flexible about what they wanted to do each day that they used the service. Staff were very good at facilitating different activities and responding to users changing needs.

Individuals that we spoke with were able to share examples of how the service had improved their lives. Examples of positive outcomes included reduced social isolation, increased community participation and the formation of new friendships/relationships. The service supported people were well and used its well-established links with partner agencies to realise their potential. This included exploring employment opportunities, participation in recruiting staff and learning new and transferable skills.

Personal plans were person-centred and outcome focused. We shared some minor observations that some plans needed to have redundant information archived more often so that information was current and easy to read. The service agreed to do this.

The service's approach was closely aligned to the Keys to Life strategic outcomes. These included helping people with learning disabilities to have a healthy life, have choice and control to be treated with dignity and protected from abuse, to live independently in society and to be active citizens.

Staff that we met and who completed our staff questionnaires told us that they enjoyed working for the service. They were clear about their roles and demonstrated positive values.

Staff had very good training opportunities and received regular feedback about their practice from co-workers and people who used the service. People who used the service described staff as "caring", "respectful" and "very friendly".

The service employed new staff using procedures that followed safe recruitment guidance. Recruitment regularly included seeking the views of people who used the service about staff who applied to work in the service. This demonstrated that the service valued the opinions of people they cared for.

What the service could do better

Opportunities for new referrals to the service were limited. This was mainly because existing users didn't often move out of the service. The provider should explore this further as part of the future development of the service.

Staff were appropriately recording and managing accidents and incidents. However, staff had no access to historical information about accidents and incidents once they logged on a database. This meant that staff had to develop "workarounds" to access archived data that they might need at a later date. (see recommendation 1).

We discussed how the service should be more consistent in recording areas for improvement identified in audits. Senior staff were recording this in different ways which could lead to confusion. This was also true for the way that attendance at staff training events was recorded.

Staff that we spoke with had mixed views about the quality and frequency of staff supervision. Some staff really valued the opportunities to meet regularly with senior staff to discuss their work and personal development. Other staff indicated that supervision was less meaningful for them. The provider agreed to explore this further with the wider staff group. All staff agreed that they received very good informal support from the senior staff team.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 1

1. Staff should be able access historical information about accidents and incidents without the need for "workaround" systems being used. The provider should take appropriate action to address this.

National Care Standards for Care at Home, Standard 4: Management and staffing

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Inspection and grading history

Date	Type	Gradings	
31 Jan 2017	Unannounced	Care and support Environment Staffing Management and leadership	5 - Very good Not assessed 4 - Good 4 - Good

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT COMMITTEE: 20 JUNE 2018

Subject: Oral Health Update

1. Purpose

1.1 To provide the Audit committee with an update following previous March Audit Committee on local oral health improvement activities contributing to the ongoing collaborative work between the HSCP, WDC and NHSGGC Oral Health Directorate (OHD).

2. Recommendation

2.1 The Audit committee is asked to note the work undertaken locally to improve oral health specifically for children and continued work with the NHSGGC Oral health directorate (OHD) to make best use of the totality of resources to improve oral health outcomes.

3. Background

3.1 The General Manager of the NHSGGC Oral Health Directorate (OHD) presented on the NHS GG&C Oral Health Directorate Report (2017) West Dunbartonshire HSCP at the March Audit committee.

3.2 Locally, planning for oral health improvement is included in the integrated children's services planning processes coordinated by the Nurtured Delivery and Improvement group of Community Planning West Dunbartonshire. In addition strong linkages have been made with the West Dunbartonshire Child Protection Committee in recognition of the fact that dental decay is almost totally preventable and that dental health is used as an 'indicative measure' of children's general health which the HSCP, WDC and NHSGGC can make improvements to.

3.3 Whilst oral health indicators and outcomes in West Dunbartonshire, particularly for children remain poor, steady improvements have been made.
There are opportunities to continue the improvement journey in all parts of the Childsmile programme which is delivered by a combination of HSCP, OHD and Dental Contractors in partnership with WDC Educational establishments.

