West Dunbartonshire
Health & Social Care Partnership

Supplementary Agenda

West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee

Date:	Monday, 7 March 2022
Time:	10:00
Format:	Zoom video conference
Contact:	Ashley MacIntyre, Committee Officer ashley.macintyre@west-dunbarton.gov.uk

Dear Member

I refer to the agenda for the above meeting that was issued on 24 February and now enclose a copy of Items 5, 9, 10, 12 and 13 which were not available for issue at that time.

Yours faithfully

JULIE SLAVIN

Chief Financial Officer of the
Health and Social Care Partnership

Note referred to:

5 REVIEW OF TERMS OF REFERENCE OF THE AUDIT AND PERFORMANCE COMMITTEE **73 - 82**

Submit report by Julie Slavin, Chief Financial Officer providing an update on the the scheduled review of the Terms of Reference (ToR) of the Audit and Performance Committee.

9 2021/22 ANNUAL ACCOUNTS AUDIT PROCESS **83 - 86**

Submit report by Julie Slavin, Chief Financial Officer providing an overview of the process for the preparation of the 2021/22 Annual Accounts of the HSCP Board identifying legislative requirements and key stages.

10 EXTERNAL AUDIT – WEST DUNBARTONSHIRE INTEGRATED JOINT BOARD ANNUAL AUDIT PLAN 2021/22 **87 - 107**

Submit report by Julie Slavin, Chief Financial Officer presenting the Annual Audit Plan produced by the HSCP Board's external auditors, Audit Scotland, for the audit of the financial year ending 31 March 2022.

12 INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE **109 - 125**

Submit report by Lesley James, Head of Children's Health, Care and Justice Services providing the findings of the most recent Care Inspectorate inspection of Fostering Services in West Dunbartonshire.

13 INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE **127 - 138**

Submit report by Lesley James, Head of Children's Health, Care and Justice Services providing the findings of the most recent Care Inspectorate inspection of Adoption Services in West Dunbartonshire.

Distribution:-

Voting Members
Rona Sweeney (Chair)
Denis Agnew (Vice Chair)
Jonathan McColl (WDC)
John Mooney (WDC)
Lesley Rousselet (GGC)
Michelle Wailes (GGC)

Non-Voting Members
Anne MacDougall

Chief Officer – Beth Culshaw
Chief Financial Officer – Julie Slavin
Chief Internal Auditor – Andi Priestman
External Audit Representatives – Christopher Gardner, Sanya Ahmed, Jack Kerr

Date of issue: 28 February 2022

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP AUDIT AND PERFORMANCE COMMITTEE

Report by Chief Financial Officer

HSCP Audit and Performance Committee: 7 March 2022

Subject: Review of Terms of Reference of the Audit and Performance Committee

1. Purpose

1.1 To provide the Audit and Performance Committee with an update on the scheduled review of the Terms of Reference (ToR) of the Audit and Performance Committee.

2. Recommendations

2.1 The members of the Audit and Performance Committee are asked to:

- Note that an initial discussion on the current Terms of Reference is required ; and
- Instruct the Chief Financial Officer and Chief Internal Auditor to schedule a formal member's session to review the Terms of Reference, after the upcoming local government elections to allow for the attendance of any new voting members.

3. Background

3.1 The current Terms of Reference (ToR) for the Audit and Performance Committee are attached at Appendix1. These were approved by the HSCP Board in November 2019 following a board member information session that was delivered by the Chief Financial Officer on 25 September 2019.

3.2 The recommendations from the last review were based on good practice guidance issued by the Chartered Institute of Public Finance and Accountancy (CIPFA) – "Audit Committee – Practical Guidance for Local Authorities and Police 2018". They were:

- Change of name from Audit Committee to "Audit and Performance Committee"; and
- Extending the non-voting membership to include two representatives from the Strategic Planning Group, to support the committee in having an appropriate mix of knowledge and skills, and independent scrutiny.

4. Main Issues

4.1 The current ToR was scheduled for review in November 2021 (two year review date), however the continuing impact of COVID-19 and subsequent variants have delayed officers in taking this forward.

4.2 On the 21 February 2022 there was an initial review meeting attended by the Chair of the Audit and Performance Committee along with the Chief Officer, Chief Financial Officer and the Chief Internal Auditor. The consensus of this high level review was that the current ToR aligns to CIPFA's good practice guidance, but there could be strengthening around membership and responsibilities.

4.3 The November 2019 ToR extended the membership to include two members of the Strategic Planning Group, but did not specify a "term of office" which now requires to be addressed. It would also be pertinent to determine whether the committee would benefit on drawing the two additional non-voting members from another forum or directly as "lay members" from the general public.

4.4 Contained within the "Responsibilities" section (para 4.2) of the current ToR is the statement: "The Audit and Performance Committee will also periodically review its own effectiveness and report the results of that review to the Partnership Board". This was last undertaken in late 2019 and since then there has been a change of both Chair and Vice Chair as well as Chief Internal Auditor.

4.5 It is also possible that the current voting membership of both the HSCP Board and the Audit and Performance Committee will change as a result of the local government elections this coming May.

4.6 After consideration of the points covered in sections 4.2 – 4.4 above it is recommended that after discussion of this paper, a formal information session is scheduled to take place after the May elections to allow for a more thorough review.

5. Options Appraisal

5.1 There is no requirement for an option appraisal for the content of this report.

6. People Implications

6.1 None.

7. Financial and Procurement Implications

7.1 There are no financial implications specific to this report.

8. Risk Analysis

8.1 It is the responsibility of the Partnership Board to establish adequate and proportionate arrangements for review of the adequacy for risk management, governance and control of the delegated resources. The Audit and Performance Committee supports the Board in the discharge of these responsibilities, therefore regular review of the ToR and the effectiveness of the Committee are essential.

9. Equalities Impact Assessment (EIA)

9.1 There is no requirement for an EIA for the content of this report.

10. Environmental Sustainability

10.1 There is no environmental sustainability impact for the content of this report.

11. Consultation

11.1 This report was shared with the HSCP Board's external auditors.

12. Strategic Assessment

12.1 The Chief Financial Officer is responsible for providing assurance on the system of internal financial control to the Audit and Performance Committee on behalf of the Health Board and Council.

12.2 The Health Board Director of Finance and the Council Section 95 Officer will ensure that the Audit and Performance Committee is provided with necessary technical and corporate support in relation to its remit.

13. Directions

13.1 There is no direction required for the content of this report.

Julie Slavin – Chief Financial Officer
Date: 24 February 2022

Person to Contact: Julie Slavin – Chief Financial Officer, Church Street, WDC Offices, Dumbarton G82 1QL
Telephone: 07773 934 377
E-mail: julie.slavin@ggc.scot.nhs.uk

Appendices: Appendix 1: Terms of Reference for HSCP's Board: Audit and Performance Committee

Background Papers: HSCP Board Reports 13 November 2019 and Audit and Performance Committee Report 11 December 2019

Localities Affected: All

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Audit and Performance Committee

Terms of Reference

1. PURPOSE

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

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

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

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

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

1.5 The West Dunbartonshire Health & Social Care Partnership Board has established this Audit and Performance Committee as a Committee of the Partnership Board to support it in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. These Terms of Reference for the Audit and Performance Committee reflect the span of responsibilities of the Partnership Board and requirements of its approved Financial Regulations, i.e.:

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

2. MEMBERSHIP

2.1 The Audit and Performance Committee will be composed of the six voting members of the Partnership Board.

2.2 The provisions in relation to duration of membership, substitution and removal of membership together with those in relation to Code of Conduct and Declarations of Interest will be those which apply to the Partnership Board.

2.3 The Audit and Performance Committee will be chaired by the Vice-Chair of the Partnership Board.

2.4 Two members of the Strategic Planning Group (a sub-committee of the Partnership Board) will be co-opted as non-voting members of the Audit and Performance Committee.

2.5 As the Audit and Performance Committee will be responsible for overseeing and providing independent assurance on the adequacy of the risk management framework, the internal control environment and the financial governance arrangements of the Partnership Board, other non-voting members of the Partnership Board shall also have the right to attend. A schedule of meetings will be published for all Partnership Board members, and those non-voting members who confirm their intention to attend the meeting will be issued with papers for that meeting.

2.6 The Chief Financial Officer will nominate an Internal Audit Service, led by a named Chief Internal Auditor, to work on behalf of the Audit and Performance Committee.

2.7 The external auditors for the Partnership Board will be appointed by the Accounts Commission.

2.8 The appointed Chief Internal Auditor will normally attend meetings of the Audit and Performance Committee.

2.9 A representative of the external auditors will normally attend meetings of the Audit and Performance Committee.

2.10 The Chief Officer and Chief Financial Officer of the Health & Social Care Partnership Board will normally attend meetings of the Audit and Performance Committee.

2.11 The Audit and Performance Committee will be provided with a secretariat function by West Dunbartonshire Council.

2.12 Other officers of the Health & Social Care Partnership, West Dunbartonshire Council and NHS Greater Glasgow & Clyde may also be invited to attend meetings.

3. REPORTING

3.1 The Audit and Performance Committee will formally provide a copy of its minutes to the Partnership Board for inclusion on the agenda's of its subsequent meetings. These minutes will be made publicly available.

3.2 The Audit and Performance Committee will provide the Partnership Board with an Annual Statement, timed to support finalisation of the accounts and the governance statement, summarising its conclusions from the work it has done during the year.

