Agenda

West Dunbartonshire
Health & Social Care Partnership

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

Date:	Monday, 27 June 2022
Time:	13:00
Format:	Hybrid Meeting
Contact:	Ashley MacIntyre, Committee Officer ashley.macintyre@west-dunbarton.gov.uk

Dear Member

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

The Convener has directed that the powers contained in Section 43 of the Local Government in Scotland Act 2003 will be used and Members will have the option to attend the meeting remotely or in person at the Civic Space, Church Street, Dumbarton.

The business is shown on the attached agenda.

Yours faithfully

JULIE SLAVIN

Chief Financial Officer of the
Health and Social Care Partnership

Distribution:-

Voting Members
Rona Sweeney (Chair)
Michelle McGinty (Vice Chair)
Martin Rooney (WDC)
Clare Steel (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: 17 June 2022

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD AUDIT AND PERFORMANCE COMMITTEE

MONDAY, 27 JUNE 2022

1 APOLOGIES

2 DECLARATIONS OF INTEREST

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

3 RECORDING OF VOTES

The Committee is asked to agree that all votes taken during the meeting will be done by roll call vote to ensure an accurate record.

4 (a) MINUTES OF PREVIOUS MEETINGS 7 - 11

Submit for approval as a correct record, the Minutes of Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee held on 7 March 2022.

(b) ROLLING ACTION LIST 13 – 14

Submit for information the Rolling Action list for the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee.

5 VERBAL UPDATE FROM CHAIR

The Chair will provide a verbal update on the recent business of the Health and Social Care Partnership.

6 MEMBERSHIP OF HSCP AUDIT AND PERFORMANCE COMMITTEE 15 - 16

Submit report by Margaret Jane Cardno, Head of Strategy and Transformation introducing the three new voting members identified by West Dunbartonshire Council as an outcome of the recent Local Government Elections.

7/

7 AUDIT PLAN PROGRESS REPORT 17 – 33

Submit report by Andi Priestman, Chief Internal Auditor monitoring the performance of Internal Audit and gaining an overview of the WD HSCP Board's overall control environment.

8 INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2022 35 – 42

Submit report by Andi Priestman, Chief Internal Auditor based on the internal audit work carried out for the year ended 31 March 2022, which contains an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health & Social Care Partnership Board's internal control environment that can be used to inform its Annual Governance Statement.

9 2021/22 LOCAL CODE OF GOOD GOVERNANCE AND ANNUAL GOVERNANCE STATEMENT 43 - 60

Submit report by Julie Slavin, Chief Financial Officer presenting the outcome of the self-evaluation of compliance of the HSCP Board's Code of Good Governance and associated improvement actions and the Annual Governance Statement for inclusion in the HSCP Board's 2021/22 Unaudited Annual Accounts.

10 2021/22 UNAUDITED ANNUAL ACCOUNTS To Follow

Submit report by Julie Slavin, Chief Financial Officer on the above.

11 INTERIM RISK REPORT – ICT INFRASTRUCTURE 61 - 64

Submit report by Margaret Jane Cardno, Head of Strategy and Transformation providing further assurance in respect of the strategic risks pertaining to ICT Infrastructure and providing clarity on the HSCP Senior Management Team decision not to escalate ICT Infrastructure as a strategic risk at this time.

12 WEST DUNBARTONSHIRE HSCP QUARTERLY PERFORMANCE REPORT 2021/22 QUARTER FOUR 65 – 91

Submit report by Margaret Jane Cardno, Head of Strategy and Transformation ensuring the West Dunbartonshire HSCP Audit and Performance Committee fulfils its ongoing responsibility to ensure effective monitoring and reporting on the programme of work as set out in the West Dunbartonshire HSCP's Strategic Plan

13 INTERIM REPORT ON PHASES 1 AND 2 OF A JOINT INSPECTION OF SERVICES FOR CHILDREN AND YOUNG PEOPLE AT RISK OF HARM IN WEST DUNBARTONSHIRE **93 - 119**

Submit report by Lesley James, Head of Children's Health, Care and Justice Services providing information on the Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire and the actions being taken by the Community Planning Partnership (CPP) to improve outcomes for children, young people.

14 INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE **121 – 133**

Submit report by Lesley James, Head of Children's Health, Care and Justice Services providing a progress update on the improvement work in relation to the Care Inspectorate inspection of Adoption Services in West Dunbartonshire 2022.

15 INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE **135 – 153**

Submit report by Lesley James, Head of Children's Health, Care and Justice Services providing an update on the improvement work undertaken in response to the inspection of Fostering Services in West Dunbartonshire.

16 CARE INSPECTORATE INSPECTION REPORTS FOR HILLVIEW CARE HOME **155 - 159**
Appendix 1 To Follow

Submit report by Val Tierney, Chief Nurse providing information regarding the most recent inspection for Hillview Care Home.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD AUDIT AND PERFORMANCE COMMITTEE

At a Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee held via video conference on Monday, 7 March 2022 at 10.01 a.m.

Present: Rona Sweeney, Lesley Rousselet and Michelle Wailes, NHS Greater Glasgow and Clyde Health Board and Jonathan McColl, West Dunbartonshire Council.

Attending: Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Sylvia Chatfield, Head of Service for Mental Health, Addictions and Learning Disabilities; Audrey Slater, Head of People and Change; Margaret-Jane Cardno, Head of Strategy and Transformation; Lesley James, Chief Social Work Officer and Head of Childrens Health, Care and Justice; Jennifer Ogilvie, HSCP Finance Manager; Val Tierney, Chief Nurse; Fiona Taylor, Senior Nurse and Acting Head of Health and Community Care; Andi Priestman, Chief Internal Auditor; Sally Michael, Principal Solicitor; Ashley MacIntyre and Lynn Straker, Committee Officers.

Also Attending: Fiona Mitchell-Knight and Christopher Gardner, Audit Scotland.

Apologies: Apologies for absence were intimated on behalf of Denis Agnew and John Mooney, West Dunbartonshire Council and lay member Anne MacDougall, Chair of the Locality Engagement Network, Clydebank.

Rona Sweeney in the Chair

DECLARATIONS OF INTEREST

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

RECORDING OF VOTES

The Committee agreed that all votes taken during the meeting would be done by roll call vote to ensure an accurate record.

MINUTES OF PREVIOUS MEETINGS

The Minutes of Meetings of the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee held on 15 November 2021 were submitted and approved as a correct record.

REVIEW OF TERMS OF REFERENCE OF THE AUDIT AND PERFORMANCE COMMITTEE

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

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

(1) to note that an initial discussion on the current Terms of Reference is required; and

(2) to instruct the Chief Financial Officer and Chief Internal Auditor to schedule a formal members' session to review the Terms of Reference, after the upcoming local government elections to allow for the attendance of any new voting members.

STRATEGIC RISK REGISTER 6 MONTH REVIEW

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation presenting the updated Strategic Risk Register.

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

(1) to approve the updated Strategic Risk Register;

(2) that future reports would include more detailed information as to the direction of the risks; and

(3) that the Head of Strategy and Transformation would provide an interim update report to the Audit and Performance Committee on Monday, 20 June 2022.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) QUARTERLY PERFORMANCE REPORT 2021/22 - QUARTER THREE

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation ensuring the West Dunbartonshire HSCP Board Audit and

Performance Committee fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in the West Dunbartonshire HSCP's Strategic Plan.

After discussion and having heard the Head of Strategy and Transformation in further explanation of the report, the Committee agreed:-

(1) to note the content of the HSCP Quarterly Performance Report 2021/22 Quarter Three and performance against the Strategic Plan 2019 - 2022 by exception;

(2) to note that due to timing issues and service priorities during the current COVID-19 pandemic this report presents partial Quarter Three data;

(3) to note that Quarter Two information previously unavailable to the Committee is contained within this report; and

(4) to note the enhancement to the format of report in the form of additional information pertaining to complaints.

Note :- Lesley Rousselet left the meeting following consideration of this item.

AUDIT PLAN PROGRESS REPORT

A report was submitted by Andi Priestman, Chief Internal Auditor monitoring the performance of Internal Audit and providing overview of the WD HSCP Board's overall control environment.

After discussion and having heard the Chief Internal Auditor in further explanation of the report and in answer to Members' questions, the Committee agreed to note the progress made in relation to the Internal Audit Annual Plan for 2021/22.

2021-22 ANNUAL ACCOUNTS AUDIT PROCESS

A report was submitted 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.

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

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

(2) to note that additional meetings of the Audit and Performance Committee and HSCP Board may require 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.

EXTERNAL AUDIT – WEST DUNBARTONSHIRE INTEGRATED JOINT BOARD ANNUAL AUDIT PLAN 2021/22

A report was submitted 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.

After discussion and having heard the Chief Financial Officer, Fiona Mitchell-Knight and Christopher Gardner, Audit Scotland in further explanation of the report and in answer to Members' questions, the Committee agreed to note the content of Audit Scotland's 2021/22 Annual Audit Plan.

INDICATIVE INTERNAL AUDIT ANNUAL STRATEGY AND PLAN 2022-2023

A report was submitted by Andi Priestman, Chief Internal Auditor seeking approval of the indicative Internal Audit Strategy and Plan for 2022-2023.

After discussion and having heard the Chief Internal Auditor in further explanation of the report and in answer to Members' questions, the Committee agreed to approve the indicative Internal Audit Plan for 2022-2023.

INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE

A report was submitted by Lesley James, Chief Social Work Officer and Head of Childrens Health, Care and Justice providing an overview of the Care Inspectorate findings, evaluations and requirements in relation to West Dunbartonshire's Fostering Service, which concluded on 10th November 2021.

After discussion and having heard the Chief Social Work Officer and Head of Childrens Health, Care and Justice in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the contents of this report and the improvement plan in Appendix 1 of the report; and

(2) that the improvement plan would remain as a standing item on the agenda for West Dunbartonshire HSCP Board meetings enabling progress to be monitored.

INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE

A report was submitted by Lesley James, Chief Social Work Officer and Head of Childrens Health, Care and Criminal Justice providing an overview of the Care Inspectorate findings, evaluations and requirements in relation to West Dunbartonshire's Adoption Service, which concluded on 10th November 2021.

After discussion and having heard the Chief Social Work Officer and Head of Childrens Health, Care and Justice in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the contents of this report and the improvement plan in Appendix 1 of the report; and

(2) that the improvement plan would remain as a standing item on the agenda for West Dunbartonshire HSCP Board meetings enabling progress to be monitored.

CARE INSPECTORATE INSPECTION REPORTS FOR QUEEN'S QUAY WITHIN OLDER PEOPLE'S CARE HOME AND DAY CARESERVICES OPERATED BY WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

A report was submitted by Fiona Taylor, Senior Nurse and Acting Head of Health and Community Care providing information regarding the most recent inspection report for Queen's Quay, Older People's Care Home and Day Care Services operated by West Dunbartonshire Health and Social Care Partnership.

After discussion and having heard Val Tierney, Chief Nurse in further explanation of the report and in answer to Members' questions, the Committee agreed to note the content of the report.

The meeting closed at 11.20 a.m.

WEST DUNBARTONSHIRE HSCP AUDIT AND PERFORMANCE COMMITTEE

ROLLING ACTION LIST

Agenda Item	Decision/ Minuted Action	Responsible Officer	Timescale	Progress/ Update/ Outcome	Status
REVIEW OF TERMS OF REFERENCE OF THE AUDIT AND PERFORMANCE COMMITTEE March 2022	To instruct the Chief Financial Officer and Chief Internal Auditor to schedule a formal members' session to review the Terms of Reference, after the upcoming local government elections to allow for the attendance of any new voting members.	Julie Slavin/ Andi Priestman	November 2022		
STRATEGIC RISK REGISTER March 2022	That the Head of Strategy and Transformation would provide an interim update report to the Audit and Performance Committee on Monday, 20 June 2022.	Margaret-Jane Cardno	June 2022		
2021-22 ANNUAL ACCOUNTS AUDIT PROCESS March 2022	To note that additional meetings of the Audit and Performance Committee and HSCP Board may require to be scheduled close to the end of 31	Julie Slavin	October 2022		

	October 2022 to conclude the approval of the 2021/22 Annual Accounts if the audit process extends beyond the end of September.				
INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE March 2022	That the improvement plan would remain as a standing item on the agenda for West Dunbartonshire HSCP Board meetings enabling progress to be monitored.	Lesley James	June 2022		
INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE March 2022	That the improvement plan would remain as a standing item on the agenda for West Dunbartonshire HSCP Board meetings enabling progress to be monitored.	Lesley James	June 2022		

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

27 June 2022

Subject: Introduction of New Members

1. Purpose

1.1 The purpose of this report is to introduce the Audit and Performance Committee to the three new voting members identified by West Dunbartonshire Council as an outcome of the recent Local Government Elections.

2. Recommendations

2.1 It is recommended that the Audit and Performance Committee note that in line with section 5.4.1 of the Scheme of Integration West Dunbartonshire Council has identified three representatives to be voting members on the HSCP Board and Audit and Performance Committee, to serve for a period of three years. Namely: Cllr Michelle McGinty; Cllr Clare Steel and Cllr Martin Rooney.

3. Background

3.1 Section 5.4.1 of the Scheme of Integration states "the Council will formally identify three representatives to be voting members on the Integration Joint Board, to serve for a period of three years. The Council retains the discretion to replace its nominated members on the Integration Joint Board."

3.2 As a result of the 2022 Local Government Election, West Dunbartonshire Council have identified the following three Elected Members to serve on the HSCP Board and Audit and Performance Committee for a period of three years: Cllr Michelle McGinty; Cllr Clare Steel and Cllr Martin Rooney.

4. Main Issues

4.1 There are no issues relating to the recommendation within this report. The HSCP Board will consider wider issues pertaining to membership in a separate report entitled "Membership of the HSCP Board" at its meeting of 27 June 2022.

5. Options Appraisal

5.1 An options appraisal is not required for this report.

6. People Implications

6.1 There are no direct people implications arising from the recommendations within this report.

7. Financial and Procurement Implications

7.1 There are no direct financial or procurement implications arising from the recommendations within this report.

8. Risk Analysis

8.1 There are no specific risks related to the recommendation within this report.

9. Equalities Impact Assessment (EIA)

9.1 An EIA is not required as those with protected characteristics are not impacted by the recommendation within this report.

10. Environmental Sustainability

10.1 A Strategic Environmental Assessment (SEA) is not required for this report.

11. Consultation

11.1 No consultation is required in relation to the recommendation within this report.

12. Strategic Assessment

12.1 The recommendations within this report supports the establishment of robust governance and decision making structures which therefore impacts on all of the HSCP Boards strategic priorities.

13 Directions

13.1 No Directions are required in respect of this report.

Name: Margaret-Jane Cardno
Designation: Head of Strategy and Transformation
West Dunbartonshire Health and Social Care Partnership
Date: 16 June 2022

Person to Contact: Margaret-Jane Cardno
Head of Strategy and Transformation
West Dunbartonshire Health and Social Care Partnership

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Appendices: None

Background Papers: None

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Chief Internal Auditor

Audit and Performance Committee: 27 June 2022

Subject: Audit Plan Progress Report

1. Purpose

1.1 The purpose of this report is to enable WD HSCP Board Audit Committee members to monitor the performance of Internal Audit and gain an overview of the WD HSCP Board's overall control environment.

1.2 The report also presents an update on the Internal Audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow and Clyde (NHSGGC) since the Audit Committee meeting in March 2022 that may have an impact upon the WD HSCP Board's control environment.

2. Recommendations

2.1 It is recommended that the Audit Committee note the progress made in relation to the Internal Audit Annual Plan for 2021/22.

3. Background

3.1 In April 2021, the Audit Committee approved the Internal Audit Annual Plan which detailed the activity to be undertaken during 2021/22.

3.2 This report provides a summary to the Audit Committee of recent Internal Audit activity against the annual audit plan for 2021/22. A summary is also provided in relation to internal audit work undertaken at West Dunbartonshire Council and NHSGGC which may have an impact upon the WD HSCP Board's control environment.

3.3 This report also details progress in addressing agreed actions plans arising from previous audit work.

4. Main Issues

4.1 The audit plan for 2021/22 is almost complete. One audit has been finalised in relation to Implementation of IJB Directions Policy and the remaining audit is at fieldwork stage.

4.2 **Implementation of HSCP Board Directions Policy**

The West Dunbartonshire Health and Social Care Partnership Board (HSCPB) requires the West Dunbartonshire Health and Social Care Partnership (HSCP) to implement its strategic plan by delivering a range of defined services. To facilitate these arrangements the HSCPB issues binding Directions to its key delivery partners, West Dunbartonshire Council and Greater Glasgow & Clyde NHS Board. These Directions are made under the Public Bodies (Joint Working) (Scotland) Act 2014.

Directions made by HSCPB to partner organisations enable stakeholders to easily identify major decisions taken by the HSCPB and help them understand changes being made to services. It is therefore important that Directions made by the HSCPB fully comply with the HSCPB's policy and procedures on Directions, which were approved by the HSCPB on 23 September 2020.

4.3 The objective of this audit is to provide the HSCPB Audit and Performance Committee with an assessment of the adequacy and effectiveness of the governance, risk management and controls surrounding the key risks in relation to the HSCPB's policy on Directions.

4.4 The overall control environment opinion was **Satisfactory**. One Amber issue was identified as follows:

Adequacy of Reporting on the implementation of the HSCPB Directions Policy (Amber)

The HSCP Board approved the Directions Policy on 23 September 2020. An implementation action plan was put in place to implement the new policy. This included the requirement to introduce and maintain a Directions Log and that the log would be reviewed twice a year by the Audit and Performance Committee and the HSCPB.

The audit has identified that although a Directions Log has been introduced and maintained, the log has not yet been reported to the Audit and Performance Committee or the HSCPB to carry out their scrutiny roles in relation to the implementation of the Directions Policy. In addition, there has been no follow up report presented to HSCPB on the implementation action plan progress.

4.5 The audit identified 3 issues, one of which we consider to be individually significant and an action plan is in place to address all issues by 30 September 2022.

4.6 In relation to internal audit action plans, there were no actions due for completion by 31 May 2022. There are 3 current action points being progressed by officers. The current status report is set out at Appendix 1.

4.7 In relation to external audit action plans, there was one action due for completion by 31 May 2022 which has missed the deadline set by management. There are 5 current actions relating to the WD HSCP Board which are being progressed by officers. The current status report is set out at Appendix 2.

4.8 In relation to internal audit work undertaken at West Dunbartonshire Council and NHSGGC, the following reports are relevant to the WD HSCP Board:

West Dunbartonshire Council

4.9 Since the last Audit Committee meeting in March 2022, there were 2 Internal Audit reports issued to the Council, which are relevant to the WD HSCP Board:

Report	**Control Environment Opinion**	**Grading of Issues**		
		Red	**Amber**	**Green**
Employee Expenses (1)	Satisfactory	0	3	3
Corporate Procurement Under £50k (2)	Satisfactory	0	2	3
	Total	**0**	**5**	**6**

(1) Currently, there is a lack of co-ordination and management of pool vehicles and cost savings analysis has not been undertaken since 2019/20.
The audit also identified that 30% of employees recorded on the list of pool car users had used their own personal vehicle on a regular basis during the period examined. Pool car users should only claim mileage in an emergency or exceptional circumstances.
It was also identified that there are high levels of mileage claims by teams and individuals which do not demonstrate value for money and may benefit from pool cars.