3.4 The current status of the four elements of the Childsmile programme is outlined in appendix 1

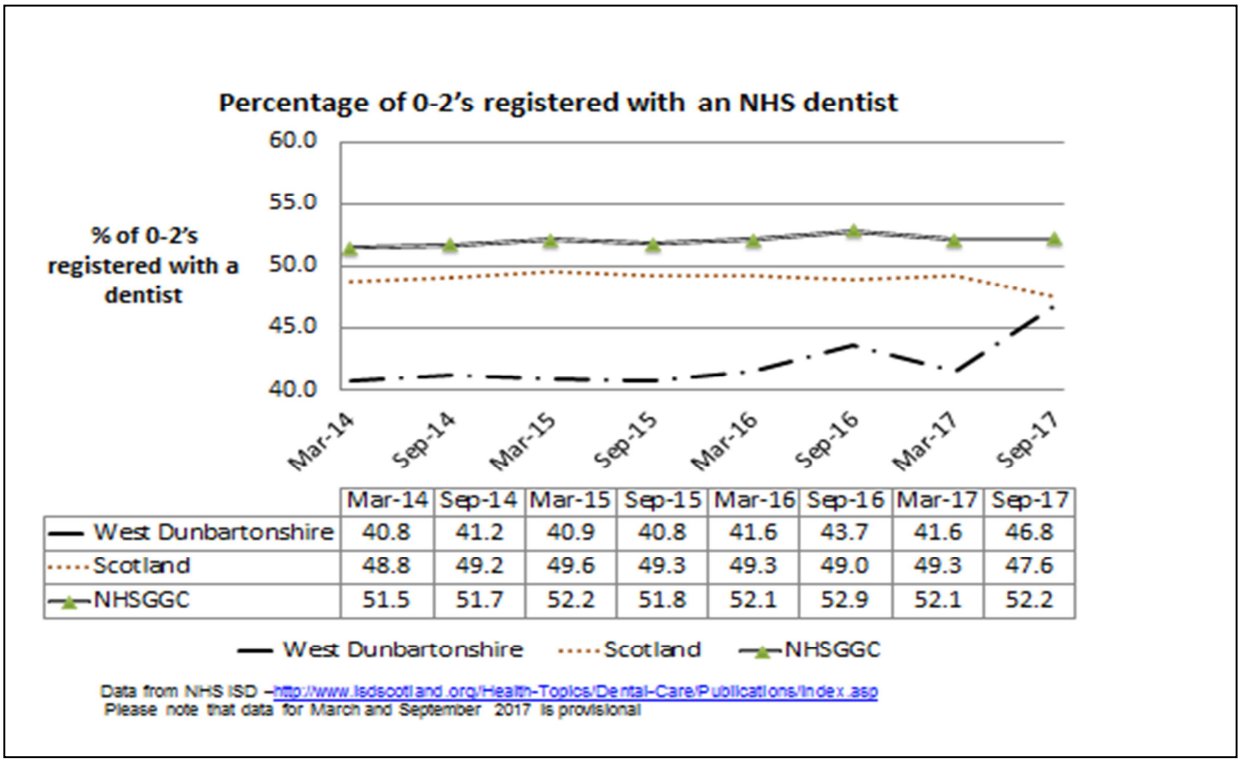
4. Main Issues

4.1 Dental Registration 0-2's

NB NHS ISD publishes provisional snapshot dental registration in January of each year based on numbers registered on the 31st of March and the 30th of September. It also publishes revised data on the provisional dental registration

figures published the previous year.

The data presented to the previous audit committee used the data published in January 2017. (Provisional data from 2016 snapshots). It is worth noting that the most current data published in January 2018 (January 2018) shows an improvement as illustrated in the graph below.



	Mar-14	Sep-14	Mar-15	Sep-15	Mar-16	Sep-16	Mar-17	Sep-17
West Dunbartonshire	40.8	41.2	40.9	40.8	41.6	43.7	41.6	46.8
Scotland	48.8	49.2	49.6	49.3	49.3	49.0	49.3	47.6
NHSGGC	51.5	51.7	52.2	51.8	52.1	52.9	52.1	52.2

Please note that all the data for 2017 is provisional

Source – NHS ISD Dental Statistics - Registration and Participation January 2018
http://www.isdscotland.org/Health-Topics/Dental-Care/

4.2 HSCP Dental Health Support Workers

The dental health support worker (DHSW) is a key role for connecting the universal health visiting service supporting families to establish good oral health practices from birth to the services offered by the dental practices. The full complement of three dental health support workers has been in operation since June 2017 and are based at the Vale Centre for Health and Care. This location enables them to continue to build good relationships with the NHSGGC OHD team who also have some staff based there.