4. RESPONSIBILITIES

4.1 The Audit and Performance Committee will advise the Partnership Board, the Chief Officer and its Chief Financial Officer on:

- The strategic processes for risk, control and governance and the governance statement;
- The annual compliance of the Partnership Board against the Local Code of Good Governance, to inform the governance statement;
- The financial governance and accounts of the Partnership Board, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- The planned activity and results of both internal and external audit as they relate to the activities of the Partnership Board;
- The adequacy of management response to issues identified by audit activity, including external audit's management letter/report;
- The effectiveness of the internal control environment, the arrangements for ensuring value for money and managing exposure to the risks of fraud and corruption;
- The effectiveness of risk management arrangements, ensuring existence of and compliance with an appropriate risk management strategy;
- The adequacy of management response to reports concerned with the delivery of performance and quality of key elements of the Strategic Plan, including review of the Quarterly Performance Report;
- Assurances relating to the corporate governance requirements for the Partnership Board; and
- Appointment of the internal audit service or for purchase of non-audit services from contractors who provide audit services.

4.2 The Audit and Performance Committee will also periodically review its own effectiveness and report the results of that review to the Partnership Board

5. RIGHTS

5.1 The Chief Financial Officer will be responsible for providing assurance on the system of internal financial control to the Audit and Performance Committee on behalf of the Health Board and Council. In doing this, the Chief Financial Officer will be reliant on both the Health Board's and Council's systems of internal control to support compliance with both organisations' policies and promote achievement of each organisation's aims and objectives, as well as those of the Partnership Board as expressed in its Strategic Plan.

5.2 The Audit and Performance Committee receive, scrutinise and comment upon the formal submission of reports, findings and recommendations by the appointed Internal Audit service, external auditor (as appointed by the Accounts Commission), Audit Scotland and Inspectorate bodies. The Chief Financial Officer will ensure that follow-up reports on actions required will be provided to the Audit and Performance Committee as agreed.

5.3 The Chief Financial Officer will prepare an Annual Governance Statement for the Audit and Performance Committee prior to its being presented to the Partnership Board.

5.4 The Chief Internal Auditor for the Partnership Board will report to the Chief Financial Officer and the Audit and Performance Committee on an annual risk-based audit plan in respect of the activities of the Partnership Board; delivery of the plan and

recommendations; and will provide an annual internal audit report, including the audit opinion.

5.5 The Audit and Performance Committee may procure specialist ad-hoc advice at the expense of the Partnership Board, subject to budgets agreed by the Chief Financial Officer and confirmed by the Partnership Board.

5.6 The appointed Chief Internal Auditor and the representative of External Audit (as appointed by the Accounts Commission) will have free and confidential access to the Chair of the Audit and Performance Committee.

6. MEETINGS

6.1 The procedures for meetings are that:

6.1.1 The Audit and Performance Committee will meet quarterly, with a provision for additional meetings if required as the discretion of the Chair of the Audit and Performance Committee; and with meetings scheduled at regular intervals between the quarterly meetings of the Partnership Board.

6.1.2 The meetings will be conducted in accordance with the Standing Orders of the Partnership Board, including:

- At least one half (i.e. three) of the six members of the Audit and Performance Committee will be present for the meeting to be deemed quorate.
- Members of the Audit and Performance Committee must disclose any direct or indirect pecuniary or other interest in relation to an item of business to be transacted at a meeting of the Audit and Performance Committee, before taking part in any discussion on that item. Where an interest is disclosed, the other members present at the meeting in question shall decide whether the member declaring the interest is to be prohibited from taking part in discussion of, or voting on, the item of business.

6.1.3 Audit and Performance Committee meetings will normally be attended by the Chief Officer, the Chief Financial Officer, appointed Chief Internal Auditor and a representative of the External Auditor.

6.1.4 The Audit and Performance Committee may ask any other officers from the Health & Social Care Partnership, West Dunbartonshire Council and NHS Greater Glasgow & Clyde to attend to assist it with its discussions on any particular matter.

6.1.5 Subject to the extent of the accommodation available and except in relation to items certified as exempt and items likely to involve the disclosure of confidential information, meetings of the Audit and Performance Committee shall be open to the public (as per the Standing Orders of the Partnership Board). The Chief Officer shall be responsible for giving public notice of the date, time and place of each meeting of the Audit and Performance Committee by posting within the main offices of the Health & Social Care Partnership not less than five days before the date of each meeting.

6.1.6 The Audit and Performance Committee may by resolution at any meeting exclude the press and public there from during consideration of an item of business where it is likely in view of the nature of the business to be transacted or of the nature of proceedings that if members of the press and public were present there would be a disclosure to them of exempt information as defined in Schedule 7A to the Local Government (Scotland) Act

1973 or it is likely that confidential information would be disclosed in breach of an obligation of confidence. The Audit and Performance Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6.1.7 Every meeting of the Audit and Performance Committee shall be open to the public but these provisions shall be without prejudice to the Audit and Performance Committee's powers of exclusion in order to suppress or prevent disorderly conduct or other misbehaviour at a meeting. The Audit and Performance Committee may exclude or eject from a meeting a member or members of the press or public whose presence or conduct is impeding the work or proceedings of the Audit and Performance Committee.

6.1.8 The Partnership Board or the Chief Financial Officer may ask the Audit and Performance Committee to convene further meetings to discuss particular issues on which they want the Audit and Performance Committee's advice.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP AUDIT AND PERFORMANCE COMMITTEE

Report by Chief Financial Officer

HSCP Audit and Performance Committee: 7 March 2022

Subject: 2021/22 Annual Accounts Audit Process

1. Purpose

1.1 To provide the Audit and Performance Committee with an overview of the process for the preparation of the 2021/22 Annual Accounts of the HSCP Board identifying legislative requirements and key stages.

2. Recommendations

2.1 The members of the Audit and Performance Committee are asked to:

- Note the contents of the report; and
- Note additional meetings of the Audit and Performance Committee and HSCP Board may be required to be scheduled close to the end of 31 October 2022 to conclude the approval of the 2021/22 Annual Accounts if the audit process extends beyond the end of September.

3. Background

3.1 The West Dunbartonshire Integration Joint Board (WDIJB), known as the West Dunbartonshire Health and Social Care Partnership Board (HSCP Board), is a legal entity in its own right.

3.2 Integration Joint Boards are specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

4. Main Issues

4.1 The annual accounts for the HSCP Board will be prepared in accordance with appropriate legislation and guidance. An overview of the process is set out below. If there has been any amendments to normal statutory deadlines due to the impact of the Covid-19 pandemic these are provided below.

4.2 **Financial Governance and Internal Control;** the regulations require the Annual Governance Statement to be approved by the HSCP Board or a committee of the HSCP whose remit include audit and governance. This will assess the effectiveness of the internal audit function and the internal control

procedures of the HSCP Board. Under the approved Terms of Reference the Audit and Performance Committee will consider the 2021/22 Governance Statement as a standalone document before inclusion in the draft unaudited annual accounts.

4.3 **Unaudited Accounts;** the regulations state that the unaudited accounts are submitted to the External Auditor no later than 30 June immediately following the financial year to which they relate. Scottish Government guidance states that best practice would reflect that the HSCP Board or committee whose remit includes audit and governance should consider the unaudited accounts prior to submission to the external auditor.

4.4 **Right to Inspect and Object to Accounts:** the public notice period of inspection should start no later than 1 July in the year the notice is published. This will be for a period of 3 weeks and will follow appropriate protocol for advertising and accessing the unaudited accounts.

4.5 **Approval of Audited Accounts**: the regulations require the approval of the audited annual accounts by the HSCP Board or a committee whose remit include audit and governance. This will take account of any report made on the audited annual accounts by the "proper officer" i.e. Chief Financial Officer being the Section 95 Officer for the HSCP Board or by the External Auditor by the 31 October (temporary amendment to normal statutory deadline of 30 September) immediately following the financial year to which they relate.

4.6 The Terms of Reference for the Audit and Performance Committee state that final approval and "sign-off" will be the responsibility of the HSCP Board. Meeting dates beyond June 2022 have not yet been finalised, however it is anticipated that a meeting will be scheduled late September with the Audit and Performance Committee meeting first to consider the audited annual accounts, the External Auditors report and proposed audit certificate (ISA 260 report) and then move straight into a meeting of the HSCP Board to conclude the final approval process.

4.7 As stated above in section 4.5 the statutory deadline has been extended to 31 October 2022 and this is the target date included within our external auditor's Annual Audit Plan (separate item on this agenda). If issues arise during the course of the audit (i.e. impact of Covid-19 on the production or audit of accounts) that mean it is not practical to certify the accounts by the end of October then our auditor will communicate this to the HSCP Board at the earliest opportunity and agree a revised timetable for the completion of the audit. Likewise, if audit resources would enable an earlier sign-off this will also be discussed and agreed with the HSCP Board. Once finalised the forward planner will reflect the proposed presentation of Annual Audit Report to the HSCP Board in September 2022. The committee will be kept updated on the progress and the possibility that a meeting of the HSCP Board may have to be convened in late October.

4.8 **Publication of the Audited Accounts:** the regulations require that the annual accounts of the HSCP Board be available in both hard copy and on the website for at least five years, together with any further reports provided by the External Auditor that relate to the audited accounts.

4.9 The annual accounts of the HSCP Board must be published by 31 October and any further reports by the External Auditor by 31 December immediately following the year to which they relate.

4.10 **Key Documents:** the regulations require a number of key documents (within the annual accounts) to be signed by the Chair of the HSCP Board, the Chief Officer and the Chief Financial Officer, namely:

Document	**Signatory**
Management Commentary	Chair of the HSCP Board Chief Officer
Statement of Responsibilities	Chair of the HSCP Board Chief Financial Officer
Remuneration Report	Chair of the HSCP Board Chief Officer
Annual Governance Statement	Chair of the HSCP Board Chief Officer
Balance Sheet	Chief Financial Officer

5. Options Appraisal

5.1 There is no requirement for an option appraisal for the content of this report.

6. People Implications

6.1 The preparation of the annual accounts and the requirement to produce all required supporting documentation and explanation to external audit is a core function of the HSCP Finance Team. The impact of additional reporting requirements associated with the response to the Covid-19 pandemic will be managed alongside this statutory activity.