(2) The audit identified that there is no mandatory Council wide fraud awareness training for staff in relation to procurement. A new fraud awareness e-learning module is being developed and is expected to be in place by 30 June 2022.
The audit also identified some supplier invoices where details included full names or surnames and an initial which were available by any officer with access to the financial management system. Under GDPR and Data Protection Act 2018, names are regarded as personal data and should not be processed at this level.

4.10 Internal Audit at West Dunbartonshire Council undertake follow up work on a monthly basis to confirm the implementation of agreed actions. Any matters of concern will be highlighted to the Committee.

NHS Greater Glasgow and Clyde

4.11 An update report has been provided by NHSGG&C Internal Audit. This has been reviewed by the Chief Internal Auditor and it can be noted that there were no Grade 4 recommendations raised (very high exposure) and no reports assessed as red.

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

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Risk Analysis

7.1 The annual audit plan for 2021/22 was constructed taking cognisance of the risks included in the WD HSCP Board risk register. Consultation with the Chief Officer and the Chief Financial Officer was carried out to ensure that risks associated with delivering the strategic plan were considered.

8. Equalities Impact Assessment (EIA)

8.1 There are no issues.

9. Environmental Impact Assessment

9.1 There are no issues.

10. Consultation

10.1 The Chief Officer and the Chief Financial Officer have been consulted on the content of this report.

11. Strategic Assessment

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

12. Directions

12.1 This report does not require a Direction.

Author: **Andi Priestman**
Chief Internal Auditor – West Dunbartonshire HSCP Board

Date: **8 June 2022**

Person to Contact: Andi Priestman – Shared Service Manager – Audit & Fraud
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Appendices: Appendix 1 – Status of Internal Audit Action Plans at 31 May 2022
Appendix 2 – Status of External Audit Action Plans at 31 May 2022

Background Papers: Internal Audit Annual Audit Plan 2021-22

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF INTERNAL AUDIT ACTION PLAN POINTS AT 31 MAY 2022

Summary:

Section 1 **Summary of Management Actions due for completion by 31/05/2022**

There were no actions due for completion by 31 May 2022.

Section 2 **Summary of Current Management Actions Plans at 31/05/2022**

At 31 May 2022 there were no audit reports delayed due to management not finalising the action plan within agreed timescales.

Section 3 **Current Management Actions at 31/05/2022**

At 31 May 2022 there were 3 current audit action points.

Section 4 **Analysis of Missed Deadlines**

At 31 May 2022 there were no audit action points where the agreed deadline had been missed.

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF INTERNAL AUDIT ACTION PLAN POINTS

SUMMARY OF MANAGEMENT ACTION PLANS DUE FOR COMPLETION BY 31.05.2022

SECTION 1

No. of Actions Due	No. of Actions Completed	Deadline missed Revised date set*	Deadline missed Revised date to be set*
0			

* These actions are included in the Analysis of Missed Deadlines – Section 4

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF INTERNAL AUDIT ACTION PLAN POINTS

SUMMARY OF CURRENT MANAGEMENT ACTIONS AS AT 31.05.2022

SECTION 2

CURRENT ACTIONS

Month	No of actions
Due for completion September 2022	3
Total Actions	**3**

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF INTERNAL AUDIT ACTION PLAN POINTS

CURRENT MANAGEMENT ACTIONS AS AT 31.05.2022

SECTION 3

Action	Owner	Expected Date
Implementation of HSCP Board Directions Policy (May 2022)		
Adequacy of Reporting on the implementation of the HSCPB Directions Policy (Amber) A report on the Directions Policy Implementation Action Plan will be taken to the September 2022 meeting of the HSCP Board. The Directions Log to go the September 2022 meeting of the HSCP Audit & Performance Committee for review. Review of Directions Log will be included on forward plans for the HSCP Audit & Performance Committee for the agreed twice a year reviews of Directions Log.	**Head of Strategy and Transformation**	**30.09.2022**
HSCP Board Meeting Minutes (Green) Minutes of the HSCP Board Meeting will specifically record Directions approved during the meeting and issuing of approved Directions to be included in the Rolling Action List for HSCP Board meetings.	**Head of Strategy and Transformation**	**30.09.2022**
HSCP Board Committee Report Template (Green) Reminder to be sent to all officers of the need to complete the relevant section of the report template, including confirmation if no Direction is required.	**Head of Strategy and Transformation**	**30.09.2022**

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF INTERNAL AUDIT ACTION PLAN POINTS
ANALYSIS OF MISSED DEADLINES

SECTION 4

Report	Action	Original Date	Revised Date	Management Comments
There are no current actions which have missed their original deadlines.				

WEST DUNBARTONSHIRE HSCP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF EXTERNAL AUDIT ACTION PLAN POINTS AT 31 MAY 2022

Summary:

Section 1 Summary of Management Actions due for completion by 31/01/2022

There was one action due for completion by 31 May 2022 which has missed the deadline set by management.

Section 2 Summary of Current Management Actions Plans at 31/01/2022

At 31 January 2022 there were no audit reports delayed due to management not finalising the action plan within agreed timescales.

Section 3 Current Management Actions at 31/01/2022

At 31 January 2022 there were 5 current audit action points.

Section 4 Analysis of Missed Deadlines

At 31 January 2022 there was one audit action point where the agreed deadline had been missed.

WEST DUNBARTONSHIRE HSCP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF EXTERNAL AUDIT ACTION PLAN POINTS

SUMMARY OF MANAGEMENT ACTION PLANS DUE FOR COMPLETION BY 31.05.2022

SECTION 1

No. of Actions Due	No. of Actions Completed	Deadline missed Revised date set*	Deadline missed Revised date to be set*
1	0	1	

* These actions are included in the Analysis of Missed Deadlines – Section 4

WEST DUNBARTONSHIRE HSCP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF EXTERNAL AUDIT ACTION PLAN POINTS

SUMMARY OF CURRENT MANAGEMENT ACTIONS AS AT 31.05.2022

SECTION 2

CURRENT ACTIONS

Month	No of actions
Due for completion June 2022	2
Due for completion September 2022	2
Due for completion March 2023	1
Total Actions	**5**

WEST DUNBARTONSHIRE HSCP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF EXTERNAL AUDIT ACTION PLAN POINTS

CURRENT MANAGEMENT ACTIONS AS AT 31.05.2022

SECTION 3

Action	Owner	Expected Date
2019/2020 Annual Audit Report (September 2020)		
Use of outcome data to shape future plans Actions to be taken to ensure IJB are well informed in its decision making. This will include how teams use data to inform operational decision making whilst also seeking to improve the quality of appropriate information to the IJB. Steps will be taken to consider national best practice in order to support good decision making in line with the delivery of the HSCP Strategic Plan.	**Head of Strategy and Transformation**	**30.09.2022**
Savings Targets The IJB should continue to improve on its mechanism for monitoring and reporting on its progress against efficiency savings targets on a regular basis.	**Chief Financial Officer**	**30.06.2022***
Best Value The IJB should agree a mechanism for undertaking a periodic and evidenced formal review of how it is achieving Best Value. This should be included and reported through the Annual Performance Report.	**Head of Strategy and Transformation**	**30.09.2022**
2020/2021 Annual Audit Report (November 2021)		
Management Commentary Revised financial plans to reflect Covid-19 The response to the Covid-19 pandemic impacted on every service delivered by the HSCP throughout 2020/21 and still continues to shape service delivery. This year's Management Commentary tried to reflect both the positive response as well as the more challenging impacts. The content and layout for the 2021/22 Management Commentary will aim to tell the West Dunbartonshire story in a more reader friendly format.	**Chief Financial Officer/ Head of Strategy and Transformation**	**30.06.2022**
Review of Standing Orders The current version of the revised scheme requires formal approval by NHSGGC before submission to the Scottish Government. This can be used as the starting point for a review of Standing Orders.	**Head of Strategy and Transformation**	**31.03.2023***

WEST DUNBARTONSHIRE HSCP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF EXTERNAL AUDIT ACTION PLAN POINTS
ANALYSIS OF MISSED DEADLINES

SECTION 4

Report	Action	Original Date	Revised Date	Management Comments
2019/2020 Annual Audit Report (September 2020)	**Savings Targets** The IJB should continue to improve on its mechanism for monitoring and reporting on its progress against efficiency savings targets on a regular basis.	**31.03.21** **31.05.22**	**30.06.22**	The Board receives an update on the progress of savings and efficiencies as part of the suite of appendices attached to the regular Financial Performance Reports. After confirmation from the Scottish Government in early February 2021 that all unachieved savings would be covered by Covid-19 funding the year-end position was broadly unchanged from the February update. However, this could have been displayed more clearly. In future the savings appendix will form part of the Outturn Report. The June 2022 A&P Committee will consider the Unaudited Accounts and the Board that follows will receive an Outturn Report which will include the final update on Savings & Efficiencies.
2020/2021 Annual Audit Report (November 2021)	**Review of Standing Orders** The current version of the revised scheme requires formal approval by NHSGGC before submission to the Scottish Government. This can be used as the starting point for a review of Standing Orders.	**31.03.22**	**31.03.23**	Although the review of the Scheme of Integration started in early 2020, due to the pandemic the required report did not progress to the NHS Board at that time. This presented an opportunity for the 6 Integration Joint Boards across the NHSGG&C area to develop a consistent Scheme across the GG&C area. The revised Schemes will be taken to the NHS Board and relevant Local Authorities in September 2022, seeking permission to move to public consultation. Final approval of the revised Schemes of Integration by Scottish Ministers is expected to conclude in March 2023. This work currently forms the basis of a review of the HSCP Board's Standing Orders and the Scheme of Officer Delegation and although this work has started it cannot be concluded until the Scheme of Integration has received Ministerial approval.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Val Tierney, Chief Nurse

AUDIT AND PERFORMANCE COMMITTEE: 27 JUNE 2022

Subject: Internal Audit Annual Report for the year ended 31 March 2022

1. Purpose

1.1 To submit the Chief Internal Auditor's Annual Report for 2021/22 based on the internal audit work carried out for the year ended 31 March 2022, which contains an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health & Social Care Partnership Board's internal control environment that can be used to inform its Annual Governance Statement.

2. Recommendations

2.1 It is recommended that the West Dunbartonshire Health & Social Care Partnership Board note the contents of this report.

3. Background

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

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

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

The annual report must incorporate:

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

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

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

4. Main Issues

4.1 The Internal Audit Annual Report for 2021/22 included at Appendix 1 concludes with the Chief Internal Auditor's independent and objective opinion that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2022 that the Health & Social Care Partnership Board requires to rely upon within both the Council and the Health Board.

Covid-19
The significant incident in late March 2020 continued to test how well the HSCP Board's risk management, governance and internal controls framework operated during 2021/22.

There were examples of innovations, new business processes and solutions and new technology being embraced in order to deliver services to the community. This was achieved using amended governance arrangements, new ways of decision-making, leadership and implementation including virtual meetings and secure remote access to systems to allow employees to work from home.

The Chief Officer and the senior management team were actively involved in the local resilience planning through their dual roles in West Dunbartonshire Council and NHS Greater Glasgow and Clyde.

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

- The Assurance Statement for the year ended 31 March 2022 from the Shared Service Manager – Audit & Fraud (Chief Internal Auditor) of West Dunbartonshire Council; and
- Information provided by the Internal Auditors of NHS Greater Glasgow and Clyde on audits that they have carried out during 2021/22.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

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

10. Impact Assessments

10.1 None.

11. Consultation

11.1 This report has been agreed with the Chief Officer and the Chief Financial Officer of the West Dunbartonshire Health & Social Care Partnership Board.

12. Strategic Assessment

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

13. Directions

13.1 This report does not require a Direction.

Author: **Andi Priestman – Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board.**

Date: **8 June 2022**

Person to Contact: Andi Priestman, Shared Service Manager – Audit & Fraud
West Dunbartonshire Council
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E-mail – andi.priestman@west-dunbarton.gov.uk

Appendix: 1 - Internal Annual Audit Report for the year ended 31 March 2022 from the Chief Internal Auditor

Background Papers: Internal Audit Progress Reports to Audit Committee in September 2021, November 2021 and March 2022

Wards Affected: All Wards

West Dunbartonshire
Health & Social Care Partnership

Internal Audit Annual Report for the year ended 31 March 2022 from the Chief Internal Auditor

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

As the appointed Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board, I am pleased to present my annual statement on the adequacy and effectiveness of the internal financial control system of the Health & Social Care Partnership Board for the year ended 31 March 2022.

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

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

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

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

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

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

The work of internal audit

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

The operational delivery of services with WDC and NHSGGC on behalf of the WD Health & Social Care Partnership Board is covered by their respective internal audit arrangements.

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

Work Performed in 2021/22

The Internal Audit Plan for 2021/22 was approved by the Health & Social Care Partnership Board Audit and Performance Committee on 25 February 2021.

A budget of 40 days was allocated to undertake the following: service the audit committee; carry out specific risk based work including carry out specific risk based work including a review of the adequacy and effectiveness of the performance management process and a review of implementation of IJB Directions; and monitor the progress of the implementation of the agreed internal audit actions plans by management.

Progress reports highlighting internal audit activity were provided to the Health & Social Care Partnership Board Audit and Performance Committee meetings in September 2021, November 2021 and March 2022. There were no significant matters arising from internal audit activity for the financial year ended 31 March 2022.

Planned work for 2022/23

Following a risk-based assessment of the activities of IJB and consultation with the Chief Officer and the Chief Financial Officer the Internal Audit Plan for 2022/23 provides for 40 days of Internal Audit resource drawn from the Internal Audit Service of West Dunbartonshire Council. This will be used to undertake the following: service this audit committee; carry out specific risk based work including a review of the adequacy and effectiveness of the workforce planning arrangements and pandemic response and recovery arrangements; and monitor the progress of the implementation of the agreed internal audit actions plans by management.

The Internal Audit Plan for 2022/23 was approved by the Health & Social Care Partnership Board Audit and Performance Committee on 7 March 2022.

Basis of Opinion

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

- The audit work undertaken by Internal Audit within the Council and the Health Board and also for the Partnership Board (IJB) during the year to 31 March 2022;
- The Assurance Statement for the year ended 31 March 2022 from the Chief Internal Auditor of West Dunbartonshire Council;
- The Assurance Statement for the year ended 31 March 2022 from the Internal Auditors for NHSGG&C;
- The review of the Local Code of Good Governance and the identified improvement actions;
- The assurance statement signed by the Chief Officer on the operation of the internal financial controls for the services for which she was responsible during the year to 31 March 2022;
- Reports issued by the External Auditors of the Council and the Health Board and other review agencies; and
- My knowledge of the Partnership Board's governance, risk management and performance monitoring arrangements.

Opinion

It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2022 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself.

Covid-19

The significant incident in late March 2020 continued to test how well the HSCP Board's risk management, governance and internal controls framework operated during 2021/22.

There were examples of innovations, new business processes and solutions and new technology being embraced in order to deliver services to the community. This was achieved using amended governance arrangements, new ways of decision-making, leadership and implementation including virtual meetings and secure remote access to systems to allow employees to work from home. The Chief Officer and the senior management team were actively involved in the local resilience planning through their dual roles in West Dunbartonshire Council and NHS Greater Glasgow and Clyde.

Signature: **Andi Priestman**

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

Date: **8 June 2022**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by the Chief Financial Officer

27 June 2022

Subject: 2021/22 Code of Good Governance and Annual Governance Statement

1. Purpose

1.1 To present to the HSCP Audit and Performance Committee:

- The outcome of the self-evaluation of compliance of the HSCP Board's Code of Good Governance and associated improvement actions; and
- The Annual Governance Statement for inclusion in the HSCP Board's 2021/22 Unaudited Annual Accounts.

2. Recommendations

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

- Note the outcome of the annual self-evaluation and the update of the improvement actions; and
- Consider the detail of the 2021/22 Annual Governance Statement and approve its inclusion in the 2021/22 Unaudited Annual Accounts.

3. Background

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

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

- resources are directed in accordance with agreed policy and according to priorities;
- there is sound and inclusive decision making; and
- there is clear accountability for the use of those resources in order to achieve desired outcomes for service users and communities.

3.3 The HSCP Board approved its first Local Code of Good Governance in May 2017 followed by a refreshed version in June 2021. Annually since June 2018 the Audit and Performance Committee has considered the outcome of the self-evaluation process and the improvement actions identified to strength compliance with the adopted Governance Framework principles.

3.4 The Annual Governance Statement (AGS) is a formal statement within the HSCP Board's annual accounts which recognises, records, assesses and publishes the governance arrangements as defined in the CIPFA/SOLACE Framework. The statement requires to be signed off by the Chair of the HSCP Board and the Chief Officer when the final audited accounts are presented later in the year.

3.5 It is recognised as good practice to consider the AGS as a standalone document by a board or committee charged with the responsibility for the oversight of the strategic processes for risk and the effectiveness of the internal control environment, as is set out in the Terms of Reference for this committee.

4. Main Issues

4.1 The annual self-evaluation review for 2021/22 has been carried out by the Chief Financial Officer and the Head of Strategy and Transformation and considered by the Senior Management Team.

4.2 The Annual Governance Statement reflects the annual self-evaluation of the HSCP Board's compliance against the Code of Good Governance as well as details on the internal control environment in which the HSCP operates and relies upon.

4.3 The self-evaluation review (as referred to above in sect 3.1) has identified that current practice is mainly fully compliant (67 sub-principles) and generally compliant (23 sub-principles) against our Code of Good Governance, with no areas identified as non-compliant.

4.4. The review has identified some areas for improvement and these are contained within Appendix 1 which also updates members on the progress of improvement actions identified in prior years.

4.5 While the HSCP's overarching priority throughout the Covid-19 pandemic was to protect the delivery of health and social care services, there has also been significant progress made in the strengthening our governance framework around the implementation of a direction's policy reflecting statutory guidance,

the refresh of eligibility criteria aligned to an new assessment tool and the approval of the Board's second Medium Term Financial Plan 2022/23 to 2026/27.

4.6 The Governance Statement, attached at Appendix 2 sets out the HSCP Board's governance arrangements as they meet the requirements of the "Code of Practice for Local Authority Accounting in the UK" (the Code) and reports on the effectiveness of the HSCP Board's system of internal control, including the reliance placed on the governance frameworks of our partners.

4.7 The work of internal audit, external audit and external inspection agencies is also reflected in the statement as well as the reliance of the HSCP Board on WDC and NHSGGC systems of internal control. This includes the Chief Internal Auditor's opinion:

''It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2022 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself.''

4.8 This Annual Governance Statement will be published within the unaudited Annual Accounts for the year ended 31 March 2022 and will be examined by external audit.

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 There is a risk that a failure to maintain a local code and develop a framework to support the gathering and updating of the necessary evidence will leave the HSCP Board unable to produce a Governance Statement. The current approach to ongoing annual assessment of compliance and reporting to this

Committee ensures that the Board can produce a meaningful Governance Statement.

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 prepared in consultation with the HSCP Board's Chief Internal Auditor and the HSCP Senior Management Team.