4.3 Improvement actions undertaken in 2017/18

For the last twelve months dental health support workers have been undertaking visits to families identified by health visitors, for new babies at 5 months with follow up visits at 12 months and 18 months.to support families with dental registration and healthy eating. The overall aim of this is to increase dental registration and participation.

4.4 Improvement actions underway for 2018/19

Dental health support workers are now working with the 5 WDC nurseries which take children aged 0-2 to further promote good oral health, dental registration with children, parents and staff within the nursery settings.

Dental registration will be included in all WDC nursery registration processes from August 2018. Nursery staff will provide information to families who have not yet registered with a dentist

Linkages with the new WDC Facilities Management Health and Nutrition coordinator are planned to support implementation of Setting the Table, Nutritional guidance and food standards for early year's childcare providers in Scotland.

4.5 Collaborative Work with the Oral Health Directorate

The HSCP continues to work in tandem with the oral health directorate on oral health issues. This includes promotional activity for National Smile Month, identification of issues with implementation of the Childsmile programme with dental practices and identification of additional nurseries and schools being eligible to join the nursery and school fluoride varnishing programme in recognition of the need in West Dunbartonshire.

Future inputs from the Oral Health directorate at local multi agency partnerships to raise awareness of the range of programmes managed centrally by the OHD will continue to be welcomed.

Updates in particular on progress by the OHD on their work with the 16 local dental practices will also be welcomed as they begin to implement the new national Oral Health Improvement Plan

5. People Implications

5.1 There are no specific people implications associated with this report

6. Financial and Procurement Implications

6.1 There are no specific financial or procurement implications associated with this report.

7. Risk Analysis

7.1 There is a continued need to ensure that the range of oral health programmes are co-ordinated as much as possible to ensure that improved oral health outcomes can be sustained**.**

8. Equality Impact Assessment (EIA)

8.1 An EIA is not required for this report.

9. Consultation

9.1. Partners across the HSCP and WDC Education have been consulted in relation to the content of this report.

10. Strategic Assessment

10.1 The oral health programmes are an integral part of the HSCP and Integrated Children's Services Planning early intervention GIRFEC activity

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Date:	22 May 2018

Person to Contact:	Jackie Irvine, Head of Children's Health, Care & Criminal Justice Services
Appendix 1:	Childsmile Programme
Background Papers:	WDHSCP IJB Audit Committee March 2018 – Oral Health Directorate Performance Report 2017 WDHSCP IJB Audit Committee June 2017 – Oral Health Directorate Performance Report 2016 http://www.child-smile.org.uk/
Wards Affected:	All

Appendix 1 – Childsmile Programme

Programme	**Current Position in West Dunbartonshire (May 2018)**	**Service Delivered or monitored by**
1 Childsmile Core	• Free dental packs of tooth brush and tooth paste to support tooth brushing at home • All 32 nurseries provide supervised toothbrushing to 3 & 4 year olds • 32/34 Schools provide supervised tooth brushing to Primary 1&2 pupils	HSCP HSCP/WDC Education NHSGGC OHD/WDC Education
2 Childsmile Practice	• Additional home support provided by Dental Health Support Workers • All 16 local dental practices provide enhanced care comprising advice, treatment and fluoride varnishing from 2 years old	HSCP NHS General Dental Practitioner Staff /NHSGGC OHD
3 Childsmile Nursery	• 8 nurseries offering fluoride varnishing 3 in Clydebank and 5 in Alexandria/Dumbarton	NHSGGC OHD
4 Childsmile School	• 15 Primary Schools offering fluoride varnishing 6 in Clydebank and 9 in Alexandria/Dumbarton	NHSGGC OHD