7. Financial and Procurement Implications

7.1 There are no financial implications specific to this report.

8. Risk Analysis

8.1 The COVID-19 Risk Register considers the risk of meeting all required statutory deadlines if the capacity of the HSCP Finance Team and our partner organisations are adversely impacted.

9. Equalities Impact Assessment (EIA)

9.1 There is no requirement for an EIA for the content of this report.

10. Environmental Sustainability

10.1 There is no environmental sustainability impact for the content of this report.

11. Consultation

11.1 This report was shared with the HSCP Board's external auditors.

12. Strategic Assessment

12.1 The preparation and audit of the HSCP Board's Annual Accounts is a statutory requirement. This report links to the strategic financial governance arrangements of the HSCP Board and both partner organisations of West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board.

13. Directions

13.1 There is no direction required for the content of this report.

Julie Slavin – Chief Financial Officer
Date: 24 February 2022

Person to Contact: Julie Slavin – Chief Financial Officer, Church Street, WDC Offices, Dumbarton G82 1QL
Telephone: 07773 934 377
E-mail: julie.slavin@ggc.scot.nhs.uk

Appendices: None

Background Papers: None

Localities Affected: All

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
AUDIT AND PERFORMANCE COMMITTEE

Report by Chief Financial Officer

HSCP Audit and Performance Committee: 7 March 2022

Subject: External Audit - West Dunbartonshire Integrated Joint Board Annual Audit Plan 2021/22

1. Purpose

1.1 To present to the Audit and Performance Committee the Annual Audit Plan produced by the HSCP Board's external auditors, Audit Scotland, for the audit of the financial year ending 31 March 2022.

2. Recommendations

2.1 The Audit and Performance Committee is asked to note and comment on Audit Scotland's 2021/22 Annual Audit Plan.

3. Background

3.1 In July 2016 the Accounts Commission appointed Audit Scotland as the external auditor for the West Dunbartonshire Integration Joint Board (commonly known as the HSCP Board) for the five year period from 2016/17 to 2020/21.

3.2 The Covid-19 pandemic has resulted in significant disruption for public sector bodies and the Auditor General for Scotland and the Accounts Commission for Scotland have extended the current appointment by one year to cover the audit of the 2021/22 financial year.

3.3 The 2021/22 audit will be the final year with Audit Scotland as the HSCP Board's external auditor. As outgoing auditors, they will work closely with their successors and the Chief Financial Officer to ensure a well-managed transition.

3.4 The initial step is the production of the Annual Audit Plan (Appendix 1). Based on discussions with staff, attendance at board meetings and a review of supporting information, the plan is focused on the identification of the main risk areas for the West Dunbartonshire Integration Joint Board.

4. Main Issues

4.1 The Annual Audit Plan contains an overview of the planned scope and timing of Audit Scotland's external audit of West Dunbartonshire Integration Joint

Board. It includes their identification of key audit risks, which are categorised into significant risk of material misstatement to the annual accounts and audit dimension risks. These key audit risks require specific testing and are detailed in Exhibit 2, 3 and 4 of the Annual Audit Report respectively.

4.2 The audit outputs and their target dates are detailed in Exhibit 5 and 6. The planned date for the issue of the Annual Audit Report and Audit Certificate of 31 October 2022 is in line with Audit Scotland's Planning Guidance 2021/22 and reflects the extension to the Local Government (Scotland) Act 1973 statutory deadline of 30 September in recognition of the pandemic disruption.

4.3 All efforts will be made to work to the end of September to allow for the presentation of Annual Audit Report to the HSCP Board in September 2022. The committee will be kept updated on the progress and the possibility that a meeting of the HSCP Board may have to be convened in late October.

5. Options Appraisal

5.1 There is no requirement for an option appraisal for the content of this report.

6. People Implications

6.1 The preparation of the annual accounts and the requirement to produce all required supporting documentation and explanation to external audit is a core function of the HSCP Finance Team. The impact of additional reporting requirements associated with the response to the Covid-19 pandemic will be managed alongside this statutory activity.

7. Financial and Procurement Implications

7.1 The proposed audit fee for the 2021/22 audit of the IJB is £27,960, which is increase of £630 (2.3%) on the 2020/21 cost. This fee is consistent with the fees for all Integration Joint Boards.

7.2 Audit Scotland's fee assumes receipt of the unaudited financial statements by 30 June 2022 and covers the cost of planning, delivery, reporting and the auditor's attendance at committees.

8. Risk Analysis

8.1 The audit of the financial statements does not relieve Partnership Board's Audit and Performance Committee (as the body charged with overseeing and scrutinising governance) or the Chief Financial Officer of their responsibilities.

9. Equalities Impact Assessment (EIA)

9.1 There is no requirement for an EIA for the content of this report.

10. Environmental Sustainability

10.1 There is no environmental sustainability impact for the content of this report.

11. Consultation

11.1 The Annual Audit Plan has been prepared in consultation with the Chief Financial Officer.

12. Strategic Assessment

12.1 The preparation and audit of the HSCP Board's Annual Accounts is a statutory requirement. This report links to the strategic financial governance arrangements of the HSCP Board.

13. Directions

13.1 There is no direction required for the content of this report.

Julie Slavin – Chief Financial Officer
Date: 24 February 2022

Person to Contact: Julie Slavin – Chief Financial Officer, Church Street, WDC Offices, Dumbarton G82 1QL
Telephone: 07773 934 377
E-mail: julie.slavin@ggc.scot.nhs.uk

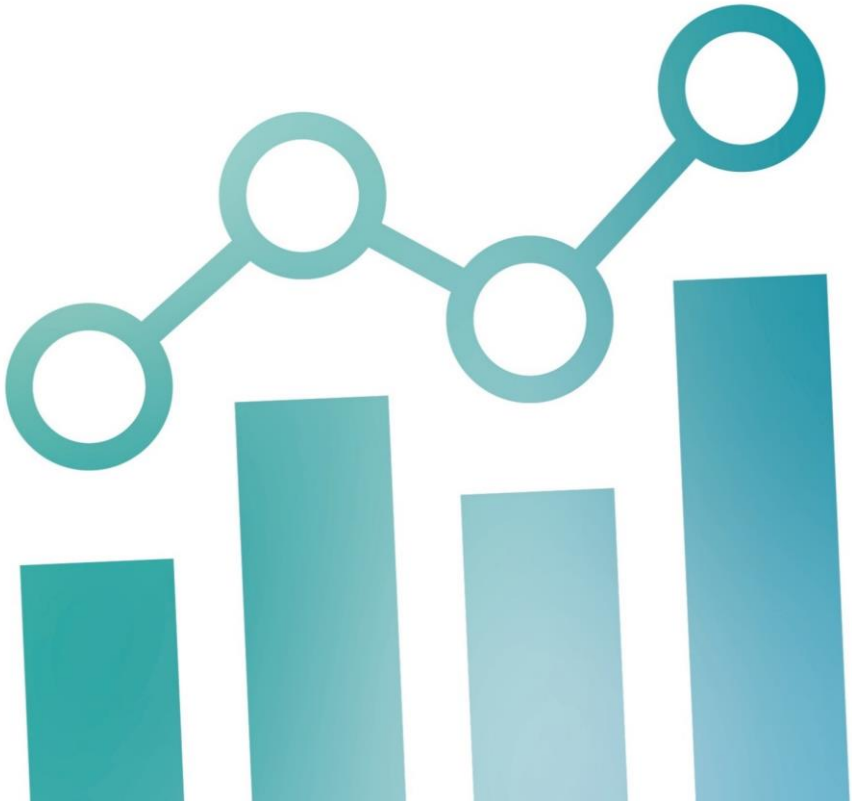
Appendices: Appendix 1: Audit Scotland – Annual Audit Plan 2021/22

Background Papers: None

Localities Affected: All

West Dunbartonshire Integration Joint Board

Annual Audit Plan 2021/22



AUDIT SCOTLAND

Prepared for West Dunbartonshire Integration Joint Board
February 2022

Contents

Introduction

Summary of planned audit work

1. This document summarises the work plan for our 2021/22 external audit of West Dunbartonshire Integration Joint Board (the Joint Board). The main elements of our work include:

- an audit of the 2021/22 annual accounts to support our opinions on the financial statements
- work to support out onions on the statutory other information published within the annual accounts including the Management Commentary, the Governance Statement, and the Remuneration Report
- consideration of arrangements in relation to the audit dimensions: financial management, financial sustainability, governance and transparency and value for money that frame the wider scope of public sector audit
- consideration of Best Value arrangements
- review the Joint Board's arrangements for preparing and publishing its Annual Performance Report

Impact of Covid-19

2. The coronavirus (Covid-19) pandemic has had a significant impact on public services and public finances, and the effects will be felt well into the future.

3. The Auditor General for Scotland, the Accounts Commission and Audit Scotland continue to assess the risks to public services and finances from Covid-19 across the full range of our audit work, including annual audits and the programme of performance audits. The well-being of audit teams and the delivery of high-quality audits remain paramount. Changes in our approach may be necessary and where this impacts on annual audits, revisions to this Annual Audit Plan may be required. Any such changes will be communicated to the Joint Board at the earliest opportunity.

Adding value

4. We aim to add value to the Joint Board through our external audit work by being constructive and forward looking, by identifying areas for improvement and by recommending and encouraging good practice. In so doing, we will help the Joint Board promote improved standards of governance, better management and decision making and more effective use of resources. Additionally, we attend

meetings of the Joint Board, and the Audit and Performance Committee, and actively participate in discussions where appropriate.

Respective responsibilities of the auditor and Joint Board

5. The Code of Audit Practice (2016) sets out in detail the respective responsibilities of the auditor, the Joint Board, Chief Officer and Chief Financial Officer. Key responsibilities are summarised below.

Auditor responsibilities

6. Our responsibilities as independent auditors are established by the Local Government (Scotland) Act 1973 and the Code of Audit Practice (including supplementary guidance) and guided by the Financial Reporting Council's Ethical Standard.