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
11 June 2022

Person to Contact: Julie Slavin – Chief Financial Officer,
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Appendices: Appendix 1: Update on Improvement Plan
Appendix 2: 2021/22 Draft Governance Statement

Background Papers: Local Code of Good Governance (wdhscp.org.uk)

West Dunbartonshire

Health & Social Care Partnership

Annual Review of Code of Good Governance Improvement Action Plan 2022

OUTSTANDING ACTIONS FROM PREVIOUS YEARS

Improvement Action	Lead Officer	Due Date	Review June 2022
Refresh and update local Self Directed Support arrangements.	Head of Strategy and Transformation	September 2020 Revised	**PART COMPLETE** Significant progress has been made in relation to the Care Inspectorate report entitled "Thematic Review of Self-Directed Support in Scotland: West Dunbartonshire Local Partnership Report" published in June 2019. The HSCP Board received a comprehensive update on the 21 March 2022. Positive progress includes: • The recruitment of an SDS Lead, due to join the HSCP on the 6 June 2022. • The My Life Assessment Tool has completed a successful pilot period (ref HSCP Board Report 25/02/21). This tool was supplemented by practitioner guidance notes and an extensive training programme focussing on asset and human rights based and outcome focused approaches and has been rolled out across HSCP services. A full review of the Area Resource Group (ARG) structure and methodology has now commenced with an initial scoping workshop taking place on the 19 January 2022. The aim of this work is to ensure consistency of practice across all HSCP services, to streamline processes and develop a model of peer support and challenge.

			In terms of commissioned services, challenges for the HSCP in recruiting a Contracts and Commissioning Manager continue, with a second round of recruitment in March 2022 ending without a successful appointment. The commissioning team has been depleted due to recent retrials although work is ongoing to build capacity within the service. Further work is required to develop systems on the implementation of SDS across the HSCP which measure and collect aggregated data on personal outcomes. This data can then be used as regular management information for relevant teams. It is recognised existing data is not yet robust enough. This work will be refined and progressed throughout 22/23 by the SDS Lead.
In partnership with NHSGGC, Scottish Government and GGC IJBs agree on methodology that allows Set Aside resources to be quantified and reflect actual activity to comply with legislation on the use of this resource in shifting the balance of care.	Chief Financial Officer	On-going subject to the Scottish Government funding the current financial gap identified at NHSGGC level.	**COMPLETE** Data sets are produced which provides actual HSCP activity across the defined specialities and the associated cost. This is reflected in the 2021/22 HSCP Board Annual Accounts. The Unscheduled Care Commissioning Plan was also agreed in 2021/22 by all 6 GGC IJBs and NHSGGC; however there remains a significant funding gap and until this is addressed actual release of financial resource will be limited.
Review the effectiveness of the new Strategic Planning Group (SPG)	Chief Officer & Head of Strategy and Transformation	October 2020 Revised	**PART COMPLETE** The Strategic Planning Group has undergone a series of development sessions supported by Healthcare Improvement Scotland. These were well attended and the SPG is now meeting regularly in order to develop the Strategic Plan. The group remains in its infancy and it would be

			premature to make an assessment of effectiveness. Self-evaluation activity will be undertaken early 2023.

Develop a robust Commissioning Plan driven by new Strategic Plan 2019 - 2022	Head of Strategy and Transformation	October 2020 Revised	**PART COMPLETE** The HSCP Board has agreed their approach to Strategic Planning. The Strategic Needs Assessment is complete and the SPG is meeting regularly to develop the Strategic Plan. The Commissioning Plan will be published in line with this work in March 2023.
Ministerial Strategic Group Review on the Progress of Integration Action Plan – from May 2019 Self Evaluation	Chief Officer	Multiple actions	**PART COMPLETE** The HSCP Board considered progress on the delivery of the MSG Action Plan on 19 August 2021. This report identified a number of areas where the actions/improvements had been implemented and those with work on-going. It was anticipated that a further report would be brought to the February 2022 Board; however with the resurgence of Covid (Omicron) in late 2021 into 2022 this has been delayed and will feature within the 2022/23 timetable.

NEW ACTIONS (June 2022)

Improvement Action	Lead Officer	Due Date
Review the current Scheme of Officer Delegation in line with the required review of the HSCP Board's Standing Orders. External audit recommended the current Standing Orders are refreshed to reflect the outcome of the statutory review of the Integration Scheme. The review of the 2015 Integration Scheme was approved by WDC in Feb 20 but the outbreak of the pandemic delayed its progression through NHSGGC Health Board. This work has recommenced in partnership with all 6 IJBs within the GGC area.	Chief Financial Officer and Head of Strategy and Transformation	March 2023
Review the Terms of Reference of the Audit & Performance Committee	Chief Financial Officer	December 2022

ANNUAL GOVERNANCE STATEMENT

Introduction

The Annual Governance Statement explains the HSCP Board's governance arrangements as they meet the requirements of the "Code of Practice for Local Authority Accounting in the UK" (the Code) and reports on the effectiveness of the HSCP Board's system of internal control, including the reliance placed on the governance frameworks of our partners.

Scope of Responsibility

The HSCP Board is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. The Board also aims to cultivate a culture of continuous improvement in the performance of its functions and to make arrangements to secure best value.

To meet this responsibility the HSCP Board has in place robust arrangements for the governance of its affairs and the effectiveness of its functions, including the identification, prioritisation and the management of risk. It has an established Audit and Performance Committee to support the Board in its responsibilities for issues of risk, control, performance and governance and associated assurance through a process of constructive challenge and continuous improvement across the partnership.

In discharging this responsibility the Chief Officer has put in place arrangements for governance which includes a system of internal control. The system is intended to manage risk to a reasonable level and to support the delivery of the HSCP Board's policies, aims and objectives. Reliance is also placed on Greater Glasgow and Clyde Health Board (NHSGGC) and West Dunbartonshire Council's (WDC) systems of internal control that support compliance with both partner organisations' policies and promotes the achievement of each organisation's aims and objectives, as well as those of the HSCP Board.

The Chief Internal Auditor reports directly to the HSCP Board's Audit and Performance Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Audit and Performance Committee on any matter.

In 2017 the HSCP Board adopted governance arrangements that are consistent with the Chartered Institute of Public Finance and Accounting (CIPFA) and the Society of Local Authority Chief Executives (SOLACE) framework "Delivering Good Governance in Local Government". Based on the framework's seven core principles a Local Code of Good Governance is in place which is reviewed annually and evidences the HSCP Board's commitment to achieving good governance and demonstrates how it complies with the recommended CIPFA standards. A copy of the code is available here (Appendix 1, xx.) on the HSCP website.

Impact of Covid-19 Response on Governance Arrangements

The governance framework in which the HSCP Board operates has continued to be impacted by the partnership's response to the Covid-19 pandemic. Business continuity processes of those charged with the delivery of health and social care services, had to mobilise rapidly to support vital frontline services to meet the challenge of the pandemic and adapt, as appropriate, current governance frameworks.

Virtual (remote) meetings have continued since March 2020 and temporary governance arrangements in relation to decision making were put in place at that time as follows:

- The suspension of normal governance arrangements during the Covid-19 pandemic and accept the alternative Board meeting arrangements; and
- Delegation of authority to the Chief Officer, in consultation with the Chair and Vice Chair of the HSCP Board and the Chief Financial Officer, be enacted "if required", to meet immediate operational demand on decisions normally requiring Board approval.

Throughout 2021/22 the HSCP Board and Audit and Performance Committee met as planned with all meetings taken place on a virtual platform (accessible by press and public on request). As public health restrictions on social distancing ease, from June 2022 meetings will move to a hybrid model with some members and officers attending meetings in person while others contribute remotely.

The schedule of weekly meetings with the Chief Officer, Chief Financial Officer, Chair and Vice Chair of the HSCP Board continued for the first quarter of 2021/22, however no decisions were required to be made using the temporary decision making powers.

The HSCP Board continued to work alongside partners to participate in the both the local and wider response to the pandemic. Amendments to the Civil Contingencies Act 2004, effective from 16 March 2021, awarded Integration Joint Boards with Category One Responder status. This status already applied to Local Authorities and NHS Bodies.

The Chief Officer and the HSCP Senior Management Team, through their roles as senior operational leaders within WDC and NHSGGC formally contributed to the pandemic response and recovery plans by being key participants in Covid-19/Business Continuity response, tactical and strategic resilience groups. See below:

The response included the implementation and continued support of service areas that had to adapt to the challenges and risks of the pandemic. These were captured on the Covid-19 Risk Register and the Local Mobilisation Plan.

The Scottish Government required that NHSGGC and each of the six HSCPs within Glasgow's boundary prepared a Local Mobilisation Plan (LMP). The LMP and associated Financial Cost Tracker set out the impact of the pandemic on services and their response as well as considering new service areas that required to be established to support health and care services. Examples include two Covid-19 Hubs (Clydebank and Dumbarton) to distribute the necessary Personal Protective Equipment (PPE), two Community Assessment Centres (Clydebank and Renton) to support the clinical assessment and testing of people referred with potential Covid-19 symptoms, a Mental Health Assessment Unit, as an alternative to presentation at Emergency Department and the creation of vaccination teams to support the delivery on the ongoing vaccination programme.

The financial costs aligned to the LMP were submitted at least quarterly to the Scottish Government and formed the basis of all funding received. The final position is set-out in detail within these accounts and confirms that full funding was received in 2021/22 to cover all Covid-19 related costs (including response and recovery) as well as advance funding for 2022/23 to support continued recovery and renewal of services.

Purpose of the Governance Framework

The governance framework is comprised of systems and processes and cultures and values by which the HSCP is directed and controlled. It is not static and is updated to reflect new legislative requirements and best practice.

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the risks facing the organisation. It enables the HSCP Board to monitor and evaluate the achievements of the strategic objectives laid out within its Strategic Plan and consider whether these have been delivered in an appropriate and cost effective manner.

Governance Framework and Internal Control System

The HSCP Board is the key decision making body, comprising of six voting members, with one from each partner organisation assuming the role of Chair and Vice Chair. West Dunbartonshire Council nominates three elected members and NHSGGC Health Board nominates three non-executive members. There are also a number of non-voting professional and stakeholder members on the HSCP Board. Stakeholder members currently include third sector, carer and staff-side representatives; professional members include the Chief Officer and Chief Financial Officer.

The HSCP Board is scheduled to meet six times per year and all agendas and meeting papers are available on the HSCP Board website.

The main features of the HSCP Board's governance framework and system of internal control is reflected in its Local Code, with the key features for 2020/21 summarised below:

- The HSCP Board is formally constituted through the Integration Scheme agreed by WDC and NHSGGC and approved by Scottish Ministers. The scheme sets out the local governance arrangements, including definition of roles, workforce, finance, risk management, information sharing and complaints;
- The HSCP Board has two governance sub-committees; Audit and Performance Committee (scheduled to meet in public four times per year) and the Strategic Planning Group;
- The scope, authority, governance and strategic decision making of the HSCP Board and Audit and Performance Committee is set out in key constitutional documents including the HSCP Strategic Plan 2019 – 2022, terms of reference, code of conduct, standing orders and financial regulations, directions policy, records management and complaints handling;
- The Performance Management Framework commits to regular performance and financial reporting to the HSCP Board and Audit and Performance Committee. These reports review the effectiveness of the integrated arrangements including delivery of the strategic priorities and the financial management of the integrated budget;
- The Medium Term Financial Plan 2022/23 – 2026/27 outlines the financial challenges and opportunities the HSCP Board faces over the next five years and provides a framework which will support financial sustainability;
- Weekly Chief Officer reports considered by the SMT and used as the basis for reporting at an executive level to our partners at corporate management teams and formal Organisational Performance Reviews (OPRs);
- Clinical and Care Governance Group – provide oversight and scrutiny of all aspects of clinical and care risk and effectiveness as well as how patient centred care is delivered.
- The Risk Management Strategy, including the risk management policy and strategic risk register, are scrutinised bi-annually by the Audit and Performance Committee with level of risk, its anticipated effect and mitigating action endorsed before being referred to the HSCP Board;
- The Reserves Policy is reviewed as part of the annual budget setting process and has identified a reasonable level of both general and earmarked reserves;
- Through the employing partner bodies performance appraisal processes are in place for all employees and integrated staff who are also required to undertake statutory and mandatory training to reinforce their obligations to protect our service users, including information security; and
- Effective scrutiny and service improvement activities are supported by the formal submission of reports, findings, recommendations and associated action plans by Audit Scotland, Ministerial Strategic Group, our external and internal auditors and the Care Inspectorate.

The governance framework described, operates within the system of internal financial controls, including management and financial information, financial regulations, administration (including segregation of duties), management supervision and a system of delegation and accountability. Development and maintenance of these systems is undertaken by the Council and the Health Board as part of the operational delivery arrangements of the HSCP.

Compliance with Best Practice

The HSCP Board's financial management arrangements conform to the governance requirements of the CIPFA statement *"The Role of the Chief Financial Officer in Local Government (2010)"*. To deliver these responsibilities the Chief Financial Officer must be professionally qualified and suitably experienced and lead and direct a finance function that is resourced and fit for purpose.

The HSCP Board complies with the requirements of the CIPFA Statement on *"The Role of the Head of Internal Audit in Public Organisations 2010"*. The HSCP Board's appointed Chief Internal Auditor has responsibility for the internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The Internal Audit service generally operates in accordance with CIPFA *"Public Sector Internal Audit Standards 2013".*

The HSCP Board's Audit and Performance Committee operates in accordance with CIPFA's *"Audit Committee Principles in Local Authorities in Scotland"* and *"Audit Committees: Practical Guidance for Local Authorities (2018)"*.

Review of Adequacy and Effectiveness

The HSCP Board is committed to continuous improvement and is responsible for conducting at least annually, a review of its governance framework including the system of internal control. The review of the effectiveness of the framework is informed by the work of the Chief Officer and the Senior Management Team who has the responsibility for the development and maintenance of the governance environment and the work of internal and external audit and other review agencies including the Care Inspectorate.

HSCP Board's Local Code Review

As stated above the HSCP Board adopted its own local code in 2017. Annually, since 2018 this is reviewed each year by the Chief Financial Officer and the Senior Management Team as part of the year end assurance processes for both partner organisations and the HSCP Board. For the 2022 review the HSCP Board which met on 27 June 2022 noted the outcome that there were no areas assessed to be non-compliant and more than three quarters were considered fully compliant. (see Appendix 1, x)

There have been a number of improvement actions identified each year and an update on these is provided below. This year's review has reflected the HSCP continued response to the global health emergency and its priority to safeguard the delivery of essential services has impacted on the full delivery of some of the improvement actions, but there is still demonstrable progress. The priority for 2022/23 will be to progress these ongoing actions and new actions to further strengthen the governance framework.

New June 2022 Actions

Improvement Action	Lead Officer(s)	Target Date
Review the current Scheme of Officer Delegation in line with the required review of the HSCP Board's Standing Orders.	Chief Financial Officer and Head of Strategy and Transformation	March 2023
Review the Terms of Reference of the Audit	Chief Financial Officer	December 2022

& Performance Committee		

Update on Previously Agreed Actions

Improvement Action	Lead Officer(s)	Target Date	June 2022 Review
Refresh and update local Self Directed Support arrangements.	Head of Strategy and Transformation	September 2020	**Part Complete:** The HSCP Board received a comprehensive update on 21 March 2022. Positive progress includes: • The recruitment of an SDS Lead, due to join the HSCP on the 6 June 2022. • The My Life Assessment Tool has completed a successful pilot period
In partnership with NHSGGC, Scottish Government and GGC IJBs agree on methodology that allows Set Aside resources to be quantified and reflect actual activity to comply with legislation on the use of this resource in shifting the balance of care.	Chief Financial Officer	On-going subject to the Scottish Government funding the current financial gap identified at NHSGGC level.	**Complete:** Data sets are produced which provides actual HSCP activity across the defined specialities and the associated cost. This is reflected in the 2021/22 HSCP Board Annual Accounts. The Unscheduled Care Commissioning Plan was also agreed in 2021/22 by all 6 GGC IJBs and NHSGGC.
Review the effectiveness of the new Strategic Planning Group (SPG)	Head of Strategy and Transformation	October 2020	**Part Complete:** The Strategic Planning Group has undergone a series of development sessions supported by Healthcare Improvement Scotland. Self-evaluation activity will be undertaken early 2023.
Develop a robust Commissioning Plan driven by new Strategic Plan 2019 - 2022	Head of Strategy and Transformation	October 2020	**Part Complete:** The HSCP Board has agreed their approach to Strategic Planning. The Strategic Needs Assessment (JSNA) is complete and the SPG is meeting regularly to develop the Strategic Plan. The Commissioning Plan will be published in line with this work in March 2023.
Ministerial Strategic Group Review on the Progress of Integration Action Plan – from May 2019 Self Evaluation	Chief Officer	Multiple actions	**Part Complete:** The HSCP Board considered progress on the delivery of the MSG Action Plan on 19 August 2021. This report identified a number of areas where the actions/improvements had been implemented and those with work on-going.

HSCP Board's 2021/22 Audit Plan and Update on 2020/21 Actions
The HSCP Board's Annual Audit Plans for 2020/21 and 2021/22 were developed to support assurance of the Board's Governance Framework.

The HSCP Board's Chief Internal Auditor presents updates on the progress of the Audit Plan and associated actions at each meeting of the Audit and Performance Committee. These are summarised below:

Internal Audit Undertaken	Overall Opinion of Control Environment	Update of Actions
June 2021 Risk Management Process: Assess the adequacy and effectiveness of the governance and controls of key risks.	**Satisfactory** Two Green ratings One Amber rating: Operational Risk Registers not documented consistently across services.	**Target Date March 2022: Complete** All HSCP Services undertook refresher training on preparation of operational risk registers. All refreshed and new operational risk registers align with the HSCP Board's strategic risks and will be reviewed annually.
June 2022 Directions Policy: Review the adequacy and effectiveness of directions.	**Satisfactory** Two Green ratings One Amber rating: The HSCP Board and Audit and Performance Committee have not received formal assurance on the implementation of the policy and level of compliance.	**Target Date September 2022:** The Directions Log to be presented at the September 2022 meeting of the Audit and Performance Committee and going forward there will be bi-annual reviews of the log.

West Dunbartonshire Council and NHSGGC Health Board
Also supporting the review of the HSCP Board's governance framework are the processes of internal controls of West Dunbartonshire Council and Greater Glasgow and Clyde Health Board.

Within WDC Chief Officers completes a Local Code of Governance Checklist which is a self-assessment against each aspect of council's local code. These are considered by the Chief Internal Auditor and inform each Chief Officer's Certificate of Assurance as well as the Council's Governance Statement.

Within NHSGGC a similar process is in operation which required the Chief Officer to complete a "Self Assessment Checklist" covering all the key areas of the internal control framework.

Other reviews to support continuous improvements and the control environment include the work undertaken by WDC & NHSGGC internal audit teams. Any specific control issues

emerging from these audits are considered through each organisation's own Audit Committee and recommendations on improvements agreed. The HSCP Board are updated on any control issues that would impact on HSCP service performance through regular performance and financial updates reports.

Progress of actions is reviewed through the partner organisations own corporate management teams of which HSCP senior officers are members of. There is also regular review by the HSCP Board's Chief Internal Auditor, Chief Officer, Chief Financial Officer and the Senior Management Team and the monthly Core Finance Group meeting.

Update on Previous Governance Issues

The 2020/21 Annual Governance Statement did not identify any significant control issues for the HSCP Board. Updates of previous HSCP Board governance issues are mainly covered under the "Review of Adequacy and Effectiveness" section above. The remaining previously reported governance issues are updated below:

- Improve sickness absence rates – this is ongoing with targeted interventions for areas with higher absence levels to support line managers and ensure individual absences are being managed in an appropriate manner to support return to work;
- Strengthen budget setting arrangements with WDC and NHSGGC and produce a robust Medium Term Financial Plan (MTFP) – the 21 March 2022 HSCP Board agreed its 2022/23 budget based on an indicative offer from NHSGGC and a formal offer from WDC including consideration of additional 2022/23 (and future years) budget pressure related to a review of the established equal split of costs of children's residential school placements. The Board also approved its second MTFP 2022/23 to 2026/27 based on both known pressures and predicted future costs and funding constraints; and
- Progress with service reviews within Learning Disability Services, Children and Families and Care at Home to ensure services are fit for the future, post pandemic – staffing challenges and the autumn 2021 resurgence of Covid-19 infections mainly linked to the emergence of the Omicron variant required services to re-focus on response which impacted on the progress of reviews. The Care at Home review did continue at pace and should be complete by the end of 2022/23. The Children and Families and Learning Disability Services reviews have underwent some initial scoping and will continue when sufficient staffing resources are secured.

Governance Issues 2021/22

The 2021/22 Internal Audit Annual Report for the HSCP Board identifies no significant control issues. As stated above the HSCP Board must also place reliance on the Council and Health Board's internal control framework. The Council's Internal Audit Annual Report has concluded that the Council's control procedures in key areas are operating as expected during 2021/22.

As stated above under "Review of Adequacy and Effectiveness" the Chief Officer of the HSCP completes a self-assessment of the HSCP's operational performance against the WDC local code. The council's Chief Internal Auditor has considered this and has identified some areas for improvement which form part of the WDC Annual Governance Statement

and progress will be monitored through the Performance Management Review Group (PMRG) and the WDC Audit Committee. These include:

- Strengthen consistency of monitoring improvement activity across both internal and external inspection;
- Strengthen training and development of staff using approved earmarked reserves to support training coordinator and course materials;
- Consider HSCP succession planning as part of the 2022/23 integrated workforce plan; and
- Strengthen self-evaluation processes through capturing feedback from complaints process to inform service improvements across the HSCP.

The Internal Auditor's for NHSGGC have also released their annual opinion which concludes:

"In our opinion NHSGGC has a framework of governance and internal control that provides reasonable assurance regarding the effective and efficient achievement of objectives."

Conclusion and Opinion on Assurance

Overall the Chief Internal Auditor's evaluation of the control environment concluded that; based on the audit work undertaken, the assurances provided by the Chief Officers of the HSCP Board, West Dunbartonshire Council and Greater Glasgow and Clyde Health Board, the review of the local code and knowledge of the HSCP Board's governance, risk management and performance monitoring arrangements:

"It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2022 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself.

<u>Covid-19</u>
The significant incident in late March 2020 continued to test how well the HSCP Board's risk management, governance and internal controls framework operated during 2021/22.

There were examples of innovations, new business processes and solutions and new technology being embraced in order to deliver services to the community. This was achieved using amended governance arrangements, new ways of decision-making, leadership and implementation including virtual meetings and secure remote access to systems to allow employees to work from home. The Chief Officer and the senior management team were actively involved in the local resilience planning through their dual roles in West Dunbartonshire Council and NHS Greater Glasgow and Clyde."

Assurance and Certification

Whilst recognising that improvements are required, as detailed above, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP Board's governance arrangements.

We consider the internal control environment provides reasonable and objective assurance that any significant risks impacting on our principal objectives will be identified and actions taken to mitigate their impact and deliver improvement.

Systems are in place to regularly review and improve the internal control environment and the implementation of the action plan will be monitored by the HSCP Senior Management Team throughout the year.

Michelle McGinty Date: 27 June 2022
HSCP Board Chair

Beth Culshaw Date: 27 June 2022
Chief Officer

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) AUDIT AND PERFORMANCE COMMITTEE

Report by: Margaret-Jane Cardno, Head of Strategy and Transformation

27 June 2022

Subject: Interim Risk Report: ICT Infrastructure

1. Purpose

1.1 The purpose of this report is to provide further assurance to the Audit and Performance Committee in respect of the strategic risks pertaining to ICT Infrastructure and provide clarity on the HSCP Senior Management Team decision not to escalate ICT Infrastructure as a strategic risk at this time.

2. Recommendations

2.1 Is it recommended that the Performance and Audit Committee note the content of this report.

3. Background

3.1 At a Meeting of the West Dunbartonshire HSCP Board Audit and Performance Committee held on Monday, 7 March 2022 the Committee considered a report by the Head of Strategy and Transformation entitled "Strategic Risk Register Six Month Review".

3.2 The Committee agreed that the Head of Strategy and Transformation provide an interim update report to the Audit and Performance Committee on Monday, 20 June 2022 (this meeting now having been rescheduled until Monday, 27 June 2022).

3.3 The purpose of this report is outlined in paragraph 1.1 and relates to the reasons why the Health and Social Care Senior Management Team have decided not to escalate ICT Infrastructure as a strategic risk at this time.

4. Main Issues

4.1 West Dunbartonshire HSCP relies on its partner organisations NHS Greater Glasgow and Clyde (NHSGGC) and West Dunbartonshire Council for this strategic ICT infrastructure and support. Both partner organisations have risk management frameworks in place and these frameworks influence the management of risk within the HSCP.

4.2 In respect of this report which focuses on ICT Infrastructure, West Dunbartonshire Council have two risks highlighted on their strategic risk register (SR0004 and SR0008), as reported to West Dunbartonshire Council Audit Committee on 2 March 2022. These

risks pertain to Information Technology (risk assessed as likelihood low and impact moderate) and Cyber Attack (risk assessed as very likely with significant impact).

4.3 NHS Greater Glasgow and Clyde have also identified Cyber Threats as a risk within its Corporate Risk Register (score 6, tolerated risk). The organization acknowledges that Cyber Threats are a dynamic and growing threat to the NHS. Until recently, much of the focus of such threats was the theft of financial data, not personal or patient information. There is now a growing risk that the NHS Board will be targeted in order to disrupt a key component of critical National infrastructure. The risk is tolerated within the organisations Corporate Risk Register and is mitigated by the controls currently in place; no additional actions are considered necessary at this time.

4.4 It is clear, as recognized by the members of the HSCP Audit and Performance Committee, that the public sector has come under increased threat of cyber-attack during the pandemic and this risk will continue to evolve.

4.5 As agile working across the public sector becomes more prevalent, with an increase in remote access users, automated and robotic processes, a focus on technology enabled care and the adoption of Cloud based technologies, both the HSCPs Partner organisations have continued to develop robust systems to identify new and emerging issues and to develop interventions to mitigate against those risk.

4.6 Mitigating actions include interventions such as:

a) Anti-malware defence system deployed to end point devices;
b) Cyber controls subject to regular review and audit;
c) Email, web policies and awareness initiatives in place;
d) Emergency patches are deployed on advice of National Cyber Security Teams and supplier guidance. The National Cyber Security Centre (NCSC) Cyber Security guidance continues to be monitored in respect of any changes regarding the geopolitical instability in Ukraine and the surrounding areas';
e) Improvements in security posture in line with the national Public Sector Action plan (PSAP);
f) Multi layered security models in place;
g) Proactive AV Patching Policy in place for the Board's devices and supplier update patches applied to operating systems on a scheduled basis.

4.7 It is clear that both the HSCPs Partner organisations have robust methodologies in place in respect of balancing cyber risk and defence. As outlined above steps have been taken to strike a balance between the current threat, the measures needed to defend against it, the implications and cost of those defences and the overall risk this presents to the both the Partner organisations, and by default

the HSCP. As such the HSCP Senior Management Team is assured that there is no requirement at this juncture to escalate ICT Infrastructure on to the HSCP Strategic Risk Register. The Senior Management Team does acknowledge that this is an emerging issue and will continue to monitor the risk and, working with Partner organisations, assess the threat level.

5. Options Appraisal

5.1 An options appraisal is not required for this report.

6. People Implications

6.1 There are no people implications arising from the recommendation within this report.

7. Financial and Procurement Implications

7.1 There are no financial and procurement implications arising from the recommendation within this report.

8. Risk Analysis

8.1 The content of this report pertains to the risks relating to ICT Infrastructure and its place on the HSCP Strategic Risk Register.

9. Equalities Impact Assessment (EIA)

9.1 An EIA has not been undertaken as the recommendation within this report does not impact on those with protected characteristics.

10. Environmental Sustainability

10.1 A Strategic Environmental Assessment (SEA) is not required for this report.

11. Consultation

11.1 The Strategic Risk Register has been reviewed and confirmed by the Health and Social Care Partnership Senior Management Team. Relevant Monitoring Officers have been consulted in the preparation of this report.

12. Strategic Assessment

12.1 Effective risk management will support local and strategic priorities and national health and wellbeing outcomes. It will prevent or mitigate the effects of loss or harm; and will increase success in delivery of the HSCP Strategic Plan, improving lives with the people of West Dunbartonshire.

13. Directions

13.1 A direction is not required for this report.

Name:	Margaret-Jane Cardno
Designation:	Head of Strategy and Transformation
Date:	2 June 2022

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WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) AUDIT AND PERFORMANCE COMMITTE

Report by: Margaret-Jane Cardno, Head of Service Strategy and Transformation

HSCP Audit and Performance Committee: 27 June 2022

Subject: West Dunbartonshire Health and Social Care Partnership (HSCP) Quarterly Performance Report 2021/22 Quarter Four

1. Purpose

1.1 The purpose of this report is to ensure the West Dunbartonshire HSCP Audit and Performance Committee fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in the West Dunbartonshire HSCPs Strategic Plan.

1.2 This report presents the HSCP performance information reported against the strategic priorities for the period January 2022 to March 2022 (Appendix I) for the Committees consideration.

1.3 It includes an Exception Report highlighting those indicators which are currently at red status (not meeting local targets and out with tolerances).

1.4 The performance information is presented in order to allow the Committee to fulfil its scrutiny function.

2. Recommendations

It is recommended that the Audit and Performance Committee:

2.1 Comment on the content of the HSCP Quarterly Performance Report 2021/22 Quarter Four and performance against the Strategic Plan 2019 - 2023 by exception.

2.2 Note that due to timing issues this report presents partial Quarter Four data.

2.3 Note that Quarter Three information previously unavailable to the Committee is contained within this report.

2.4 Comment on the enhancement to the format of report in the form of additional information pertaining to complaints.

3. Background

3.1 The Performance Framework monitors the HSCP's progress against a suite of performance measures, as outlined in the West Dunbartonshire HSCP's Strategic Plan.

3.2 Development work continues to refine the performance information reported and ensure alignment with local and national developments.

4. Main Issues

4.1 The West Dunbartonshire HSCP performance indicators include a suite of challenging targets. To date, targets have been set using local trends and taking into consideration demographic projections. In due course further work will be undertaken to ensure the targets set against each indicator remain appropriate moving forward.

4.2 It should be noted that due to timing issues this report presents partial Quarter Four data. This is reflective of a similar position in terms of previous reporting on Quarter Three. However, the indicators which were incomplete in Quarter Three have been incorporated into this report.

4.4 The HSCP have 45 performance indicators. Of the 31 reported on in Quarter Four, eight indicators are in Red Status which is out with target tolerances. These exceptions are detailed in Appendix I together with information about improvement actions currently being taken to address these performance issues.

4.5 Ongoing measurement against this suite of indicators provides an indication of how the HSCP is making progress towards the key objectives of integration, in particular how health and social care services support people to live well and independently in their communities for as long as possible.

4.6 Importantly they help to demonstrate how the HSCP is ensuring best value in respect of ensuring good governance and effective management of resources, with a focus on improvement, to deliver the best possible outcomes for the public.

4.7 It is recognised that the factors influencing changes in performance can be various and complex. Performance monitoring arrangements continue to be refined and developed to ensure appropriate scrutiny and ownership of the factors and issues affecting performance.

4.8 The HSCP Board are also asked to note the inclusion of enhanced complaints reporting data. Within the Model Complaints Handling Procedure developed by the Scottish Public Services Ombudsman (SPSO) is a requirement to report performance in relation to complaints internally on a quarterly basis and publicly on an annual basis in line with the SPSO's Model Complaints

Handling Reporting Framework. As part of our commitment to best practice, openness and transparency we will include this framework within our Quarterly Performance Report going forward.

5. Options Appraisal

5.1 Not required for this report.

6. People Implications

6.1 There are no people implications arising from the recommendations within this report.

7. Financial and Procurement Implications

7.1 There are no financial and procurement implications arising from the recommendations within this report.

8. Risk Analysis

8.1 There are no risks identified as a result of the recommendations within this report. This report does however support the mitigation of the following risk as contained within the HSCP Strategic Risk Register:

- Performance Management Information: Failure to review and scrutinise performance management information; creates a risk of the HSCP being unable to manage demand analysis, service planning and budget management across totality of the organisational responsibilities.

8.2 The performance information is considered by relevant Managers in line with operational risk registers. No risks have been identified which would be proposed for escalation to 'strategic risk' status for the HSCP Board.

9. Equalities Impact Assessment (EIA)

9.1 An equality impact assessment is not required as the HSCP Audit and Performance Committee is not being asked to take a substantive decision at this time and the report does not have a differential impact on any of the protected characteristics

10. Environmental Sustainability

10.1 Not required for this report.

11. Consultation

11.1 The Chief Financial Officer and Monitoring Officer within Regulatory Services have been consulted in the preparation of this report.

12. Strategic Assessment

12.1 Not required for this report.

13 Directions

Not required for this report.

Name:	Margaret-Jane Cardno
Designation:	Head of Strategy and Transformation
Date:	2 June 2022

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Appendices:

Appendix 1: West Dunbartonshire HSCP Performance Report 2021/22: Quarter Four January – March 2022.

Appendix 2: West Dunbartonshire Delayed Discharge Performance.

Appendix 3: West Dunbartonshire Delayed Discharge Action Plan.

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership
Performance Report 2021/22: Quarter 4 January – March 2022

Due to timing issues and service priorities during the current COVID-19 pandemic, both within the HSCP and externally, some data is not yet available. On review, Unscheduled Care targets for 2020/21 have been retained for 2021/22 due to the impact of the pandemic on the workstreams upon which these targets were based.

It should also be noted that Unscheduled Care data, i.e. hospital data, is subject to change historically.

PI Status	
	Alert
	Warning
	OK
	Unknown
	Data Only

Short Term Trends	
	Improving
	No Change
	Getting Worse

Early Intervention

Ref	Performance Indicator	Q4 2021/22				Q3 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
1	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	Published late June	95%	Not yet available	Not yet available	93.4%	
2	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	Published late June	95%	Not yet available	Not yet available	98.6%	
3	Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%			100%	
4	Percentage of child protection investigations to case conference within 21 days	60%	95%			78.1%	
5	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on non-offence (care and protection) ground	121	N/A			95	

Ref	Performance Indicator	Q4 2021/22				Q3 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
6	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on offence grounds	22	N/A			16	
7	Number of delayed discharges over 3 days (72 hours) non-complex cases	15	0			7	
8	Number of bed days lost to delayed discharge 18+ All reasons	2,749	1,459			2,280	
9	Number of bed days lost to delayed discharge 18+ Complex Codes	1,452	N/A			1,363	
10	Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over	2,225	1,104			1,429	
11	Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	1,138	N/A			584	
12	Number of emergency admissions 18+	Not yet available	2,295	Not yet available	Not yet available	2,145	
13	Number of emergency admissions aged 65+	Not yet available	1,135	Not yet available	Not yet available	1,127	
14	Emergency admissions aged 65+ as a rate per 1,000 population	Not yet available	68	Not yet available	Not yet available	66.8	
15	Number of unscheduled bed days 18+	Not yet available	17,735	Not yet available	Not yet available	18,439	
16	Unplanned acute bed days (aged 65+)	Not yet available	12,157	Not yet available	Not yet available	13,192	
17	Unplanned acute bed days (aged 65+) as a rate per 1,000 population	Not yet available	727	Not yet available	Not yet available	782.1	
18	Number of Attendances at Accident and Emergency 18+	Not yet available	4,720	Not yet available	Not yet available	5,078	
19	Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	25.1%	24%			25.5%	
20	Number of clients receiving Home Care Pharmacy Team support	259	258			297	
21	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	33%	90%			31%	
22	Percentage of carers who feel supported to continue in their caring role when asked through their Adult Carer Support Plan	97.4%	95%			97.6%	
23	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	Published late June	90%	Not yet available	Not yet available	95.8%	
24	Percentage of Adult Support and Protection clients who have current risk assessments and	73%	100%			50%	

Ref	Performance Indicator	Q4 2021/22				Q3 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
	care plan/protection plan						
25	Number of people receiving Telecare/Community Alarm service - All ages	1,918	2,200			1,933	
26	Number of patients with an eKIS record	20,509	N/A			20,636	

Access

Ref	Performance Indicator	Q4 2021/22				Q3 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
27	Number of people receiving homecare - All ages	1,425	N/A			1,443	
28	Number of weekly hours of homecare - All ages	10,519	N/A			10,987	
29	Total number of homecare hours provided as a rate per 1,000 population aged 65+	524	570			541	
30	Percentage of people aged 65 and over who receive 20 or more interventions per week	38.1%	35%			40.6%	
31	Percentage of homecare clients aged 65+ receiving personal care	98.6%	95%			98.6%	
32	Number of people aged 75+ in receipt of Telecare - Crude rate per 100,000 population	18,384	20,945			18,482	
33	Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	Not yet available	30%	Not yet available	Not yet available	20.5%	
34	Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	Not yet available	32%	Not yet available	Not yet available	28.1%	
35	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	65.9%	98%			78%	
36	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	79.5%	80%			79.7%	
37	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	32.9%	80%			47.6%	

Resilience

Ref	Performance Indicator	Q4 2021/22				Q3 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
38	Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	96%	90%			98.9%	

Ref	Performance Indicator	Q4 2021/22				Q3 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
39	Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	6	18			5	
40	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	45.6%	90%			71.3%	

Assets

Ref	Performance Indicator	Q4 2021/22				Q3 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
41	Prescribing cost per weighted patient (Annualised)	£163.36	GGC average	Not yet available		£171.00	
42	Compliance with Formulary Preferred List	77.13%	78%			77.54%	

Inequalities

Ref	Performance Indicator	Q4 2021/22				Q3 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
43	Balance of Care for looked after children: % of children being looked after in the Community	89%	90%			89.9%	
44	Percentage of looked after children being looked after in the community who are from BME communities	71%	N/A			75%	
45	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	N/A*	75%			100%	

*No 16 or 17 year olds left care in the quarter

Please find October to December 2021 data below for those indicators we were unable to report on in our Quarter 3 Performance Report.