7. Auditors in the public sector give an independent opinion on the financial statements and other information within the annual accounts. We also review and report on the arrangements within the Joint Board to manage its performance and use of resources. In doing this, we aim to support improvement and accountability.

The Joint Board, Chief Officer and Chief Financial Officer responsibilities

8. The above are responsible for maintaining accounting records and preparing annual accounts that give a true and fair view.

9. Also, they have the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enable them to deliver their objectives.

10. The audit of the annual accounts does not relieve management or the Joint Board of their responsibilities.

Managing the transition to 2022/23 audits

11. Audit appointments are usually for five years but were extended to six years due to Covid-19. 2021/22 is the final year of the current appointment and we will work closely with our successors to ensure a well-managed transition.

Annual accounts audit planning

Materiality

12. Materiality is an expression of the relative significance of a matter in the context of the annual accounts as a whole. We are required to plan our audit to determine with reasonable confidence whether the annual accounts are free from material misstatement. The assessment of what is material is a matter of professional judgement over both the amount and the nature of the misstatement.

Materiality levels for the 2021/22 audit

13. We assess materiality at different levels as described in Exhibit 1. The materiality values for the Joint Board are set out in Exhibit 1.

Exhibit 1
2021/22 Materiality levels for the Joint Board

Materiality	Amount
Planning materiality – This is the figure we calculate to assess the overall impact of audit adjustments on the financial statements. It has been set at 1.5% of gross expenditure for the year ended 31 March 2022 based on the latest audited financial statements for 2020/21.	£3.377 million
Performance materiality – This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality, this would indicate that further audit procedures should be considered. Using our professional judgement, we have assessed performance materiality at 70% of planning materiality.	£2.364 million
Reporting threshold (ie clearly trivial) – We are required to report to those charged with governance on all unadjusted misstatements more than the 'reporting threshold' amount.	£0.100 million

Source: Audit Scotland

Significant risks of material misstatement to the annual accounts

14. Our risk assessment draws on our cumulative knowledge of Joint Board its major transaction streams, key systems of internal control and risk management

processes. Also, it is informed by our discussions with management, meetings with internal audit, attendance at committees and a review of other relevant information.

15. Based on our risk assessment process, we identified the following significant risk of material misstatement to the annual accounts. This risk has the greatest impact on our planned audit procedures. Exhibit 2 summarises the nature of the risk, the sources of assurance from management arrangements and the further audit procedures we plan to perform to gain assurance over the risk.

Exhibit 2
2021/22 Significant risk of material misstatement to the annual accounts

Significant risk of material misstatement	Sources of management assurance	Planned audit response
1. Risk of material misstatement due to fraud caused by the management override of controls As stated in International Standard on Auditing (UK) 240, management is in a unique position to perpetrate fraud because of management's ability to override controls that otherwise appear to be operating effectively.	• Owing to the nature of this risk, assurances from management are not applicable in this instance	• Assurance will be obtained from the auditors of NHS Greater Glasgow and Clyde and West Dunbartonshire Council over the completeness, accuracy and allocation of income and expenditure. • We will consider any unusual material transactions identified through our audit testing for any evidence of management override of controls.
2. Hospital acute services (set-aside) The "set-aside" is the Joint Board's share of the delegated acute services provided by NHSGGC hospitals on behalf of the Joint Boards. It reflects actual cost and activity data. In 2020/21, audit testing identified a material error in the IJB's set-aside figure. This error was due to a change in the formatting of the central Health Board spreadsheet. The accounts were amended to show the correct figures. Due to the	• Working papers to be provided to support the calculation of the 2021/22 set aside figure for the IJB.	• Review and testing of the calculation of the set aside figure in the accounts.

Significant risk of material misstatement	Sources of management assurance	Planned audit response
error, this will be an area for audit focus in 2021/22.		

Source: Audit Scotland

16. Based on our assessment of the likelihood and magnitude of risk, we have assessed that there are currently no other risks of material misstatement for the 2021/22 audit of West Dunbartonshire Integration Joint Board. We will keep this under review as the audit progresses. If our assessment of risk changes and we consider risks identified to be significant, we will communicate this to management and those charged with governance and revise our planned audit approach accordingly.

Consideration of the risks of fraud in the recognition of income and expenditure

17. As set out in International Standard on Auditing (UK) 240*: The auditor's responsibilities relating to fraud in an audit of financial statement*, there is a presumed risk of fraud over the recognition of income. We must consider the risk that income may be misstated due to fraud, resulting in a material misstatement in the annual accounts. We have rebutted this risk for the Joint Board on the basis that it is almost wholly funded by NHS Greater Glasgow and Clyde and West Dunbartonshire Council. We have assessed that the risk of material misstatement arising from fraud over the Joint Board's income streams to be limited. This limitation is to such an extent we have excluded the risk of fraud over income from our significant audit risks.

18. In line with Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom*, as most public-sector bodies are net expenditure bodies, the risk of fraud is more likely to occur in expenditure. We have rebutted the risk of material misstatement caused by fraud in expenditure in 2021/22 as we do not consider this to be a significant risk for the Joint Board. This is on the basis that all transactions are processed by the partner bodies rather than the Joint Board directly, and that all expenditure is undertaken by the partners which are public sector bodies.

19. We have not, therefore, incorporated specific work into our audit plan in these areas over and above our standard audit procedures. Our audit testing will maintain an oversight of any unusual transactions or accounting entries.

Audit risk assessment process

20. Audit risk assessment is an iterative and dynamic process. Our assessment of risks set out in this plan may change as more information and evidence becomes available during the progress of the audit. Where such changes occur, we will advise management and where relevant, report them to those charged with governance.

Audit dimensions and Best Value

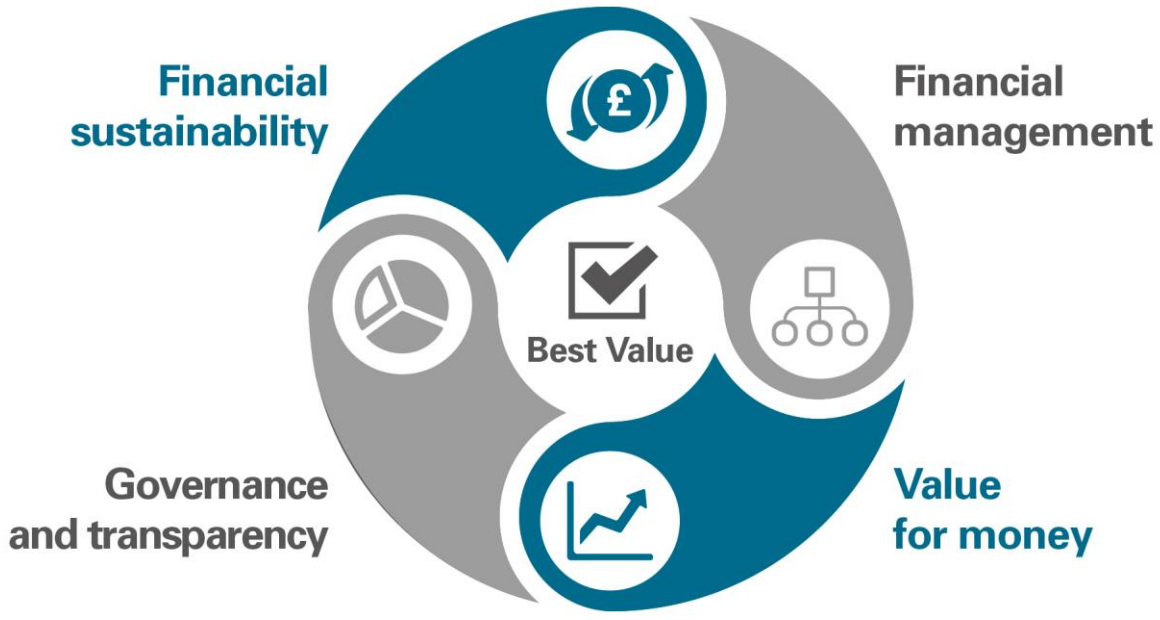
Introduction

21. The Code of Audit Practice sets out the four dimensions that frame the wider scope of public sector audit. The Code of Audit Practice requires auditors to consider the adequacy of the arrangements in place for the audit dimensions in audited bodies.

Audit dimensions

22. The four dimensions that frame our audit work are shown in Exhibit 3.

Exhibit 3
Audit dimensions



Source: Code of Audit Practice

23. In summary, the four dimensions cover the following:

- **Financial management** – financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively.
- **Financial sustainability** – as auditors, we consider the appropriateness of the use of the going concern basis of accounting as part of the annual

audit. We will also comment on financial sustainability in the longer term. We define this as medium term (two to five years) and longer term (longer than five years).

- **Governance and transparency** – governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership, and decision-making and transparent reporting of financial and performance information.

- **Value for money** – value for money refers to using resources effectively and continually improving services.

Best Value

24. The Joint Board has a statutory duty to make arrangements to secure Best Value. We will consider and report, where necessary, on these arrangements.

Audit dimension risks

25. We have identified audit risks in the areas set out in Exhibit 4. This exhibit sets out the risks, sources of assurance from management arrangements and the further audit procedures we plan to perform to gain assurances over the risks. Conclusions from this work will be reported in our 2021/22 Annual Audit Report.

Exhibit 4
2021/22 Audit dimension risks

Audit dimension risk	Sources of management assurance	Planned audit response
1. Planning for financial sustainability There remains uncertainty around financial sustainability as the wider impact of Covid-19 is not yet known. The IJB's medium-term financial plan was last updated prior to the onset of the Covid-19 pandemic in March 2020**.** Further updates were delayed as a result of its impact. **Risk**: Without a revised financial plan, the Joint Board may not effectively plan the financial sustainability of its service.	• Regular monitoring and reporting to the Integration Joint Board on the financial position.	• Monitor progress in developing a revised medium-term financial plan. • Assess the revised financial plan and conclude whether this includes appropriate scenario planning to address identified budget gaps and service pressures. • Consider budget monitoring reports, including progress in realising efficiency savings • Review of the Joint Board's year-end reserves position, including the earmarking of reserves.

Audit dimension risk	Sources of management assurance	Planned audit response
2. Service pressures The Covid-19 pandemic continues to place significant pressure on health and social care services commissioned by all Joint Boards and delivered by its partners. Unprecedented demand reflects the significant backlog of service users and patients seeking health and social care services. As a result, some key performance targets, for example in delayed discharges, have not been met. **Risk:** Covid-19 pressures may exceed the Joint Board's commissioning ability and also each partner's ability to meet the levels of service user and patient demand in West Dunbartonshire.	• Quarterly performance monitoring reports to the Joint Board and the Performance and Audit Sub-Committee. • Review of progress against the Joint Board's Covid-19 recovery and renewal plan.	• Review progress against strategic objectives reported within the Joint Board's Annual Performance Report. • Review quarterly performance reports to assess the extent the Board is meeting service performance targets. • Monitor progress in development of operational delivery and improvements plans which reflect learning from the pandemic and the shift to the balance of care.
3. Workforce sustainability An appropriately resourced and skilled workforce is fundamental to the Joint Board's ability to meet service demands. In common with other health and social care bodies, the Joint Board is facing significant workforce pressures. This is due to a combination of unfilled vacancies in both health and social care, but also high levels of staff absence due to the direct impact of Covid-19, or increasingly, wellbeing issues and individual health concerns that may have been exacerbated during the pandemic. **Risk:** The Joint Board is unable to sustain services due	• The Joint Board recognises the risk faced by heightened workforce pressures and is seeking ways to address these challenges and enhance staffing levels.	• Monitor reports taken to the Joint Board and Audit and Performance Committee in respect of workforce sustainability. • Review financial monitoring and performance reports to identify issues arising due to workforce sustainability.

Audit dimension risk	Sources of management assurance	Planned audit response
to significant workforce pressures.		
4. Governance arrangements It is essential that the Board provides effective scrutiny and oversight of the IJB's operations. We observed the most recent Board meeting. It was a very short meeting and, in our opinion, provided limited opportunities for members to discuss and scrutinise the agenda items. **Risk:** Meetings of the Joint Board do not provide adequate opportunity for members to scrutinise and challenge decisions.	• Effective scrutiny and oversight at Board discussions.	• We will continue to attend Board meetings to assess if effective governance is demonstrated.
5. Integration scheme It is a statutory requirement that the local authority and health board carry out a review of the integration scheme within five years of the establishment of the IJB. While a revised scheme was considered by the Joint Board in February 2020, this has not been subject to approval by the health board or Scottish Ministers. When approved, changes to the integration scheme will need to be reflected in the Joint Board's standing orders. **Risk:** The Integration Scheme and Standing Orders do not reflect the current operation of the Joint Board.	• Engagement with partner bodies to seek approval and implementation of the revised integration scheme	• Monitor progress in the approval and implementation of the revised integration scheme. • Review updated standing orders and assess whether they accurately reflect the terms of the revised integration scheme.

Source: Audit Scotland

Reporting arrangements, timetable, and audit fee

Reporting arrangements

26. Audit reporting is the visible output for the annual audit. All Annual Audit Plans and the outputs, as detailed in Exhibit 5, and any other outputs on matters of public interest will be published on our website: www.audit-scotland.gov.uk.

27. Matters arising from our audit will be reported on a timely basis and will include agreed action plans. Draft management reports will be issued to the relevant officers to confirm factual accuracy.

28. We will provide an independent auditor's report to the Joint Board and the Accounts Commission setting out our opinions on the annual accounts. We will provide the Joint Board and the Accounts Commission with an annual report on the audit containing observations and recommendations on significant matters which have arisen during the audit.

29. Exhibit 5 outlines the target dates for our audit outputs, and we aim to issue the independent auditor's report by the statutory deadline of 31 October 2022. We acknowledge this will be challenging due to the ongoing pressures and uncertainties caused by Covid-19.

Exhibit 5
2020/21 Audit outputs

Audit Output	Target date	Audit and Performance Committee Date
Annual Audit Plan	07/03/2022	07/03/2022
Independent Auditor's Report	31/10/2022	TBC
Annual Audit Report	31/10/2022	TBC

Source: Audit Scotland

Timetable

30. To support an efficient audit, it is critical that the timetable for producing the annual report and accounts for audit is achieved. We have included a proposed timetable for the audit at Exhibit 6 that has been discussed with management.

31. Covid-19 has had a considerable impact on the conduct and timeliness of the audit. We recognise that it is in the best interests of public accountability to get the reporting of audited accounts back to pre-pandemic timelines. To this end, 2021/22 is a transition year with the reporting deadline brought forward by one month relative to the two prior years. We are identifying ways to work more efficiently to expedite the 2021/22 audits whilst at the same time maintaining high standards of quality.

32. We will continue to work in close partnership with management with clarity over timescales and the requirement for high quality unaudited accounts and supporting working papers. Progress will be discussed with management and finance officers over the course of the audit.

Exhibit 6
Proposed annual report and accounts timetable

Key stage	Provisional Date
Consideration of the unaudited annual accounts by those charged with governance	20/06/2022
Latest submission date for the receipt of the unaudited annual accounts with complete working papers package.	By 30/06/2022
Latest date for final clearance meeting with the Chief Financial Officer	Date TBC
Issue of Letter of Representation and proposed Independent Auditor's Report	Date TBC
Agreement of audited and unsigned annual accounts	Date TBC
Issue of Annual Audit Report to those charged with governance.	Date TBC
Signed Independent Auditor's Report	By 31/10/2022

Source: Audit Scotland

Audit fee

33. The proposed audit fee for the 2021/22 audit of the Joint Board is £27,960 (2020/21: £27,330). In determining the audit fee, we have taken account of the risk exposure of the Joint Board, the planned management assurances in place and the level of reliance we plan to take from the work of internal audit.

34. Where our audit cannot proceed as planned through, for example, late receipt of unaudited annual accounts, the absence of adequate supporting working papers or being unable to take planned reliance from the work of internal audit, a supplementary fee may be levied. An additional fee may also be required in relation to any work or other significant exercises out with our planned audit activity.

Other matters

Internal audit

35. International standards on Auditing (UK) 610: *Considering the work of internal audit r*equires us to:

- consider the activities of internal audit and their effect on external audit procedures;
- obtain an understanding of internal audit activities to inform our planning and develop an effective audit approach that avoids duplication of effort;
- perform a preliminary assessment of the internal audit function when there is scope for relying on internal audit work which is relevant to our financial statements' responsibilities; and
- evaluate and test the work of internal audit, where use is made of that work for our financial statements responsibilities to confirm its adequacy for our purposes.

36. The Joint Board's internal audit function is provided by the West Dunbartonshire Council Internal Audit team. We have reviewed the Joint Board's internal audit function and They found that the internal audit services operate in accordance with Public Sector Internal Audit Standards and have sound documentation standards and reporting procedures in place.

37. From our initial review of the internal audit plan, we do not plan to place formal reliance on internal audit's work for our financial statements' responsibilities. We may consider aspects of internal audit's work in respect of our wider audit dimension responsibilities.

Independence and objectivity

38. Auditors appointed by the Auditor General for Scotland or Accounts Commission must comply with the Code of Audit Practice and relevant supporting guidance. When auditing the financial statements, auditors must also comply with professional standards issued by the Financial Reporting Council and those of the professional accountancy bodies. These standards impose stringent rules to ensure the independence and objectivity of auditors. Audit Scotland has robust arrangements in place to ensure compliance with these standards including an annual *'fit and proper'* declaration for all members of staff. The arrangements are overseen by the Director of Audit Services, who serves as Audit Scotland's Ethics Partner.

39. The engagement lead (i.e. appointed auditor) for the Joint Board is Fiona Mitchell-Knight, Audit Director. Auditing and ethical standards require the

appointed auditor to communicate any relationships that may affect the independence and objectivity of audit staff. We are not aware of any such relationships pertaining to the audit of the Joint Board.

Quality control

40. International Standard on Quality Control (UK) 1 (ISQC1) requires a system of quality control to be established, as part of financial audit procedures, to provide reasonable assurance that professional standards and regulatory and legal requirements are being complied with and that the independent auditor's report or opinion is appropriate in the circumstances.

41. The foundation of our quality framework is our Audit Guide, which incorporates the application of professional auditing, quality and ethical standards and the Code of Audit Practice (and supporting guidance) issued by Audit Scotland and approved by the Auditor General for Scotland. To ensure that we achieve the required quality standards, Audit Scotland conducts peer reviews and internal quality reviews. Additionally, the Institute of Chartered Accountants of Scotland (ICAS) have been commissioned to carry out external quality reviews.

42. As part of our commitment to quality and continuous improvement, Audit Scotland will periodically seek your views on the quality of our service provision. We welcome feedback at any time, and this may be directed to the engagement lead.

West Dunbartonshire Integration Joint Board

Annual Audit Plan 2021/22

Audit Scotland's published material is available for download on the website in a number of formats. For information on our accessibility principles, please visit:
www.audit-scotland.gov.uk/accessibility

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AS.4.0

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP AUDIT AND PERFORMANCE COMMITTEE

Report by Head of Children's Health, Care and Justice Services

HSCP Audit and Performance Committee: 7 March 2022

Subject: Inspection of Fostering Services in West Dunbartonshire

1. Purpose

1.1 To provide an update to committee on the recent inspection of Fostering Services in West Dunbartonshire

2. Recommendations

2.1 To note the contents of this report and the improvement plan in appendix 1.

3. Background

3.1 West Dunbartonshire Council Fostering Service provides a fostering service for children and young people in the local authority area. At the time of the inspection 43 fostering families were looking after 60 children and young people.