Early Intervention

Ref	Performance Indicator	Q3 2021/22				Q2 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
1	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	93.4%	95%			96.6%	
2	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	98.6%	95%			97.2%	

Ref	Performance Indicator	Q3 2021/22				Q2 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
5	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on non-offence (care and protection) ground	95	N/A			85	
6	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on offence grounds	16	N/A			27	
7	Number of delayed discharges over 3 days (72 hours) non-complex cases	7	0			11	
12	Number of emergency admissions 18+	2,145	2,295			2,213	
13	Number of emergency admissions aged 65+	1,127	1,134			1,090	
14	Emergency admissions aged 65+ as a rate per 1,000 population	66.8	68			64.6	
15	Number of unscheduled bed days 18+	18,439	17,735			18,633	
16	Unplanned acute bed days (aged 65+)	13,192	12,157			12,571	
17	Unplanned acute bed days (aged 65+) as a rate per 1,000 population	782.1	727			745.3	
18	Number of Attendances at Accident and Emergency 18+	5,078	4,720			5,692	
23	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	95.8%	90%			95.3%	

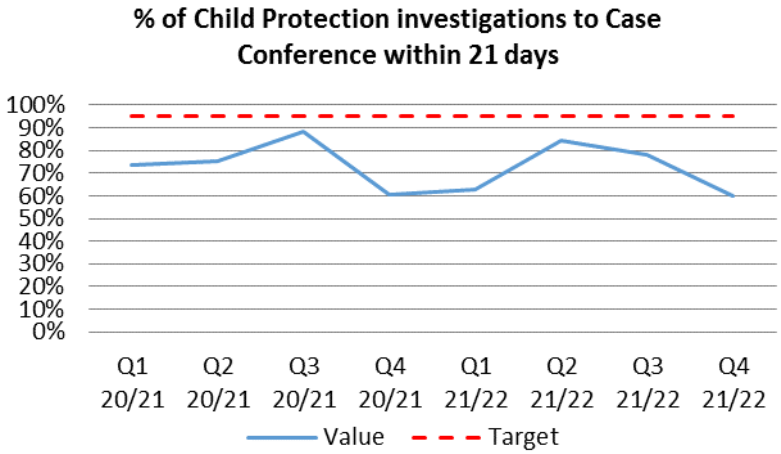
Assets

Ref	Performance Indicator	Q3 2021/22				Q2 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
41	Prescribing cost per weighted patient (Annualised)	£171.00	GGC average	N/A		£166.88	
42	Compliance with Formulary Preferred List	77.54%	78%			76.05%	

West Dunbartonshire Health and Social Care Partnership
Exceptions Reporting: Quarter 4 January - March 2022

Performance Area: Child Protection

Quarter	Value	Target
Q1 20/21	73.3%	95%
Q2 20/21	75.0%	95%
Q3 20/21	88.0%	95%
Q4 20/21	60.5%	95%
Q1 21/22	62.5%	95%
Q2 21/22	84.2%	95%
Q3 21/22	78.1%	95%
Q4 21/22	60.0%	95%



Key Points:

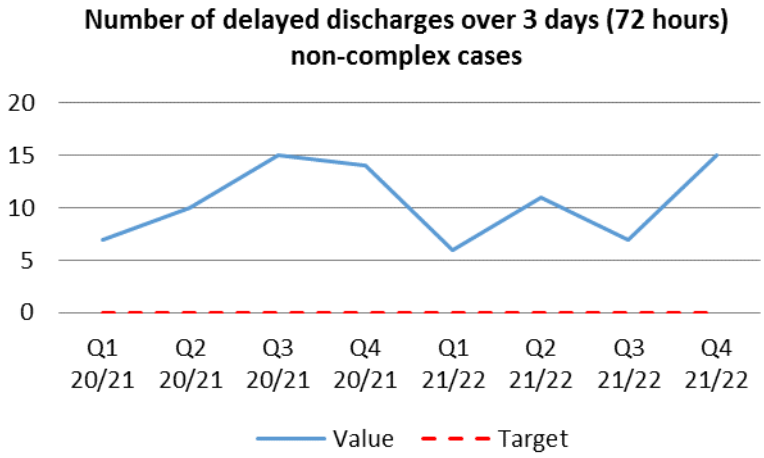
Of the 25 case conferences due to take place during January to March, 15 were carried out within the 21 day timescale.

Improvement Actions:

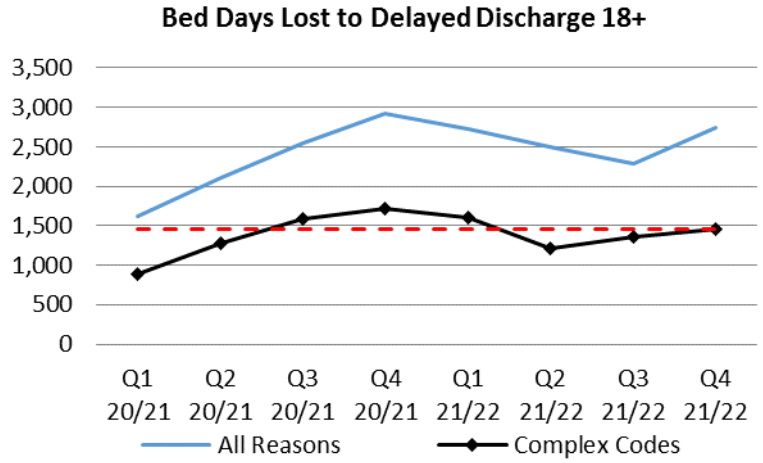
Timescales for a number of key stages in the Child Protection journey are now being routinely monitored through the implementation of the Child Protection Minimum Dataset which is being analysed and reported to the Child Protection Committee on a quarterly basis. This rich dataset should allow us to identify trends, areas for improvement and any recording gaps. Independent audit activity is currently underway in respect of children who have been subject to child protection registration in the last 12 months using the Care Inspectorate audit tool. A full report with analysis and recommendations will be produced for Children's Services to drive improvement activities, this will be reported to Child Protection Committee in due course.

Performance Area: Delayed Discharge

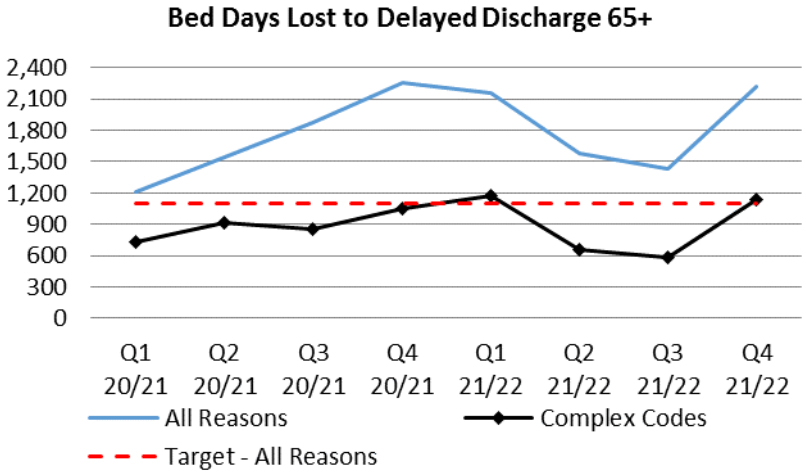
Quarter	Value	Target
Q1 20/21	7	0
Q2 20/21	10	0
Q3 20/21	15	0
Q4 20/21	14	0
Q1 21/22	6	0
Q2 21/22	11	0
Q3 21/22	7	0
Q4 21/22	15	0



Quarter	All Reasons	Complex Codes
Q1 20/21	1621	893
Q2 20/21	2101	1276
Q3 20/21	2542	1594
Q4 20/21	2913	1718
Q1 21/22	2726	1598
Q2 21/22	2505	1210
Q3 21/22	2280	1363
Q4 21/22	2749	1452



Quarter	All Reasons	Complex Codes
Q1 20/21	1210	727
Q2 20/21	1541	910
Q3 20/21	1878	848
Q4 20/21	2256	1053
Q1 21/22	2163	1180
Q2 21/22	1575	662
Q3 21/22	1429	584
Q4 21/22	2225	1138



Key Points:

Focused efforts to facilitate hospital discharges in a safe and timely way have continued however delays have steadily risen throughout the quarter from 24 in early January to a peak of 39 at the end of March. In total there were 85 people with a delayed discharge compared with 62 in the previous quarter. While overall numbers of delays have increased, a small number of people with particularly lengthy delays were able to be discharged during this period.

Improvement Actions:

Daily meetings between all 6 Health and Social Care Partnerships and the Health Board are continuing. These meetings provide supportive inputs from peers and senior figures, as well as provide transparency and accountability across the HSCPs and Health Board.

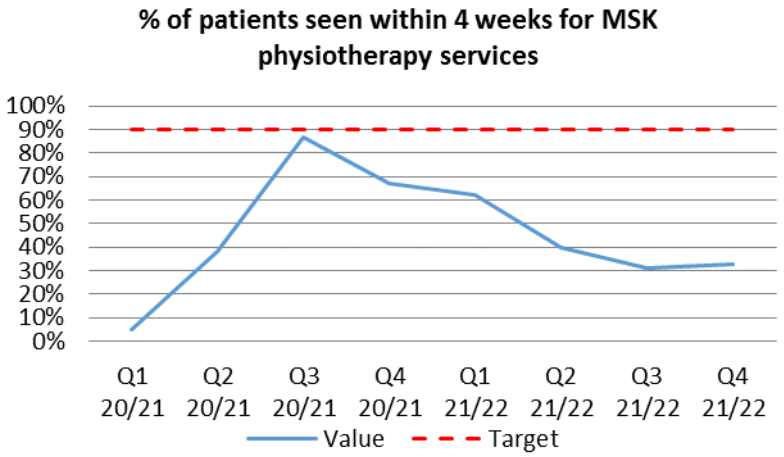
Weekly meetings with a focus on all West Dunbartonshire delays continue with the Discharge Team which has representation from the Hospital Discharge team, Social Work and Mental Health Officer team to facilitate discharges.

Local data is continually monitored and analysed to identify areas for improvement.

Chronology data-gathering complete on long term Adults with Incapacity (AWI) cases and non-AWI cases. This work continues to be used to evidence and identify any bottlenecks or delays in processes.

Performance Area: Musculoskeletal (MSK) Physiotherapy

Quarter	Value	Target
Q1 20/21	5%	90%
Q2 20/21	38%	90%
Q3 20/21	87%	90%
Q4 20/21	67%	90%
Q1 21/22	62%	90%
Q2 21/22	40%	90%
Q3 21/22	31%	90%
Q4 21/22	33%	90%



Key Points:
There has been a sharp rise in the number of patients waiting over the 4 week target during January to March 2022 however all patients categorised as urgent continue to be seen within 4 weeks.
During January the service once again had to redeploy 13% of the available workforce to support acute colleagues with the impact of the Omicron variant. This meant that caseloads had to be fully absorbed by remaining staff to ensure continuity of patient care.

There were also unprecedented levels of sickness absence within the service in February 2022.

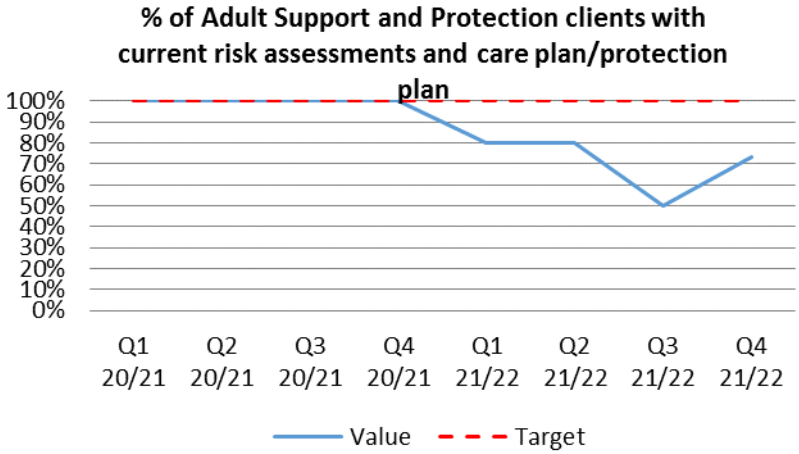
Newly qualified staff have had very little face to face experience due to the pandemic affecting practice placement experience. This has resulted in newly qualified practitioners requiring more time for supervision and support to ensure governance requirements are met.

Improvement Actions

All patients requiring a first appointment continue to predominately be managed by Virtual Patient Management in the first instance. We are continuing to remobilise face to face provision based on clinical decision making/clinical need and orthopaedic post-operative patients are now escalated for face to face at first point of contact. Due to the ongoing infection control and social distancing requirements face to face capacity in Physiotherapy sites across Greater Glasgow and Clyde is around 30% of normal service provision.

Performance Area: Adult Support and Protection

Quarter	Value	Target
Q1 20/21	100%	100%
Q2 20/21	100%	100%
Q3 20/21	100%	100%
Q4 20/21	100%	100%
Q1 21/22	80%	100%
Q2 21/22	80%	100%
Q3 21/22	50%	100%
Q4 21/22	73%	100%

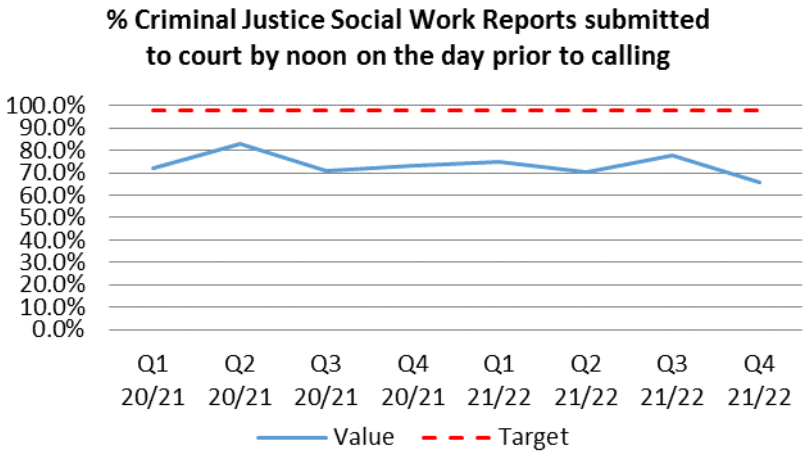


Key Points:
8 of the 11 Adult Support and Protection clients during January to March 2022 have a current risk assessment and care plan/protection plan. Increase scrutiny has identified that not all plans are in place and figures for 2021/22 have been amended to reflect this.

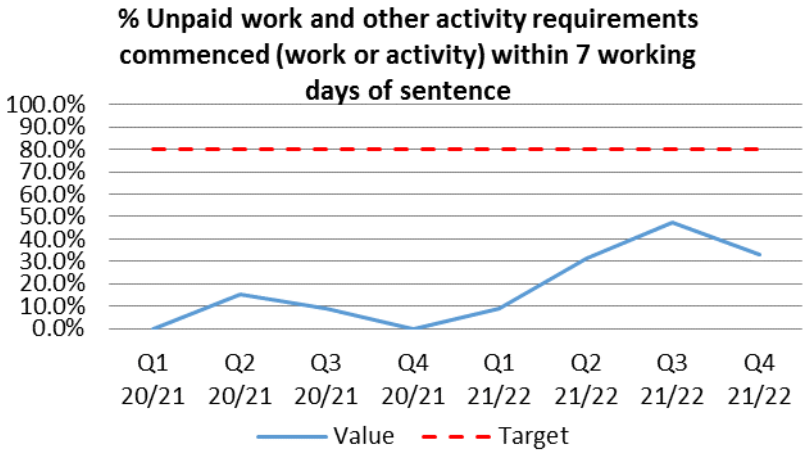
Improvement Actions:
This increased level of scrutiny will continue and processes are being put in place to highlight any gaps to officers involved. Extensive training has been undertaken across all staffing levels ensuring that there is strong governance and clarity around the procedures. Procedures have been updated with regard to the duty system and audit work is being implemented over the next few months the outcomes of which will be reported to the Adult Protection Committee at an appropriate time. This will provide assurance that improvement actions have been imbedded into practice.

Performance Area: Criminal Justice

Quarter	Value	Target
Q1 20/21	72.0%	98%
Q2 20/21	83.0%	98%
Q3 20/21	71.0%	98%
Q4 20/21	73.0%	98%
Q1 21/22	75.0%	98%
Q2 21/22	70.5%	98%
Q3 21/22	78.0%	98%
Q4 21/22	65.9%	98%



Quarter	Value	Target
Q1 20/21	0.0%	80%
Q2 20/21	15.0%	80%
Q3 20/21	9.0%	80%
Q4 20/21	0.0%	80%
Q1 21/22	9.0%	80%
Q2 21/22	31.3%	80%
Q3 21/22	47.6%	80%
Q4 21/22	32.9%	80%



Key Points:
At the outset of Quarter 4 the Omicron variant began causing a spike in Covid-19 transmission rates. In an attempt to create a circuit break and protect staff and service users, the Unpaid Work Service extended its normal closure period into the 2nd week in January. As the quarter progressed the transmission of Covid cases continued to increase, in particular during March 2022, increasing staff and service user sickness rates.

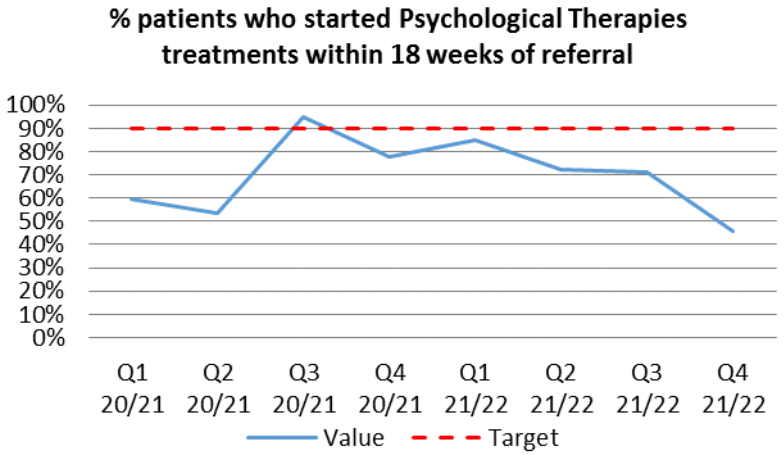
Some staff turnover was also a factor with new staff requiring training.

Improvement Actions:
With restrictions lifting and the threat of Covid reducing, figures should start to return to that of Quarter 3.

The refurbishment of the unpaid work workshop is nearing completion and this will facilitate further opportunities to both expand the service and increased opportunities for service users.

Performance Area: Psychological Therapies

Quarter	Value	Target
Q1 20/21	59.6%	90%
Q2 20/21	53.4%	90%
Q3 20/21	95.1%	90%
Q4 20/21	77.6%	90%
Q1 21/22	84.8%	90%
Q2 21/22	72.4%	90%
Q3 21/22	71.3%	90%
Q4 21/22	45.6%	90%



Key Points:
92 people started Psychological Therapies treatments between January and March: 42 waited less than 18 weeks from the point of referral.