3.2. The service recruits, assesses and supports fostering families in the West Dunbartonshire local authority area to provide care to children and young people in need of such a service. The methodology of the inspection was slightly altered in line with guidance and regulation in relation to pandemic.

3.3 The inspections evaluated three key areas across the Fostering Service:

- How well do we support people's wellbeing;
- How good is our leadership;
- How well is our care and support planned?

4. Main Issues

4.1 The Care inspectorate assessed that relationships between children and their caregiver families were positive, caring and lasting. Carers spoke respectfully about children's families and fondly about the children and young people in their care.

4.2 It was assessed that children and young people were helped to understand their rights and the Care inspectorate heard how even very young children could access advocacy services to support their views being heard. This

meant that children and young people experienced respectful, compassionate relationships in their living situations.

4.3 Inspectors recognised that children needed to feel safe and protected from abuse or harm. However gaps in training and records for foster carers around child protection was an identified concern in addition to the frequency of visiting for some children by social workers.

4.4 Relationships with professionals for children and young people were not maintained as well as they could be. Social workers changed due to the structure of the local authority. For example, in most situations social workers changed at the age of 12 and if there were plans to move to a permanent fostering situation, a different supervising social worker was allocated.

4.5 The inspection identified a lack of evidence of self-evaluation and management oversight of key systems and processes and is an area for significant improvement. A lack of independent chairing contributed to lack of independent oversight, scrutiny and challenge. Inspection noted that support of an administrator would help the service strengthen system and process to ensure consistency and afford the oversight required. Clarity of the aims and objectives of the service that is both understood by staff and carers requires to be further developed.

4.6 The lack of evidence of clear planning or clarity about the Child's Plan is an identified area for improvement. It was understood that most children knew they had a Child's Plan but most did not know if or how they could access this. In addition there was little evidence of children's views being sought or considered in their plan.

4.7 The Care inspectorate assessed that relationships between children and their caregiver families were positive, caring and lasting. Carers spoke respectfully about children's families and fondly about the children and young people in their care. Children and young people were helped to understand their rights and the Care inspectorate heard how even very young children could access advocacy services to support their views being heard. This meant that children and young people experienced respectful, compassionate relationships in their living situations.

4.8 Inspectors recognised that children needed to feel safe and protected from abuse or harm. However gaps in training and records for foster carers around child protection was an identified concern in addition to the frequency of visiting for some children by social workers.

4.9 Relationships with professionals for children and young people were not maintained as well as they could be. Social workers changed due to the structure of the local authority. For example, in most situations social workers changed at the age of 12 and if there were plans to move to a permanent fostering situation, a different supervising social worker was allocated.

4.10 The inspection identified a lack of evidence of self-evaluation and management oversight of key systems and processes and is an area for significant improvement. A lack of independent chairing contributed to lack of independent oversight, scrutiny and challenge. Inspection noted that support of an administrator would help the service strengthen system and process to ensure consistency and afford the oversight required. Clarity of the aims and objectives of the service that is both understood by staff and carers requires to be further developed.

4.11 The lack of evidence of clear planning or clarity about the Child's Plan is an identified area for improvement. It was understood that most children knew they had a Child's Plan but most did not know if or how they could access this. In addition there was little evidence of children's views being sought or considered in their plan.

4.12 The regular lack of a minute of discussion of planning meetings, such as Looked After Children reviews meant that planning was not transparent and was unclear how the view of children had been considered.

5. Options Appraisal

No options appraisal has been carried out. The service is a statutory regulated services as such requires to deliver the identified requirements.

6. Improvement Activity

The service has implemented some immediate actions as detailed in this briefing. This has included actions around training for carers in Child protection and updated provision in the carer's handbook is now subject to a full refresh.

6.1 The service is seeking to enhance all current permanence tracking processes and will build on areas that can improve our understanding of the planning processes for children in our care.

6.2 The Family Placement team have met as a whole service and have commenced actions around provision that will seek to make clear our aims and objectives. The manager of the service is reviewing current processes and systems and identifying key measures and data sets to be implemented to ensure oversight of service is taken forward at pace. The service has also began to explore how we could improve our internal recording of processes and events. This may require further business support as current administration support has been identified as being an essential ingredient in ensuring the necessary oversight required for the service and will form part of a review of business support within the service.

6.3 An improvement plan has been developed for fostering services attached in Appendix 1. Support from the HSCP's Strategy and Transformation team has helped to ensure the action plan is SMART and actions and desired outcome

are clear, with priority actions being taken to satisfy the requirements as specified. Senior manager across the wider children services system are working closely to ensure that improvement in timescales and permanency planning with clear and visible care plans in place for Looked After children.

6.4 Significantly the Inspection team have identified lack of independent scrutiny of chairs, lack of minute taking for children meetings and review and lack of management and support of processes, oversight and data as requiring significant action and resource implication may require to be considered to meet the requirements laid out.

6.5 The lack of a clear continuing care policy has resulted in young people with care placement s who are 18 years or over with continuing care relationships not being fully recognised in relation to their right to sustained support and this is under development by the Senior Manager for the service.

6.6 How well do we support people's wellbeing? - Weak

Requirement

1. By 30 April 2022, the provider must ensure that all foster care families understand their role in relation to protecting the children and young people in their care.

2. By 30 April 2022, the provider must ensure that all children in need of permanent foster care have their assessments completed and plans carried out without unnecessary delay.

3. The provider must take steps to support young people to remain with their foster carers post 18 years.

6.7 How good is our Leadership? – Weak

Requirement

1. By 30 April 2022, the provider must ensure the management vision for the service is communicated and that appropriate systems are in place to support quality assurance and improvement within the service.

6.8 How well is our care and support planned? – Adequate

Requirement

1. By 30 April 2022, the provider must ensure a clear, outcome focussed child's plan is in place and accessible to children using the fostering service.

7. Options Appraisal

7.1 Not required.

8. People Implications

8.1 A review of chairing arrangements for children's statutory meetings is part of improvement planning, as is review of exiting business support function around the recording of meetings to ensure decisions and progress of planning is effectively recorded.

8.2 This may have people implication in relation to resourcing to support deliverables in these key areas.

9. Financial and Procurement Implications

9.1 Any Financial implications will be determined following the review activity detailed in 6.1.

10. Risk Analysis

10.1 Failure to deliver on the requirement and improvement areas identified within this report could result in statutory functions not being adequately fulfilled and cause reputational damage to the HSCP and wider Council**.**

11. Equalities Impact Assessment (EIA)

11.1 No equalities impact assessment required at this time.

12. Environmental Sustainability

12.1 No current issues.

13. Consultation

13.1 No formal consultation is required at present.

14. Strategic Assessment

14.1 No strategic assessment is currently required.

Name	Lesley James
Designation	Head of Children's Health, Care and Justice Services Chief Social Work Officer
Date	9th February 2022

Person to Contact	Lesley James Lesley.james@west-dunbarton.gov.uk
Appendices:	Appendix 1 – Action Plan
Background Papers	No background papers.

17/02/2022

Fostering Improvement Plan

Theme 1 – How well do we support people's wellbeing
Requirements (3)

Complete		Progressing Adequately		Not Meeting Timescales	
Outcomes for this Theme	**Actions to Achieve Outcomes**	**Lead and Governance Reporting**	**Implementation by When**	**Implementation Progress RAG**	**Measures**
Requirement 0ne By 30th April 2022, the provider must ensure that all foster care families understand their role in relation to protecting the children and young people in their care**.** As shown in A & B below.	Training on Child protection to be carried out for all WDC carers. This to be progressed as mandatory training and reviewed yearly. Handbook for carers to be updated.	**Paul Kyle,** **Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber** **(see below)**	All Carers will have completed this training programme and the progression of the mandatory component is built in to the yearly review process. Carers will have a handbook to reference requirements.
A) All foster carers attend training in child protection	Carers advised of requirement for training. Trainers selected and training plan being developed. Dates schedule being co-ordinated through business support. Training scheduled March/April 2022, with day and evening sessions to accommodate carer's needs.				

	Training to move to mandatory for all carers and will be evaluated at each foster care review beyond April 2022 and a record of training to be established for each carer. To be co-ordinated around the yearly FC review.				
B) The fostering handbook including information about child protection has been received by all foster carers	Working group established to develop handbook. To be progressed onto an electronic format for carers and built in yearly reviews to be set by the working group to ensure the handbook is maintained at an operational level.				
Requirement Two By the 30th April 2022, the provider must ensure that all children in need of permanent foster care have their assessments completed and plans carried out without unnecessary delay. As shown in A, B and C below.	That each child in need of permanent care is identified and that there is a plan in place for each child to ensure that there is no drift within the care plans.	**Paul Kyle,** **Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber** **(see below)**	Children in need of permanence will have been identified by the management team and there will be an agreed plan in place to ensure each child's circumstances are fully considered. There will be operational procedures to help guide and support manager's reflections on all aspects of the child's journey within the permanence process and that any resource implications are understood and addressed. Children's plans will be progressed without unnecessary delay.

a) All children in need of permanent fostering have their plans reviewed by managers.	Spreadsheet created from CAREFIRST. All children identified as in need of permanence have been scoped by the family placement team and these require to be discussed with fieldwork services to enable our ambitions in reaching this requirement. Senior Managers meeting set up for 7th March 2022 to align tasks to working groups.				
b) Managers maintain an overview of all timescales taken when planning for children in need of permanent foster care and address and resource any delays.	Working groups to be established following the Senior managers meeting on the 7th march 2022. As a minimum expectation there will a revisiting of permanence processes, considering the learning from the PACE programme and the implementation of renewed management procedures that will evaluate timescales and				

	enable positive managerial intervention to support any delay in permanence.				
c) Assessments are carried out within timescales.	An evaluation of all children who have a permanence plan will enable positive action around any drift identified and plans modified to ensure agreed timescales are maintained. Working group around this to be set at the Senior managers meeting on 7th march 2022.				
Requirement Three By the 30th April 2022, the provider must take steps to support young people to remain with their foster carers post 18 years. As shown in A, B and C below.	That all young people post 18 years of age will benefit from the right to remain in their existing placement and there will be continuing care processes in place that reflect this need. That their carers will benefit from support, advice and training surrounding their extended care as adults.	**Paul Kyle,** **Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber** **(see below)**	Young people will be able to remain in their existing placements beyond 17 years, in line with continuing care legislation. Carers will be confident in their ability to meet the growing needs of those young adult that they offer care too. That there is clear assessment processes and local guidance/policy in place to meet this expectation.
a) They decide how best to assess, train and approve foster carers as adult placement carers.	Senior Managers meeting set up for 7th March 2022 to align tasks to working groups. Training around provision for young adults within				

	Foster care and residential care will be considered by this workstream.				
b) How best to assess young people to ensure that continuing care is in their best interests.	Working group to be re-established to generate policy/guidance documents and create training requirements across the staff and carers groups. Senior Managers meeting set up for 7th March 2022 to align tasks to working groups.				
c) Any action is in line with regulations on continuing care.	Working group to be re-established to generate policy/guidance documents and create training requirements across the staff and carers groups. Kinship care to be scoped within this workstream. Senior Managers meeting set up for 7th March 2022 to align tasks to working groups.				

Theme 2 – How good is our leadership *Requirements (1)*					
Complete		**Progressing Adequately**		**Not Meeting Timescales**	
Outcomes for this Theme	**Actions to Achieve Outcomes**	**Lead and Governance Reporting**	**Implementation by When**	**Implementation Progress RAG**	**Measures**
Requirement One By 31st April 2022, the provider must ensure that management vision for the service is communicated and that appropriate systems are in place to support quality assurance and improvement within the service. As shown in A, B and C below.	Develop clear aims an objectives for the service. Develop key management systems to ensure appropriate oversight of key systems, processes and events. Create appropriate independent scrutiny to ensure professional challenge to the service aimed at improving practice.	**Paul Kyle,** **Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber** **(see below)**	The service will have a clear statement around the service aims and objectives. Management systems will be robust, clear and understandable – enabling the service to utilise data to reflect service developments. Key, independent scrutiny will be in place.
a) A statement of aims and objectives is developed detailing what the service aims to provide and how.	The fostering service has commenced activity around evaluating the service objectives and that these will be upgraded to reflect what the service provides and how this is carried out. Benchmarking/networking with other local authorities has commenced.				
b) **Management systems are developed to ensure**	Interrogation of our current systems within the context of the fostering team has commenced, with local				

	appropriate oversight of key systems, processes and events.	systems being re-aligned and updated where required. This will provide a significant emphasis on the oversight arrangements for managers. Appropriate, independent scrutiny will be considered as part of the need to offer independent support to foster carer reviews and the recruitment of same within our formal panel process. Above areas will be actioned within the Family placement management team in conjunction with the HOS. Consideration into other models has commenced, with formal links have been made with other council's to consider models and approaches to reaching this outcome.				
c)	**Appropriate independent scrutiny is in place to ensure**	The findings of the working group will be presented to SMT via a management report, highlighting current				

professional challenge to the service aimed at improving practice.	provision and any challenges noted to allow appropriate scrutiny across the service to take place.				

Theme 3 – How well is our care and support planned
Requirements (1)

Complete		**Progressing Adequately**		**Not Meeting Timescales**	
Outcomes for this Theme	**Actions to Achieve Outcomes**	**Lead / Governance Reporting**	**Implementation by When**	**Implementation Progress RAG**	**Measures**
Requirement One By 31st April 2022, the provider must ensure a clear, outcome focused plan is in place and accessible to children using the fostering service. As shown in A, B, C, D, E and F below.	An audit of all children in foster care to be carried out to ensure that each child has an up to date child's plan in place and that this is outcome focused (SMART) around their needs. An audit of the contribution and voice of the child. Ensuring that minutes are containing these views. Ensure that there is a monitoring process in place to review and build upon each child's plan and that	**Paul Kyle,** **Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber** **(see below)**	Procedures will be in place to ensure that child's plans are carried out timeously, that these are reviewed within agreed timescales using GIRFEC principles. That plans and minutes of review meetings are reflective of the child's voice. That each child is aware of the advocacy support that is available to them and that their meetings will be independently supported. That all plans are SMART and that these are appropriately recorded and sent to care providers and children/young people without delay.

	this has professional, independent scrutiny in place. Ensure that each care provider and child/young person has access to this plan. An audit of our LAAC processes, ensuring these meet GIRFEC principles.				There will be reporting methodology in place to ensure that LAAC processes are met within agreed timeframes and that managers will gain business reports on delays across all children/young people.
a) **An audit of childs' plans is undertaken to ensure they are outcome focused and SMART**.	Senior Managers meeting set up for 7th March 2022 to align tasks to working groups and agree key individuals for workstream. Work group to be established to consider all aspects of our LAAC processes, including refresh on our procedures to ensure that they meet agency standards and can meet the expectations of a SMART outcome focused plan. To include our learning from the PACE programme. Audit of names have been identified by the fostering manager. This will allow us to consider areas surrounding care plans, the LAAC processes, the child's voice and oversight of the				

	processes that surround this. An evaluation of the business support model is required to meet the expectations surrounding the recording of associated meetings and reviews.				
b) The role of the fostering service is well articulated in the plan.	To be addressed via workgroup.				
c) A copy of the Child's Plan and any updates are received by foster carers.	Process to be addressed via workgroup.				
d) The format of the Child's Plan is accessible to children in foster care who wish a copy.	Process to be addressed via workgroup.				
e) The views of children and carers is contained within the minutes of planning meetings.	Process to be addressed via workgroup			.	
f) Appropriate independent scrutiny is in place to ensure professional	The findings of the working group will be presented to SMT via a management report, highlighting current provision and any				

challenge to the service aimed at improving practice.	challenges noted to allow appropriate scrutiny across the service to take place.				

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP AUDIT AND PERFORMANCE COMMITTEE

Report by Head of Children's Health, Care and Justice Services

HSCP Audit and Performance Committee: 7 March 2022

Subject: Inspection of Adoption Services in West Dunbartonshire

1. Purpose

1.1 To provide Committee with the findings of the most recent Care Inspectorate inspection of Adoption Services in West Dunbartonshire.

2. Recommendations

2.1 To request that Committee notes the content of the report and the improvement plan contained in appendix 1 which will take forward both the stated requirements and the areas for further improvement within the service

3. Background.

3.1 West Dunbartonshire Council Adoption Agency provides a service for children and young people aged from birth to 18 years and their families.

3.2 The service recruits and supports adoptive parents to provide families for. Those children who cannot be with their birth parents or extended family members, and whose needs have been assessed as best met in an adoptive family.

3.3 The service covers the West Dunbartonshire Council area working co-operatively with neighbouring local authorities and approved voluntary agencies in providing placements and seeking placements for children.

3.4 The methodology of the inspection was slightly altered in line with guidance and regulations in relation to the pandemic.

3.5 The inspections evaluated three key areas across the Adoption Service:

- How well do we support people's wellbeing;
- How good is our leadership;
- How well is our care and support planned?

4. Main Issues

4.1 Care Inspectorate Findings

The Care Inspectorate identified there was some oversight of who was completing the training and feedback from training did not appear to be robustly scrutinised.

4.2 There was evidence of a good evaluation of the overall preparation group, however, this could be improved to be timelier and more targeted to ensure that parent's views are routinely sought and acted upon.

4.3 Adoption services assessment and support was robust; however, review of the services permanency process was of concern.

4.4 It was noted that West Dunbartonshire adoption service had completed considerable work with (Permanence and Care Excellence) PACE to improve since the last inspection which has resulted in the development of clearer procedures and changes to the process. However, there remained delays for children and data by the service did not affect the desired change.

4.5 Inspectors found evidence that planning was not actioned in a timely manner with delays in the completion of parenting assessments. Delays in achieving permanence, directly impacted on children's opportunity to move to a permanent or adoptive family.

4.6 The services approach to monitoring of key systems, processes and events did not occur in a holistic and systemic manner. There were positive examples of staff and senior management tracking and monitoring individual cases, however, the broader overview of statutory checks was not evidenced.

4.7 The professionalism of the senior staff on the adoption panel was evident and their efforts to take unbiased decisions. However, the provider should ensure that the panel has independent oversight, this would remove any unconscious bias and allow robust challenge of the service to occur.

4.8 Inspectors found that there was no overview of panel members training, additionally, there was no panel supervision or appraisals taking place. This impacts on the services ability to support panel members effectively.

4.9 There was no overview of adopter training which would allow the service to evaluate the provision of and uptake purchased or in-house training.

4.10 The Care Inspectorate saw examples of training opportunities for adoptive families, these were available at pre and post adoption stages with additional links to external agencies.

4.11 There was evidence of a good preparation group for adoption with observations from this linked into the assessment process. This continual process of assessment supported a holistic view of prospective adoptive parent's skills and readiness.

4.12 Children living with their adoptive families were engaged in age-appropriate a activities. The service supported families to access supports such as additional nursery hours.

4.13 Analysis of documentation supported staff inclusion of individual children's likes and dislikes, preferences and personality through the assessment, matching and moving stages of the adoption process. There were observations of positive relationships between children and their adoptive parents, with parents telling us about the supportive relationships they had with West Dunbartonshire staff.

4.14 The Care Inspectorate heard about young people moving with memory boxes to support them to understand their history and saw information shared with carers about how to talk with children about difficult subjects.

4.15 Adopters told inspectors that they had information through the service documentation to provide children with a narrative about their previous life experiences. Adoptive families were supported by the service to maintain links with previous carers ensuring continuity of relationships for children through their permanence journey.