There are a number of vacancies across the teams which is impacting on caseload capacities. However, we have a new Consultant Psychologist in post in Helensburgh Community Mental Health Team and an additional 1 Whole Time Equivalent Mental Health Therapist has been employed within the Primary Care Mental Health Team. This increases the number of assessments and treatment capacity.

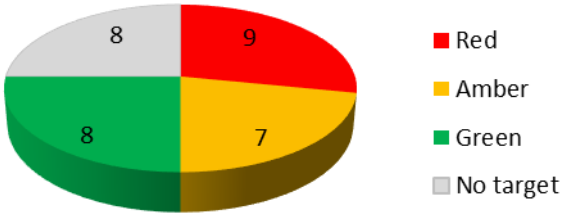
Improvement Actions:
We are actively processing vacancies as quickly as possible to ensure as little impact on waiting times as possible and longest waits are being offered appointments across the area as space becomes available.

Three members of staff within the Primary Care Mental Health Team are working 9 additional hours per week.

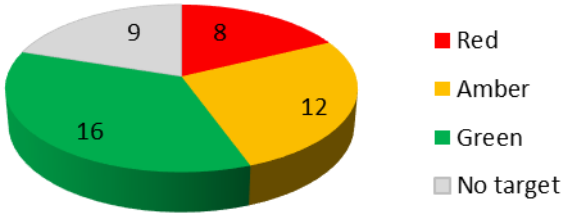
We are continuing the Wellbeing Nurse rollout and continue to monitor waiting times progress via the local Psychological Therapies monitoring group and are currently targeting erroneous data on the dashboard.

Summary of Strategic Plan Key Performance Indicators

Quarter 4: January to March 2022
(Partial Data)



Quarter 3: October to December 2021
(Full Data)



West Dunbartonshire Health and Social Care Partnership
Complaints Reporting: Quarter 4 January-March 2022

Within the Model Complaints Handling Procedure developed by the Scottish Public Services Ombudsman (SPSO) is a requirement to report performance in relation to complaints internally on a quarterly basis and publicly on an annual basis in line with the SPSO's Model Complaints Handling Reporting Framework.

As part of our commitment to best practice, openness and transparency we will include this framework within our Quarterly Performance Report going forward.

These indicators are set by the SPSO and should provide opportunities for benchmarking and identify good practice and areas for improvement on a local and national basis.

During January – March 2022 the following learning points or actions were identified through the investigation of complaints received by the HSCP.

Service Area	Lessons Learned/Actions Taken
Children's Health, Care and Criminal Justice	• Requirement to raise awareness for Social Work staff around scope of involvement particularly when court order exists and ensure that any advice/guidance offered is not contrary or in relation to legal matters.
MSK Physiotherapy	• A change to the filing system has been recommended to ensure outstanding queries are not lost to follow up.

SPSO Indicator	Measure	Q1	Q2	Q3	Q4

2	Number of Stage 1 complaints (whether escalated to Stage 2 or not)	16	21	13	16
	Number of complaints direct to Stage 2	8	7	6	10
	Total number of complaints	24	28	19	26
3	% closed within timescale - Stage 1	Not yet available			
	% closed within timescale - direct to Stage 2	2	1	2	2
	% closed within timescale - escalated to Stage 2	1	None recorded as escalated	None recorded as escalated	None recorded as escalated
4	Average response time - Stage 1	Not yet available			
	Average response time - direct to Stage 2	25	23	23	24
	Average response time - escalated to Stage 2	18	None recorded as escalated	None recorded as escalated	None recorded as escalated

The accurate recording of Stage 1 complaints, their outcomes and timescales across both West Dunbartonshire Council and NHS Greater Glasgow and Clyde systems is in early development stages.

Indicator 5: Outcomes of Complaints

Stage 2 – Quarter 4 2021/22

	Model Complaints Handling Procedure	
Outcome	NHSGGC	WDC*
Fully Upheld		
Partially Upheld	1	1
Not Upheld	2	2
Unsubstantiated		
Total	3	3

*4 Complaints ongoing

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Report by Interim Head of Health and Community Care

27 June 2022

Subject: West Dunbartonshire Delayed Discharge Performance

1. Purpose

1.1 The purpose of this report is to report on the progress of the quality improvement underway to improve performance in relation to delayed discharges.

2. Background

2.1 In March 2022 West Dunbartonshire HSCP performance was identified as having deteriorated in comparison to other HSCPs in both GG&C and also in Scotland, particularly in the number of delayed coded against AWI. A quality improvement action plan was written to identify and monitor areas for improvement.

2.2 Key points of the Improvement Plan include:

- Review of existing processes and pathways within the Community Hospital Discharge Team (CHDT).
- Develop and pilot a delays tracker on microstrategy
- Review of the pathways under Code 9 (AWI) inclusive of the use of 13ZA legislation
- Focussed quality improvement work in partnership with colleagues in the Vale of Leven Hospital (Wards 14 / 15 / Lomond)

The detail of the Plan can be seen in Appendix 1.

2.3 Table 1. Delays statistics

	08/03/2022	06/04/2022	05/05/2022	10/06/2022
Number of Delays	31	25	34	23
Average Bed Days Lost	48	44.7	38	48.8
Average Bed Days Lost - Non-AWI	18.1	38.6	15.6	11.2
Average Bed Days Lost - AWI	78.9	49.5	78.2	77.8
Care Home Delays	4	5	3	2
11A/B Assessment Delays	6	3	15	5
AWI	15	14	13	13

2.4 The table demonstrates an overall reduction in all delays, both AWI and non AWI. Average ‘bed days lost’ to non AWI has decreased however AWI bed

days lost remains static. The figures for Care home and 11A/B delays are a snapshot.

2.4 The Delays Tracker has provided additionally to enhance the Quality Improvement Action Plan and has been cross reference against existing key areas of focus for improvement. The tracker will enhance the process by providing further analysis of delays chronologies and allowing refinement of the improvements.

2.5 Figure 2. Delay Reasons (May 2022)

Delay Reason	Delay Reason Descpription	Average Days on Code	Total Days Lost	% of Total Days
Blank	UNKNOWN	2	149	16.5%
11A	Awaiting commencement of post-hospital social care assessment (including transfer to another area team)	2	41	4.5%
11B	Awaiting completion of post-hospital social care assessment (including transfer to another area team)	10	399	44.2%
24A	Awaiting place availability in Local Authority Residential Home	5	31	3.4%
24C	Awaiting place availability in Nursing Home (not NHS funded)	8	192	21.3%
24F	Awaiting place availability in care home (EMI/Dementia bed required)	8	8	0.9%
25D	Awaiting completion of social care arrangements - In order to live in their own home - awaiting social support (non-	4	16	1.8%
25E	Awaiting completion of social care arrangements to live in own home - awaiting procurement/delivery of	1	5	0.6%
25F	Awaiting completion of social care arrangements for Specialist Housing provision (including sheltered housing and	4	35	3.9%
51	Legal issues (including intervention by patient's lawyer), e.g. informed consent	14	27	3.0%

2.6 Area of focus from analysing the tracker:

- Unknown codes
- Assessment timescales (11A / 11B)
- Transfer to Care Homes (24C Private Nursing)
- AWI codes (Code 9) - specifically Private Guardianship applications.

2.7 Assessment timescales remain a challenge and discussion continues with the Social Workers in the team to target improvement actions. It is important to acknowledge that a comprehensive assessment for those with complex health and social care needs, in tandem with the need for capacity assessments to inform this process, can be time consuming.

A component of the restructuring of the CHDT is to target resources to enable an increase in assessments before people are fit for discharge thereby reducing the time assessments take once coded as a delay.

2.8 Bed days lost attributed to ‘place availability in Nursing Home’ was higher than anticipated and improvement work was implemented early in the action plan. Discussions with care home managers is underway to identify further areas of improvement.

2.9 Delays attributed to AWI in West Dunbartonshire remain high and the tracker provides significant detail that was previously unseen. The highest number of bed days lost are attributed to Private Guardianship applications.

Discussions are in progress to consider what further proactive steps the HSCP can take to engage with Solicitors to work with the CHDT to actively progress cases.

3. Next Steps

3.1 The initial action plan is being refreshed to articulate the next steps in the quality improvement process to monitor and assure the sustainability of all actions.

- Continue to refine the tracker, testing the indicative performance measures
- Quality improvement work in identified wards in the Vale of Leven Hospital
- Ongoing restructuring of the current CDHT
- Link all actions with Discharge without Delay, Unscheduled Care. Action Plan and Winter Monies initiatives to demonstrate a state of readiness ahead of winter 22/23.

Action Plan Tracker

Completed	
In Progress	
Late	

Item	Action	Due date	Who	Status and comments	RAG
Enhance scrutiny of timescales through FFD to discharge date	Daily update huddles to review 'in scope' delays and twice weekly 'deep dive' to monitor complex delays MH / LD / AWI's.	14.03.22	Liz Kerr	**Completed** Daily huddles started 30 /3/22 FT attending daily huddles to maintain scrutiny of progression through to discharge. FT: Chair deep dive twice /week, based on Renfrewshire model, with relevant service leads and concurrent review of the process of collating relevant reports. 22/04/22- now business as usual	
	Record keeping on Carefirst to demonstrate key dates/ decision making.	31.03.22	SW staff in all teams	**Completed** 8th March- all HDT SW asked to complete accurate record keeping 18th March – LD and MH Leads asked to implement same.	
	Develop microstrategy to allow codes to be maintained	08.04.22	Callum Alexander / FT /P McG	FT / CA / PMcG met to review, CA to speak to F Paton re proof of concept to maintain AWI codes as they alter to allow KPI monitoring. Selectors can be set, alerts set to flag breaches of timescales. SW names can be identified also. Automated reports.	

				Pending IT build, CA is completing a manual report to demonstrate chronologies. 5/4/22 Build is progressing, slower than anticipated due to the complexity of the work required to develop the functionality. Aim to have it available by 08/04/22 22/04/22 Functionality moving towards trialling in WD – date to be confirmed 03/05/22 Initial report generated, and subsequent meetings to refine. Initial pilot phase underway.	

Item	Action	Due date	Who	Status and comments	
Standardised record keeping to demonstrate key decisions on Carefirst	FT to work with LK to develop standards of record keeping- minimum date requirements to allow clear identification of decisions relating to discharges.	31.03.22	FT / LK	Data requirements completed and sent to SSW. Next steps- implement and monitor	
	Develop audit schedule	8/4/22	FT	HSCP approach being implemented	
	Implement audit schedule and follow PDSA cycle / action planning to support sustainability of improvements.	November 2022	LK / Berny Smith	HSCP approach being implemented	

Item	Action	Due date	Who	Status and comments	
Review existing pathways through AWI to improve timescales	Set up 3 new clipboards - MHO referrals - Guardianship referrals - AAG referrals Also business support to monitor timeous allocation. Monitor for - numbers referred - timescales to allocate - timescales for MLA completion →	11.03.22	Sylvia Chatfield	New clipboards in place. Monitor this as a change process to ensure it works and is effective. All clipboards will be collated into a 'bundle' so staff are aware of the processes. 5/4/22 WD Legal Team to letter Solicitors to seek their support to progress cases timeously. 7/4/22 WD Legal- are not legally allowed to letter Solicitors in this manner as the contract of engagement is between the client and Solicitor. We don't have a role to interfere in that contract.	

	Review thresholds for decision making to move to use AWI legislation. Monitor for - reduction in referrals - quality of referrals	08.04.22 Monitoring ongoing	Sylvia Chatfield	March 8th SC met with SW's in CHDT to discuss thresholds. 5/4/22 SSW (Liz Kerr and Maggie Hart) reviewing AAG process, inclusive of those who should be consulted in the process. Reports to be run monthly to monitor referrals and presented to CO	
	Review WD paperwork required from Consultants for capacity assessments / medical assessments as these are different from other HSCP's and flow between SW and wards to monitor progression of these	March 2022	Sylvia Chatfield	Inverclyde have a low number of AWI related delays and their 13ZA guidelines have been reviewed to allow a comparison and opportunities to improve the WD practice shall be adopted. Links with item 2 – key dates recorded to identify delays relating to this.	
	Work with Wards 14 /15 and Lomond at the Vale of Leven to scrutinise pathways and explore opportunities to reduce delays.	30.04.22	FT / M O'Rourke	Initial meeting held with CO's and FT March. Planned second meeting early April to define the plan 12.04.22 M O'R unable to attend until mid May 10/06/22 FT / M o'R initial meeting, test of change process to be agreed and implemented.	

Item	Action	Due date	Who	Status and comments	
Review existing HSCP flow chart defining the discharge pathway •Non delays	Discussion with IOM / Team Leads identified wider issues to explore as a quality improvement process across the wider CHDT do improve flow. Review across all 3 components and interdependencies of the HDT - Early assessment	21.03.22	FT	Discussed options with IOM / SSW. No 'quick wins' identified. Challenges with existing workloads for all SW in the CHDT. 14/3/22 actively seeking Agency SW support to target delays for an initial period of 4 weeks.	

•Delay •AWI delay with proxy •AWI delay without proxy	- Fit for discharge - Delays			Ongoing work to review opportunities to revise current allocation across all the H&CC Integrated teams being led by FT. 10/06/22 Process mapping identified opportunities to realign staff within the CHDT teams and also recruitment is underway for permanent posts (inclusive of SW) to enhance the team. Manager from another service area seconded to lead this process.	

Item	Action	Due date	Who	Status and comments	
Review proportionate % AWI across Acute sites	Data analysis	17.03.22	FT / PMcG	**Completed** Dec – Feb Average 14% of GGC total	
Review proportionate % of Care Home placements across Acute sites	Data analysis	17.03.22	FT / PMcG	**Completed** Dec- Feb Average of 7% of GGC total	

Item	Action	Due date	Who	Status and comments	
Care Home pathways have previously been scrutinised to ensure the process is free from delay, however further review is beneficial	Care Home Managers to be asked for feedback re current timescales for admissions, and any current issues with quality of MLA's they are receiving. This is a continuous dialogue that was already in place and having reviewed it there is assurance that the process remains as planned but the Head H&CC will continue to monitor. Ensure PH guidance is followed and risk assessments are in place to facilitate safe	31.03.22	FT	**Completed** MLA's are sent to care homes with a read receipt on the day of ARG funding agreement. Managers prioritise pre assessment and agreement of placement as soon as possible. Limitations are linked to available staffing due to Covid related absences, both to assess and then to support a new person in a home – depending on the care needs. Some homes have also chosen to stagger admissions (weekly) due to Covid related pressures and although this had reduced, the current peak has caused further pressures with staff absences and also outbreaks within the homes.	

	discharges from closed wards when applicable.			MLA format- Managers report that they find this less effective at identifying the client care needs than the previous assessment tool. Work is ongoing to gain further examples of potential improvement work that would enhance the sharing of relevant information in a quick manner. 30/3/22- continuous dialogue via Care Home Managers meetings.	

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE AUDIT AND PERFORMANCE BOARD

Report by Head of Lesley James, Head of Children's Health Care & Criminal Justice, Chief Social Work Officer

27th June 2022

Subject: Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire

1. Purpose

1.1 This report provides information on the Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire and the actions being taken by the Community Planning Partnership (CPP) to improve outcomes for children, young people.

1.2 The Inspection was led by the Care Inspectorate and involved scrutiny partners drawn from Healthcare Improvement Scotland, Education Scotland and HM Inspectorate of Constabulary. The active period of the Inspection process ran from October 2021 until March 2022 and gathered evidence drawn from a range of sources across a 2 year period prior to the commencement date.

1.3 The Interim report was published on 24 May 2022.

2. Recommendations

2.1 Note the publication of the Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire.

2.2 Note that the Community Planning Partnership remains in a period of monitoring and evaluation of progress by the Care Inspectorate and a further report will be prepared by the Inspection Team at a time yet to be confirmed.

3. Background

3.1 The focus for this Inspection was the cohort of children and young people at risk of harm including those who have been subject to an initial referral to a multi-agency process because of concerns about their safety and wellbeing; children and young people who have a formal plan; or, children and young people who have received an alternative service to improve and support their

wellbeing. The Inspection covers a two year period prior to the date in September 2021.

3.2 This Inspection is part of the national scrutiny and assurance process designed to support Community Planning Partnerships to carry out and use self-evaluation to improve outcomes for children and young people.

3.3 West Dunbartonshire is one of a number of Partnerships to undertake a Joint Inspection of services for children and young people at risk of harm over 2021/22. There are some key changes to Inspection process and approach from the Inspections carried out over 2018-2020. These are –

- Change of focus from children in need of care and protection to children and young people at risk of harm supported by revised Inspection Statements.
- Amplified voice of children and young people including the face to face meetings with children, young people and their parents; the focused Network of Support sessions with staff directly providing services to a sample of 6 children and young people; survey of children, young people and their parents.
- Reduced pre Inspection submission requirements and timetable for submission – including the later submission of the Position Statement and supporting evidence in January 2021 rather than at the start of the Inspection process.
- Remote reading of case records, revised case recording template and guidance.
- A more concise public report detailing the assessment of the Partnership's performance in respect of the key Inspection Statements.
- Evaluation on the six point scale for Quality Indicator 2.1 – impact on children and young people.

4. Main Issues

Inspection Process

4.1 The footplate for this Inspection has been further modified due to the impact of the pandemic and the local and national measures in place. The Inspection Team have had no opportunity to meet face to face with partners, staff, children and young people and their parents. The planned focus group meetings with the strategic planning groups; the sample of 6 Network of Support meetings [including those with children and young people] and the face to face meetings or discussions drawn from the additional 40 sample of children, young people and parents did not take place. This means that there is variance from the expected process and this is acknowledged in the Interim Report. Additionally the Partnership did not receive an evaluation statement under Quality Indicator 2.1 which considers the impact on children, young people and evaluates the extent to which children and young people in need of protection, those who are looked after at home or away from home, in

continuing care or care leavers are listened to; can build positive relationships; receive care and support required; and, can move onto positive adulthood.

4.2 To reach conclusions the Inspection Team have drawn on evidence from the following sources – Partnership's Position Statement and supporting evidence [this is essentially a self-evaluation]; staff survey; file reading; children, young people and parent survey [drawn from a sample of 60]; the Link Inspector report; outcome from previous Inspections [including service based inspections]; national data returns; Police Scotland and Education services information; and, internet publications such as Council, NHS GG&C and Health and Social Care Partnership Board meeting papers.

4.3 The Partnership's Position Statement and supporting evidence was submitted on 26 January 2022 and outlined the key achievement and areas for improvement which are reflected in the Interim Report.

Interim Report

4.4 The Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire was published on the Care Inspectorate website on 24 May 2022. **[appendix 1]**

4.5 The report provides overarching key messages to the Partnership underpinned by further detail under each of the 4 Inspection Statements. The key messages are -

- The Partnership was responding effectively when concerns about children and young people were first identified;
- Children and young people said they had an opportunity to develop a relationship with key members of staff;
- There are discrepancies between how staff saw their practice and what we saw in children and young people's records;
- Following the initial identification of harm, the quality of key processes was inconsistent;
- From reading records, there was little evidence of children's views being solicited or taken into account when decisions were made that affected them;
- There was little follow up analysis of the impact of services to improve outcomes for children and young people at risk of harm;
- To be more impactful, the Child Protection Committee's oversight and scrutiny of data and quality assurance activity required development;
- Strategic leaders needed to work collaboratively to understand their activity and its impact on children and young people at risk of harm.

4.6 **Statement 1:** Children and young people are safer because risks have been identified early and responded to effectively

- The Partnership maintained child protection services and tried to reduce the impact of Covid -19 pandemic on the operational delivery of services to children and families;
- There was a marked contrast between the confidence expressed by staff in their abilities and what we saw in records;
- When concerns about children were first identified, the Partnership responded promptly;
- There were delays in 40 % of inter-agency referral discussions taking place and they had not taken/been recorded for a third of the children whose records we read;
- Improvement is needed in both the response to follow up concerns and the effectiveness of reducing risk for children and young people with little evidence of risk reduction in children's records.

Work on Domestic abuse including the No Home for Domestic Abuse Policy are highlighted as positive steps within the Report

4.7 **Statement 2:** Children and young people's lives improve with high-quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm.

- The majority of children, young people, parents and carers who responded to our survey said they happy with the level of contact they had with their worker during the Covid-19 pandemic;
- Assessments, chronologies and plans had been completed by staff but the quality of these needed to improve with most rated as adequate with a few unsatisfactory;
- The majority of children's plans were being reviewed within timescales, however, the quality of most reviews was rated as 'adequate' [this means that strengths just outweighed weaknesses];
- The Partnership highlighted a range of activities intended to support children and young people at risk of harm. We could not always see the impact of these or how they related to an overarching plan for service delivery;
- There was limited evidence that learning from audit or scrutiny activity was being used to influence practice development or improvement.

The Report notes the positive steps taken by the Partnership and across NHS GG&C to address the waiting times for children and young people who require mental health services from Child and Adolescent Mental Health Services.

4.8 **Statement 3:** Children and young people and families are meaningfully and appropriately involved in decisions about their lives. They influence service planning, delivery and improvement.

- The majority of children, young people, parents and carers in the sample had opportunities to develop a relationship with a key member of staff
- We rated the quality of how well children had been listened to, heard and included by staff as adequate [in Inspection this means that strengths just outweigh weaknesses] or below in records
- There was little evidence to suggest that children and young people are given opportunities for involvement in development activities, service planning and review

4.9 Statement 4: Collaborative strategic leadership, planning and operational management ensure high standards of service delivery

- Key plans across the Partnership were not well aligned to the overarching vision for children's services
- The approach leaders and managers were taking to monitor practice standards and quality assurance was under developed
- To be more impactful the Child Protection Committee's oversight and scrutiny of data requires development

Collective leadership and collaborative working is subject to further commentary in the body of the report and includes the need to better measure and understand the impact of services using a cohesive framework which can then be applied to influence service improvement and areas for investment.

5. Options Appraisal – Next Steps

As noted above the Care Inspectorate and scrutiny partners did not undertake the planned programme of engagement of face to face meetings with children, young people and their family members or focus groups with operational staff and strategic planning partners. The Inspection Team are confident in the conclusions and key messages within the report. The report notes that the Inspection Team are more confident that the Partnership now recognises and knows where changes need to be made. However, the Interim Report also states that they do not think the Partnership would be able to take all the actions necessary without external support and challenge.

As part of the dedicated support the Inspection Team have developed and are delivering a series of 9 workshops to the Partnership on the following topics – multi-agency record reading; Inter agency Referral Discussions; using data; self-evaluation; involvement of children and young people; quality assurance; leadership relating to Quality Indicators and self-evaluation.

In common with all other Inspections of care and health services an Action or Improvement Plan has been developed to prioritise activity and address the areas identified through self-assessment activity and the conclusions contained within the report. This will be shared with Members in the near future and the Improvement or Action Plan draws on other strategic planning and operational review activity in relation to services for children and young people at risk of harm. Strengthened governance arrangements have been put in place to support delivery, including an

Executive Oversight Group which reports to the multi-agency Public Protection Chief Officers Group of the Community Planning Partnership.

The Partnership remains in a period of monitoring and evaluation of progress by the Care Inspectorate and a further report will be prepared by the Inspection Team at a time yet to be confirmed.

6. People Implications.

6.1 In order to strengthen scrutiny, management oversight and collaborative leadership, additional fixed term posts have been requested from HSCP reserves. This includes;

- Independent Review Co-ordinators to enhance scrutiny of Looked After Children's planning arrangements and to ensure children are at the centre with their views being sought and heard.
- An additional senior manager on a fixed term 2 year contract to support improvement and scrutiny across the children and families service.
- Integrated Children services lead to support the Nurture DIG and the work of Integrated children's services planning across the community planning partnership.

7. Financial and Procurement Implications

7.1 The preparation of the annual financial statements includes a comprehensive review of HSCP reserves. This review covers existing reserves (both un-earmarked and earmarked) and the evaluation of any new reserve proposals. The Chief Financial Officer will present to the HSCP Audit and Performance Committee the draft unaudited accounts which will include a new earmarked reserve of circa. £0.714m to support the Action Plan and associated posts. The position will also be reflected in the 2021/22 Financial Outrun report for the HSCP Board's consideration at the 27th June 2022 meeting. It is anticipated that the posts will be fixed term for the period of two years, subject to review as part of the Children and Families Service Review.

8. Risk Analysis

8.1 The Community Planning Partnership will require to maintain focus on the delivery of the improvement actions during the period of dedicated support and beyond to embed the improvement in service delivery and strategic planning for children and young people at risk of harm. The enhanced arrangements in relation to governance have been put in place to identify and mitigate the risk of any drift in activity.

9. Equalities Impact Assessment (EIA)

9.1 Not required. The Joint Inspection is carried out under section 115 of part 8 of the Public Services Reform (Scotland) Act 2010 and is led by the Care

Inspectorate working alongside Education Scotland, Her Majesty's Inspectorate of Constabulary in Scotland and Health Improvement Scotland.

10. Environmental Sustainability

10.1 None required.

11. Consultation

11.1 Not required. The Joint Inspection is carried out under section 115 of part 8 of the Public Services Reform (Scotland) Act 2010 and is led by the Care Inspectorate working alongside Education Scotland, Her Majesty's Inspectorate of Constabulary in Scotland and Health Improvement Scotland.

12. Strategic Assessment

12.1 No strategic assessment required.

13. Directions

13.1 Directions are contained within the financial report being presented to the HSCP Board on 27 June 2022.

Name	Lesley James
Designation	Head of Children's Health, Care and Justice Services Chief Social Work Officer
Date	1st June 2022

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Appendices:

1. Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire.

Background Papers: N/A

Appendix 1

care inspectorate

Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire

Prepared by the Care Inspectorate in partnership with Education Scotland, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland

24 May 2022

Education Scotland Foghlam Alba

Healthcare Improvement Scotland

HMICS Improving Policing Across Scotland

HAPPY TO TRANSLATE

Contents

Introduction

Our remit

At the request of Scottish Ministers, the Care Inspectorate is leading joint inspections of services for children and young people at risk of harm. As a result of the Covid-19 pandemic, the programme of joint inspections of services for children was paused between March 2020 and June 2021 and recommenced in July 2021. The remit of these joint inspections is to consider the effectiveness of services for children and young people up to the age of 18 at risk of harm. The inspections look at the differences community planning partnerships are making to the lives of children and young people at risk of harm and their families.

Joint inspections aim to provide assurance on the extent to which services, working together, can demonstrate that:

1. Children and young people are safer because risks have been identified early and responded to effectively
2. Children and young people's lives improve with high quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm
3. Children and young people and families are meaningfully and appropriately involved in decisions about their lives. They influence service planning, delivery and improvement
4. Collaborative strategic leadership, planning and operational management ensure high standards of service delivery.

The inspections also aim to consider the impact of the Covid-19 pandemic and the continuation of practice to keep children and young people safe.

The terms that we use in this report

- When we say **children at risk of harm**, we mean children up to the age of 18 years who need urgent support due to being at risk of harm from abuse and/or neglect. We include in this term children who need urgent support due to being a significant risk to themselves and/or others or are at significant risk in the community.

- When we say **young people**, we mean children aged 13-18 to distinguish between this age group and younger children.

- When we say **parents** and **carers**, we mean those with parental responsibilities and rights and those who have day to day care of the child, including kinship carers and foster carers.

- When we say **partners**, we mean leaders of services who contribute to community planning. This includes representatives from West Dunbartonshire Council, Greater Glasgow and Clyde NHS, Police Scotland and third sector organisations.

- When we say **staff**, we mean any combination of people employed to work with children, young people and families in West Dunbartonshire.

Appendix 1 contains definitions of some other key terms that we use.

Our approach

Inspection teams include inspectors from the Care Inspectorate, Healthcare Improvement Scotland, Her Majesty's Inspectorate of Constabulary in Scotland and Education Scotland. Teams also include young inspection volunteers, who are young people with direct experience of care or child protection services. Young inspection volunteers receive training and support and contribute to joint inspections using their knowledge and experience to help us evaluate the quality and impact of partners' work.

We take a consistent approach to inspections by using the quality framework for children and young people in need of care and protection, published in August 2019. Inspectors collect and review evidence against all 22 quality indicators in the framework to examine the four inspection statements.

How we conducted this inspection

Our joint inspection process normally consists of three phases:

- Surveys and record reading
- Analysis of publicly available information, partnership position statement and evidence
- Engagement with children, young people and families and focus groups with staff.

The inspection of services for children at risk of harm in the West Dunbartonshire community planning partnership area took place between October 2021 and March 2022. Due to constraints presented by the ongoing Covid-19 pandemic, we did not undertake the engagement phase with West Dunbartonshire that was planned for February 2022. This meant that we did not meet children, young people and families or conduct focus groups with staff.

We recognised the significant challenges for the partnership in managing the ongoing impact of the pandemic and the resources needed to do so. Moreover, the need to postpone meetings with children and families in the context of another Covid-19 wave meant that a much longer time had elapsed since we read children's records than would usually be the case. For some families, an interview would now be inappropriate. In this context, all four bodies involved in the inspection agreed a different approach to the norm was needed.

The activities the inspection team were able to undertake between October 2021 and March 2022 to gather the evidence reflected in this report were:

- We carried out a staff survey and received 536 responses from staff working in a range of services
- We reviewed 14 survey responses from children and young people and 21 from parents and carers
- We reviewed practice by reading a sample of records held by services for 60 children and young people at risk of harm
- We read a position statement prepared by the partnership and we undertook an analysis of all available evidence and reviewed publicly available information about the partnership
- The young inspection volunteers reviewed the partnership's online resources and social media
- We met with the partnership on three occasions throughout the inspection which included discussions on how to conclude the inspection.

We judged that from this activity we had sufficient evidence to reach confident conclusions about key strengths and areas for development. Given that we did not meet with children, young people, parents and carers whose records we had read, we were not able to evaluate quality indicator 2.1 - Impact on children and young people.

Key facts

Total population: 88,340 people

Proportion of children:
In 2020 17.5% of the population were under the age of 16, slightly above the national average of 16.8%

On 30 June 2020, the population of West Dunbartonshire was 88,340. This is a decrease of 0.7% from 88,930 in 2019.

The proportion of datazones (40%) in West Dunbartonshire within the 20% most deprived SIMD datazones in Scotland is amongst the highest across the country. By contrast, it has one of the lowest proportions of datazones (6%) within the 20% least deprived datazones.

West Dunbartonshire had the second highest prevalence of domestic violence incidents recorded by Police Scotland in 2020/21, at 168 incidents per 10,000 population, compared to the national average of 119.

In 2020/21, West Dunbartonshire had a rate of 15.1 child protection investigations (per 1,000 of the 0 – 15yr population), higher than the Scottish average of 12.8.

Key Messages

- The partnership was responding effectively when concerns about children and young people were first identified
- Children and young people said they had an opportunity to develop a relationship with a key member of staff
- There are discrepancies between how staff saw their practice and what we saw in children and young people's records.
- Following the initial identification of harm, the quality of key processes was inconsistent
- From reading records, there was little evidence of children's views being solicited or taken into account when decisions were made that affected them
- There was little follow up analysis of the impact of services to improve outcomes for children and young people at risk of harm
- To be more impactful, the child protection committee's oversight and scrutiny of data and quality assurance activity required development
- Strategic leaders needed to work collaboratively to understand their activity and its impact on children and young people at risk of harm.

Statement 1: Children and young people are safer because risks have been identified early and responded to effectively.

Key messages

- The partnership maintained child protection services and tried to reduce the impact of the Covid-19 pandemic on the operational delivery of services to children and families
- There was a marked contrast between the confidence expressed by staff in their abilities and what we saw in records
- When concerns about children were first identified, the partnership responded promptly
- There were delays in inter-agency referral discussions taking place and they had not taken place for a third of the children whose records we read
- Improvement is needed in both the response to follow up concerns and the effectiveness of reducing risk for children and young people.

Response during the Covid-19 pandemic

Despite experiencing high levels of infection as the Covid-19 pandemic progressed, the West Dunbartonshire partnership were successful in maintaining services to, and contact with, children at risk of harm and their families. They continued to deliver essential child protection services alongside providing families with much needed practical support. Weekly contact with children and young people subject to child protection registration was maintained. The majority of children and young people and most parents and carers who responded to our survey felt that they had sufficient contact with a member of staff during the pandemic.

Identification of concerns

When concerns about children were first identified, these were shared with the police and social work without delay and they responded promptly. The named person was informed in every record we read. Immediate action was taken at this stage to keep children safe which was enabled by clear initial decision making between partners.

Staff who completed our survey reported that they felt confident in their knowledge, skills and their ability to identify, report and assess risks and concerns. They felt supported and challenged by their managers to achieve a high standard of practice and staff from all agencies said they received regular supervision. However, although most staff felt confident that local child protection arrangements were effective and took place in a timely way, this was not for the most part supported by our record reading findings after the initial concern was identified and reported.

Effectiveness of response

An Inter-Agency Referral Discussion (IRD) should be held to ensure all the relevant information is shared between the key agencies so that decisions and actions are well informed and coordinated. No IRD had taken place in just over a third of our sample of records. Police and social work were involved in all IRDs, when they occurred, with health also in attendance at almost all of these. Education, additionally, were involved in the majority of IRDs.

Once the partnership had decided to proceed to an initial multi-agency meeting, the quality of the response in some cases was evaluated as good or better but the majority were evaluated as adequate. There was appropriate representation from agencies and clear decisions were again made in almost all cases. Most meetings took place within timescales and almost all had a written record. However, we considered that risks and needs had been partially considered in just under half of the records we read. Children and young people who were of an age to have had their views and experiences considered, had not contributed to the initial multi-agency meeting. The contribution of parents and carers was better in most cases.

Results from the staff survey highlighted that the majority of social work and social care staff agreed children at risk of harm were living in the right environment to keep them safe. However, some staff groups in other agencies disagreed with the statement. The majority of respondents agreed or strongly agreed that children and young people are being supported to recover from their experiences of harm. Responses from health and police staff do highlight variations with some disagreeing with the statement. It would benefit the partnership to use the survey results themselves to identify gaps and understand these discrepancies.

The partnership had identified improvements that needed to be made to ensure that IRDs focused on the immediate needs of the child. However, these had not yet impacted on practice and the partnership agreed that improving IRDs is a priority area of focus.

The partnership was addressing specific issues of concern for children and families in the area. These included children and young people's mental health, online harm and domestic abuse. Domestic abuse was an enduring concern and a significant factor for families of children whose names were on the child protection register. The Violence Against Women and Girls Partnership had supported the introduction of Multi-Agency Risk Assessment Conferences (MARAC) in 2020 and the No Home for Domestic Abuse Policy. This promotes a zero tolerance approach to domestic abuse within local authority properties. These were promising steps but it was too early for the partnership to know about the direct impact on children and young people.

Staff competence and confidence

The difference between the quality of practice we saw in records and the responses from staff to some of the survey questions was a concern for us. Survey results showed a workforce who said they were confident of their knowledge, skills and abilities. The majority of staff agreed that children were being protected from harm with some variance in responses from individual agencies. Most staff told us they were confident that child protection processes were effective. However, this was not supported by all aspects of the record reading findings. The results we saw for the quality of assessments, plans and chronologies in particular were in marked contrast to the perception of staff. The discrepancy in these two sources of evidence raised important questions regarding what led to this level of confidence and how managers were assuring themselves of the standards and quality of practice.

Almost all staff stated they were receiving supervision or had opportunities to speak to a line manager in a way that challenged them to achieve a high standard of practice. We had limited additional information on how staff were supported to reflect and improve their skills or received feedback. As a result, we were less confident about how staff were being supported to maintain the level of confidence they conveyed in their responses.

Almost all staff said they knew what standards of practice were expected of them. The majority of respondents agreed or strongly agreed that participation in regular multi-agency training and development opportunities had strengthened their contribution to joint working. Most practitioners who completed our survey were satisfied that training had increased their personal confidence and skills in working with children at risk of harm. The ongoing impact of the Covid-19 pandemic had reduced the partnership's capacity to provide training and the child protection committee had a recovery plan in place to address this.

Performance management and quality assurance

The partnership was undertaking some quality assurance activity. However, their efforts were not being well used to inform any changes in practice. There was a lack of clarity about how the learning was informing the partnership about its performance. There was limited evidence about how the partnership was using feedback, data and quality assurance activity consistently to understand the effectiveness of the work undertaken to keep children and young people safe. An overarching framework for quality assurance would provide the partnership with a structure and agreed approach to better realise the impact of their work.

During our inspection we saw examples of how data could have been better used to help the partnership further understand its strengths and areas for development. These included the number and age profile of children on the child protection register; the use of child protection orders; the application of initial child protection processes and the scale or complexity of presenting risks.

It was encouraging that the partnership had realised the need to develop its oversight of quality assurance and had established posts to support the child protection committee in this activity.

Statement 2: Children and young people's lives improve with high quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm.

Key messages

- The majority of children, young people, parents or carers who responded to our survey said they were happy with the level of contact they had with their worker during the Covid-19 pandemic.
- Assessments, chronologies and plans had been completed by staff but the quality of these needed to improve.
- The majority of children's plans were being reviewed within timescales, however, the quality of most reviews was rated as adequate.
- The partnership highlighted a range of activities intended to support children and young people at risk of harm. We could not always see the impact of these or how they related to an overarching plan for service delivery.
- There was limited evidence that learning from audit or scrutiny activity was being used to influence practice development or improvement.

Staff survey feedback

Responses to the staff survey indicated that most staff who were supporting children at risk of harm considered that they were working well together. They reported that the Getting it Right for Every Child approach was having a positive impact on the lives of children at risk of harm. Most said they felt proud of the contribution they were making to improve the wellbeing of children at risk of harm and their families. Staff survey responses suggested that joint training and access to child protection training were working well and staff were benefitting from the opportunities. Social work staff were less positive. Most staff felt that learning and training had increased their skills and confidence.