4.16 All statutory checks were completed, and that assessments and references were of a high quality. Following placement with adoptive families supervising social workers, maintained links with families and adopters told us about strong and positive relationships with the service staff.

4.17 There were examples of the service financially supporting young people to remain in education through the extension of adoption allowances and the use of professional relationships to advocate for additional health supports.

4.18 Inspectors were impressed with the approach of the carers and adopters they met and read about to meet the needs of children in their care. Actions suggested that they understood early trauma and the impact this had on children and that they took steps to be calm and nurturing in their approaches.

4.19 The medical component of the preparation group for adopters was good with positive adaptations having taken place utilising technology to increase participant pre learning and support the session.

4.20 The adoption panel membership was broad with a range of voices across professional backgrounds. During the observed panel there was good evidence of appropriate questioning and challenge by the panel members and the panel chair.

4.21 A number of strengths in the staff approaches, individual case tracking and in the identification of areas to improve. We also experienced a service and management team who were open, insightful into the difficulties and keen to use the inspection as a form of audit to begin to build an improvement plan.

4.22 There was evidence of a service awareness of the concerns around permanence and improvements in the service in this area through the previous work with Permanence and Care Excellence programme (PACE).

Requirements on the Service:

How well do we support people's wellbeing? - Weak

Requirement
By 1 February 2022, the provider must improve the quality of permanence planning for children to promote stability in children's lives.

How good is our leadership? - Weak
Requirement
By 30 April 2022, the provider must ensure that the management vision for the service is communicated and that the appropriate systems are in place to support quality assurance and improvement within the service.

How well is our care and support planned? - Adequate
Requirement
By 30 April 2022, the provider must ensure a clear, outcome focused Child's Plan is in place with statutory timeframes recorded as part of the action planning.

5. Options Appraisal

No options appraisal has been varied out. The service is a statutory regulated services as such requires to deliver of the identified requirements.

6. Improvement Activity

6.1 The SMART Improvement plans is attached at appendix 1.

The service has implemented some immediate actions including around training oversight for adopters and consideration of the components of an adopter's handbook which was viewed as good practice.

6.2 The service is seeking to enhance all current permanence tracking processes and will build on areas that can improve our understanding of the planning processes for children in our care. This will include appraising our learning from the previous PACE programme and the benefits that that had made in understanding and responsiveness surrounding a child's permanence journey.

6.3 There is need to ensure the Adoption panel processes is clear and the senior manager/Chair is currently taking forward streamlining of processes. The need for an independent chair had previously been raised and this matter will be reviewed.

6.4 The Inspection team have identified lack of independent scrutiny of chairs, lack of minute taking for children's meetings and review and lack of management and support of processes, oversight and data as requiring significant action and resource implication may require to be considered to meet the requirements laid out.

6.5 A review of chairing arrangements for children's statutory meetings is part of the wider service improvement planning considerations improvement, as is review of exiting business support function around the recording of meetings to ensure decisions and progress of planning is effectively

7. People Implications

7.1 No current people implications.

8. Financial and Procurement Implications

8.1 Any Financial implications will be determined following the review activity detailed in 6.5

9. Risk Analysis

9.1 Failure to deliver on the requirement and improvement areas identified within this report could result in statutory functions not being adequately fulfilled and cause reputational damage to the HSCP and wider Council**.**

10 Equalities Impact Assessment (EIA)

10.1 There is no requirement to undertake and equalities as no proposed policy change.

11. Environmental Sustainability

11.1 No environmental sustainability issues at present.

12. Consultation

12.1 No formal consultation currently required.

13. Strategic Assessment

13.1 No strategic assessment currently required.

14. Directions

14.1 No Directions

Name	Lesley James
Designation	Head of Children's Health, Care and Justice Services Chief Social Work Officer
Date	9th February 2022
Person to Contact	Lesley James Lesley.james@west-dunbarton.gov.uk
Appendices:	Appendix 1 – Improvement Plan – To follow.
Background Papers	No background papers.

Adoption Improvement Plan

Theme 1 – How well do we support people's wellbeing *Requirements (1)*					
Complete		**Progressing Adequately**		**Not Meeting Timescales**	
Outcomes for this Theme	**Actions to Achieve Outcomes**	**Lead and Governance Reporting**	**Implementation by When**	**Implementation Progress RAG**	**Measures**
Requirement 0ne By 1 February 2022, the provider must improve the quality of permanence planning for children to promote stability in children's lives. **Extension agreed 30/04/2022** As shown in A & B below.	Develop a permanency aligned to permanency milestones and LAC regulations for all children who require a permanence plan.	**Paul Kyle, Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber**	There will be in place a monitoring procedure for all children where a decision for permanence has been reached. There will be reporting systems built in to enable management oversight of the progression of children's plans and any delays in the permanence process will be understood, with actions created to address identified problems.
a) Permanence is monitored in order to improve permanence decisions, timescales and outcomes for young people.	Revisit the permanence tracking process along with colleagues from fieldwork. Review all children who have a current permanence plan Senior managers meeting on the 7th march 2022 to determine the membership of ongoing scrutiny forum				

	Tracking process to be agreed and aligned to CAREFIRST team				
b) Where monitoring identifies drift and delay the provider must ensure that this is addressed with clear action planning across young people's plans.	Management scrutiny to be revisited and updated with actions around completion of those where drift and delay has occurred. Profile to be raised with any child's circumstances where it is deemed problematic to move circumstances forward.				

Theme 2 – How good is our leadership					
Requirements (1)					
Complete		**Progressing Adequately**		**Not Meeting Timescales**	
Outcomes for this Theme	**Actions to Achieve Outcomes**	**Lead and Governance Reporting**	**Implementation by When**	**Implementation Progress RAG**	**Measures**
Requirement One By 31st April 2022, the provider must ensure that the management vision for the service is communicated and that the appropriate systems are in place to support quality assurance and improvement within the service. As shown in A,B & C below.	Develop a vision with clear aims an objectives for the service. Develop key management systems to ensure appropriate oversight of key systems, processes and events. Create appropriate independent scrutiny to ensure professional challenge to the service aimed at improving practice.	**Paul Kyle,** **Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber**	The service will have a clear statement around the service aims and objectives. Management systems will be robust, clear and understandable – enabling the service to utilise data to reflect service developments. Key, independent scrutiny will be in place.
a) A statement of aims and objectives are updated, detailing what	The adoption service has commenced activity around evaluating the service objectives and that these				

the service aims to provide and how.	will be upgraded to reflect what the service provides and how this is carried out. Benchmarking/networking with other local authorities has commenced.				
b) Management systems are developed to ensure appropriate oversight of key systems, processes and events.	Interrogation of our current systems within the context of the adoption team has commenced, with local systems being re-aligned and updated where required. This will provide a significant emphasis on the oversight arrangements for managers.				
c) Appropriate independent scrutiny is in place to ensure professional challenge to the service aimed at improving practice.	Appropriate, independent scrutiny will be considered as part of the need to offer independent support to all aspects of our permanence panel process. Consideration into other models has commenced, with formal links having been made with other council's to consider models and approaches to reaching this outcome. Findings of these will be reported back to the Head of Service for financial consideration.				

Theme 3 – How well is our care and support planned Requirements (1)					
Complete		**Progressing Adequately**		**Not Meeting Timescales**	
Outcomes for this Theme	**Actions to Achieve Outcomes**	**Lead and Governance Reporting**	**Implementation by When**	**Implementation Progress RAG**	**Measures**
Requirement One By 31st April 2022, the provider must ensure a clear, outcome focussed Child's Plan is in place with statutory timeframes recorded as part of the action planning. As shown in A,B,C & D below.	An audit of all children in foster care to be carried out to ensure that each child has an up to date child's plan in place and that this is outcome focused (SMART) around their needs. An audit of the contribution and voice of the child. Ensuring that minutes are containing these views. Ensure that there is a monitoring process in place to review and build upon each child's plan and that this has professional, independent scrutiny in place. Ensure that each care provider and child/young person has access to this plan. An audit of our LAAC processes, ensuring these meet GIRFEC principles.	**Paul Kyle,** **Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber**	Procedures will be in place to ensure that child's plans are carried out timeously, that these are reviewed within agreed timescales using GIRFEC principles and within statutory timeframes. That plans and minutes of review meetings are reflective of the child's voice. That each child is aware of the advocacy support that is available to them and that their meetings will be independently supported. That all plans are SMART and that these are appropriately recorded and sent to care providers and children/young people without delay. There will be reporting methodology in place to ensure that LAAC processes are met within agreed timeframes and that managers will gain business reports on delays across all children/young people and that any delays will be considered in a solution focussed manner, with actions created to prevent further drift/delay. That the adoption service will have a clearly recorded role within plans to statutory timelines.
a) An audit of children's plans is undertaken to	Senior Managers meeting set up for 7th March 2022				

ensure they are outcome focused and SMART.	to align tasks to working groups and agree key individuals for workstream. Work group to be established to consider all aspects of our LAAC processes, including refresh on our procedures to ensure that they meet agency standards and can meet the expectations of a SMART outcome focused plan. To include our learning from the PACE programme. Audit of names have been identified by the fostering manager. This will allow us to consider areas surrounding care plans, the LAAC processes, the child's voice and oversight of the processes that surround this. An evaluation of the business support model is required to meet the expectations surrounding the recording of associated meetings and reviews.				
b) Statutory timeframes are included as part of the planning and review process.	To be addressed via workgroup.				

c) Where timeframes have been delayed there are clear actions and resources identified to remedy this.	To be addressed via workgroup.				
d) The adoption service have a clearly recorded role in ensuring compliance within plans to statutory time frames.	The adoption service will carry out further networking to help with the design of this role. This will occur across neighbouring authorities and formal professional links that will enable us to carry out a refresh on how we co-ordinate this task locally. Any changes required will be clearly stated in a management report, establishing clear aims and objectives to any identified changes in this area of practice.				