Assessing risk and need and planning

Staff had completed assessments, chronologies and plans that considered needs, concerns and risks for children in all of the records we sampled. However, their quality was not of a sufficiently high standard; the majority of assessments, chronologies and plans were rated as adequate, and a few were unsatisfactory. There was limited evidence that chronologies were used to identify patterns of significant events and experiences. The majority of plans were reviewed within timescales, but the quality of reviewing was mostly rated as adequate or below. This meant we did not have confidence that the partnership was developing plans to provide timely interventions to meet needs and reduce risk, maximise safety and improve wellbeing. Furthermore, the child's voice was not always present in the records we read, with the result that there was limited evidence that their views were being acted on in the planning process.

Support for children and young people at risk of harm

Services continued to work together during the Covid-19 pandemic restrictions and physical and virtual contact was maintained with children and young people during the lockdown periods. Practical support, including food and shelter, was also made available. Some care leavers were enabled to stay in touch digitally. Children and young people, as well as parents and carers, were generally content with the level of support that they had received.

The effectiveness of work to reduce risks of abuse or neglect from parents or carers, or from within the community, was assessed as good in less than half the sample we read. In most instances, in the small number of cases where there were risks of the child harming themselves or others, practice to reduce those risks needed to be more effective.

The partnership had introduced an adult services parenting capacity assessment and a strengths-based approach to supporting parents with alcohol and drug issues. There was limited evidence of their impact. Improving the lives of children through specific parenting interventions was a strategic outcome within the integrated children's service plan but aspects of this work were in need of a refresh. While our record reading found that most children and young people were impacted by parental behaviour, we could not see evidence of collaborative working between children and adult services.

It was difficult to establish whether mental health outcomes were improving for children and young people. Half of the respondents to the staff survey disagreed or strongly disagreed that mental health outcomes for children and young people were improving. Several new initiatives and services had been launched in response to meeting young people's mental health and wellbeing needs. For example, 'Young People In Mind' was promoting the mental health and wellbeing of looked after and accommodated children and young people. It would have been helpful to have seen evaluations or audits of these supports in order to assess their effect, or the longer term consequences for vulnerable young people. Steps had been taken across the Greater Glasgow Health Board Child and Adolescent Mental Health Service

(CAMHS) which had positively impacted in reducing waiting times in West Dunbartonshire.

Quality improvement leading to better outcomes

While there is good intention and a willingness to encourage new initiatives, performance measurement and evaluation had not been sufficiently developed to help the partnership understand where to best concentrate their efforts to support improved outcomes for children and families. There was agreement about some key areas for improvement but there were no corresponding targets and no clear line to actions intended to achieve objectives.

Evidence of scrutiny and analysis of data relating to performance measures and quality assurance was limited, although the partnership was developing a self-evaluation framework. It was not always clear how learning from audit activity was leading to change. Self-evaluation had shown that performance in meeting key child protection timescales was inconsistent but improvement targets had yet to be set. There was little indication that information gathered was being used to improve either the quality or timeliness of child protection processes. For example, an increase in the number of referrals to the Scottish Children's Reporter Administration (SCRA) and a decrease in the number resulting in compulsory measures, had not apparently been explored. A commitment had been made to the Wave Trust's campaign to reduce child abuse by 70% by 2030. It was unclear though, how the campaign's implementation would be measured, or how, in 2030, the council would know if its commitment had achieved the desired aim.

Statement 3: Children and young people and families are meaningfully and appropriately involved in decisions about their lives and influence service planning, delivery and improvement.

As we did not undertake the engagement phase of this inspection, we had limited evidence to address this statement.

Key Messages

- Children and young people who were of an age to have had their views and experiences considered, had not contributed to the initial multi-agency meeting.
- The majority of children, young people, parents and carers in the sample had opportunities to develop a relationship with a key member of staff.
- We rated the quality of how well children had been listened to, heard and included by staff as adequate or below in records.
- There was little evidence to suggest that children and young people are given opportunities for involvement in development activities, service planning and review.

The majority of children and young people in the record reading sample had the opportunity to develop a relationship with a key member of staff. Based on the small sample of children, young people, parents and carers who responded to our survey, most children and young people agreed that their worker listened to their views and opinions. Most also agreed that their worker spent time with them and gave them the help that they needed all, or most, of the time. Children and families were mostly satisfied with the help they were receiving to maintain supportive relationships with the people they cared about.

It was unclear how the wishes and expectations of children and young people were sought, listened to and considered. The majority of respondents to the staff survey felt that children and young people participated meaningfully in decisions that affected their lives and had their views respected. How children were listened to, heard and included by professionals was rated as less than good in the majority of records we read. We saw very few examples of children and young people's views being recorded in meetings which had taken place about them.

Parents and carers had slightly more opportunities to be involved in discussions and planning than children or young people. A majority of staff were confident that families and all relevant agencies actively contributed to effective plans for children and young people. We evaluated how well children, young people and families were listened to in just over half the records as good or better. However, all parents and kinship carers agreed that staff communicated well and helped them to understand what needed to change to keep children safe.

The availability of independent advocacy for both parents and carers and children and young people was inconsistent. In our survey, less than half of parents and carers said that they had an opportunity to speak with an independent advocate. This was in line with our staff survey with fewer than half of staff agreeing that advocacy was made available.

Statement 4: Collaborative strategic leadership, planning and operational management ensure high standards of service delivery.

Key messages

- Key plans across the partnership were not well aligned to an overarching vision for childen's services
- The approach leaders and managers were taking to monitoring practice standards and quality assurance was under developed
- To be more impactful, the child protection committee's oversight and scrutiny of data requires development.

Impact of leaders on staff

Survey results indicated that staff felt well supported and confident in their standards of practice. This varied between agencies but indicated that the overall level of confidence in recognising and reporting signs of abuse was high. What was less certain was the extent to which managers and leaders were monitoring and driving up standards.

The records we read indicated that staff were working collaboratively when they had identified and responded to immediate risk. While this was borne out in record reading, we did not see any direct ways in which this had been influenced by leadership. We saw little evidence of supervision or quality assurance activity in records or how learning from the child protection committee was used to influence practice. Although staff felt that leaders had a clear vision for the delivery and improvement of services provided to children at risk of harm, a significant percentage did not experience that as clearly.

Governance arrangements

The partnership had appropriate governance arrangements and we saw that different corporate visions were in place. While these individually had value, key plans were not well enough connected to an overall vision. Furthermore, it was unclear how plans and leadership of strategy, improvement and change were communicated to and understood by staff, children, young people and families. We did not see opportunities for children and young people to be involved in shaping the partnership's visions and values.

We are not yet confident that collective leadership across the partnership is as strong and effective as it needs to be. With significant work ahead to embed the Promise, implement the National Child Protection Guidelines 2021 and new Joint Investigative Interview process, this raised some questions about whether the partnership recognised the collaborative approach required to effectively progress these priorities.

The Child Protection Committee

Although there were appropriate governance structures across organisations, we were less confident following the activity we completed about how effectively the public protection chief officers group was overseeing the work of the child protection committee. We were not assured the child protection committee was maximising its oversight of practice or influencing improvement. Actions were appropriately assigned to a lead officer to take forward but how the progress of actions was jointly monitored was not evident from the minutes of subsequent committee meetings. A data subgroup of the child protection committee had been convened but consistent analytical systems were not yet in place to effectively make use of audit and other data to inform strategic planning, service development and resourcing.

It was difficult to establish to what extent strategic leaders were working collaboratively as a partnership and whether accountability for leading and directing work to keep children safe was representing the full range of relevant partners.

Conclusion

While the partnership's initial response to identifying and reporting concerns was good, the effectiveness of services in improving children's lives was unclear. Our record reading results raised concern about how children and families are supported to sustain safe and positive changes in their lives. We were concerned about the disparity between staff's own views about how effective their work is, and our assessment of performance, from what we read in records. This led us to question whether managers need to be more realistic in their assessment of performance and more challenging of themselves and each other.

We were struck by the number of initiatives and activities that partners were involved in. It was clear to us that there was little follow-up or analysis of the impact of proposed actions, particularly by the child protection committee. Actions were not reviewed under a cohesive framework, the use of which could subsequently influence service improvement and help target resources. This lack of cohesion was reflected at a strategic leadership level where we saw little evidence of improvement in outcomes which leads us to question how much the partnership understands it's activity and impact.

What happens next?

The Care Inspectorate and scrutiny partners agreed not to undertake a full engagement week based on reasons outlined in the introduction of this report. We decided that the most appropriate course of action would be to support the partnership to undertake improvements in the areas we have identified. While we are more confident the partnership now know where changes need to be made, we do not think they would be able to take all the actions necessary without external support and challenge. The partnership has agreed with this approach and has recognised the need for improvement.

We asked the leadership team in West Dunbartonshire to provide an improvement plan which they have done and it includes areas highlighted in this inspection. The partnership has established governance arrangements to oversee its improvement action planning which will be chaired by the chief social work officer.

Along with scrutiny partners, the Care Inspectorate will lead a series of improvement sessions to support the partnership with the key areas for development. During late May and June 2022, we will facilitate nine sessions with a range of staff to help focus the direction of improvement activity. Thereafter we will monitor and evaluate the partnership's progress for an agreed period of time and report on the improvements it has made.

Appendix 1: Key Terms

CAMHS (child and adolescent mental health services) are the NHS multi-disciplinary teams that provide assessment and treatment/interventions in the context of emotional, developmental, environmental and social factors for children and young people experiencing mental health problems, as well as training, consultation, advice and support to professionals working with children, young people and their families.

Child protection committees are the locally-based, inter-agency strategic partnerships responsible for child protection policy and practice across the public, private and third sectors. Working on behalf of chief officers, their role is to provide individual and collective leadership and direction for the management of child protection services in their area.

A **Children's Service Plan** is a strategic plan prepared by local authorities and relevant health boards. It sets out the provision of children's services and related services in a local authority area.

Getting it Right for Every Child (GIRFEC) is a national policy designed to make sure that all children and young people get the help that they need when they need it.

Independent advocacy refers to a person providing advocacy who is not involved in providing the services to the individual, or in any decision-making processes regarding their care.

An **initial multi-agency meeting** is the first formal occasion in which the chair and attendees consider whether child protection registration, vulnerable young person's or care and risk management planning is necessary. Examples include initial child protection planning meetings or case conferences; and initial care and risk management multi-agency meetings or equivalent.

An **inter-agency referral discussion (IRD)** is the start of the formal process of information sharing, assessment, analysis and decision-making following reported concern about abuse or neglect of a child or young person up to the age of 18 years, in relation to familial and non-familial concerns, and of siblings or other children within the same context. This includes an unborn baby that may be exposed to current or future risk.

Multi Agency Risk Assessment Conferences (MARAC) MARACs are regular, local meetings where information about domestic abuse victims at risk of the most serious levels of harm is shared between representatives from a range of local agencies to inform a co-ordinated action plan to increase the safety of the victim and their children.

Named persons are a core component of the GIRFEC approach, and are a professional point of contact within universal services, if a child, young person or their parents need information, advice or help. Local arrangements and the term used to describe this role or function may vary from area to area.

The Promise is the main report of Scotland's independent care review published in 2020. It reflects the views of over 5,500 care experienced children and adults, families and the paid and unpaid workforce. It described what Scotland must do to make sure that its most vulnerable children feel loved and have the childhood they deserve.

The **Scottish Children's Reporter Administration (SCRA)** is a national body which focuses on children most at risk. Its role is to decide when a child needs to go to a Children's Hearing, help children and families to take part in hearings and provide accommodation for hearings.

Scrutiny partners represent the scrutiny bodies that take part in joint inspections. This includes the Care Inspectorate, Education Scotland, Healthcare Improvement Scotland, and Her Majesty's Inspectorate of Constabulary for Scotland.

A **Significant Case Review (SCR)** is carried out where a child has died, or has been significantly harmed, or where they have been at risk of harm. SCRs aim to find out if anything could have been done to prevent harm, and what could be done to stop a similar event happening in the future. This term was in common usage until 2021 when it was replaced by the term 'learning review' in the updated national guidance.

Young Inspection Volunteers are young people (aged 18 - 26) with experience of care services who are specifically trained to support the Care Inspectorate with our inspections. They are part of the inspection team.

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE AND AUDIT COMMITTE

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

27th June 2022

Subject: Inspection of Adoption Services in West Dunbartonshire

1. Purpose

1.1 To provide the Committee with a progress update on the improvement work in relation to the Care Inspectorate inspection of Adoption Services in West Dunbartonshire 2022.

2. Recommendations

2.1 To request that Committee notes the content of the report and the improvement plan contained in appendix 1.

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?

Requirements on the Service:

How well do we support people's wellbeing? - Evaluated Weak
Requirement
By 1 February 2022, the provider must improve the quality of permanence planning for children to promote stability in children's lives. Partially complete.

How good is our leadership? – Evaluated 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. Complete.

How well is our care and support planned? –Evaluated 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. Complete.

4. Main Issues for Improvement

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 participant 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 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.

5. Improvement Activity

5.1 Training and feedback from training did not appear to be robustly scrutinise (4.1 & 4.9)

There was recognition that training logs were incomplete surrounding Adopters. This area has been strengthened to incorporate a training log recorded on our CARERFIRST system for each Carer/Adopter. The team leader role to ensure scrutiny and oversight of training records beyond the senior worker has been made explicit.

5.2 More targeted to ensure that participant views are routinely sought and acted upon from preparation groups 4.2

Preparation groups were challenged around the evaluation of the overall sessions. The Care Inspectorate recognised that there would be greater benefits to an evaluation process being built in to each session, rather than an overall evaluation at the end of the group learning. All future groups will have individual evaluation built in to the end of each workshop and participants feedback actively considered

5.3 Review of the services permanency process was of concern. 4.3, 4.4, 4.5 and 4.6

Revised processes have been develop to ensure greater management oversight of key systems. This has included the development of business tracking procedures that can enable managers to understand any drift and delay in children's plans. Renewed reporting systems have also been refreshed and engagement with our CAREFIRST colleagues to support this has occurred. A new permanence tracking group has been created and these meetings will assist in the evaluation of work being carried out to allow children reach positive destinations at the earliest opportunity. These meetings are chaired by Senior Managers of the Service to ensure leadership and focus to drive improvement in current permanence delays. Team Leaders from within the operational teams will now be responsible for the Chairing of the Legal Advice Meeting, ensuring early management oversight. These advice meetings are scheduled on a monthly basis, to ensure availability of key staff and to reduce drift and delay. A flow chart of Looked After children's planning process and timescales has been updated aligned to national Looked After Regulation and training for staff being scheduled.

5.4 The provider should ensure that the panel has independent oversight 4.7

The introduction of an independent chair will provide unbiased decision making. As a service there has been agreement to appoint an independent Chair for a period of initially one year subject to review. They will oversee the Charing responsibilities for our adoption/permanence panel. This will commence at our next meeting at the end of June 2022.

5.5 No overview of panel members training, additionally, there was no panel supervision or appraisals taking place 4.8 4.9

Challenges surrounding the pandemic have undoubtedly impacted on the priority of focus in this area and what has been possible to deliver. However, notwithstanding this, it has been accepted that this is an area for improvement. To date, one full developmental session with all panel members has taken place. The panel continue to have formal appraisals before and after each panel input. This ensures a readiness for each meeting and ability to reflect on any challenges identified and for these to generate change where this might be necessary. Some individual sessions have also occurred and from those discussions additional training has been identified and implemented.

5.6 Leadership requirement – Management must ensure that the management vision for the service is communicated

The aims and objectives of the service has been updated, with a variety of communication methods used to outline the service position. This has included the sharing of this ethos with our staff and carers across the services with internet and social media platforms now updated.

5.7 Leadership requirement – Systems are in place to support quality assurance and improvement across the service

There is now a single management meeting for the Senior Managers to come together. Permanence tracking meetings are now in place and the chairing of our legal Advice Meetings are now conducted by Team leaders. Further bolstering of our data collection and analysis has enabled greater oversight across the management team. Key members of the team have been working within the care inspectorate workshops that will further assist with this development. Individual auditing around case files has commenced across Children Services. This will seek to identify trends in input and help us seek clarity on what improvements and training might be essential. Independent reviewing and Fostering and Adoption panel chairing arrangement are being progressed to ensure oversight and scrutiny on children's planning subject to Board approval.

5.8 Leadership requirement – Systems are in place to support quality assurance and improvement across the service

Business support processes are being updated, ensuring that the most efficient and desirable use of staff time is made and that this fits with the business tracking processes across all of the service.

6. Options Appraisal

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

7. People Implications

7.1 Progress of 4 appointments to ensure independent scrutiny and chairing arrangements for children's statutory meetings and the chairing of formal adoption and permanence panel is part of our improvement requirements. In order to strengthen scrutiny, management oversight and collaborative leadership, additional fixed term posts have been proposed and job evaluated.

8. Financial and Procurement Implications

8.1 The preparation of the annual financial statements includes a comprehensive review of HSCP reserves. This review covers existing reserves (both un-earmarked and earmarked) and the evaluation of any new reserve proposals. The appointment of four fixed term independent reviewing officer posts for Looked after children and an appointment of independent Fostering and Adoption Panel chair is being progressed subject to approval of the HSCP Board.

8.2 The Chief Financial Officer will present to the HSCP Audit and Performance Committee the draft unaudited accounts which will include a new earmarked reserve of circa. £0.530m to support the Action Plan and associated posts. This position will also be reflected in the 2021/22 Financial Outturn Report for the HSCP Board's consideration at the 27 June meeting. It is anticipated that the posts will be fixed term for the period of two years, subject to review as part of the Children and Families Service Review.

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	1st June 2022

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

Adoption Improvement Plan UPDATED 26/5/22

Theme 1 – How well do we support people's wellbeing Requirements (1)					
Complete (Green)		**Progressing Adequately (Amber)**		**Not Meeting Timescales (Red)**	
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 permanence process aligned to permanence milestones and LAC regulations for all children who require a permanence plan.	**Clinical & Care Governance** **Paul Kyle, Senior Manager (LAAC)**	**30/04/2022**	**Amber**	Enhanced tracking has been put in place and monitoring plans are in place for each team via bi-monthly meetings. Reporting systems are built in to enable management oversight of the progression of children's plans and any delays in the permanence process are 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. Tracking process to be agreed and aligned to CAREFIRST team	**Kathy Currie Senior Social Worker (Adoption) Family Placement Team** **Mark Mulvenna Team Leader (Under 12's)** **Scott Barclay Team Leader (Under 12's)** **Elaine Kelly,**		**Amber** Permanence for children in foster ca	Permanence Tracking Business object report has been set up from Care first to provide information on children's permanence plans to identify drift in delay. This has been shared with Team Leaders across the service to enable the plans to be reviewed. Permanence Tracking Review Meeting scheduled on a bi-monthly basis to monitor and track permanence which will be chaired by senior managers from across the service. Dates 31 May 2022 10:00-12:00

		Team Leader (Youth Services) **Jean Cameron Team Leader Family Placement Team** **Care first team**		Over 12's and CWD (Elaine's Team) pern Clydebank (Scott's Team) Permanence A Vale (Mark's Team) Permanence April 22	28th June 2022, 10 a.m. – 12 noon 26th July 2022, 10 a.m. – 12 noon 27th Sept 2022, 10 a.m. – 12 noon 29th Nov 2022, 10 a.m. – 12 noon Reviewed Care First reporting arrangements and are in development of additional Care First fields to assist with reporting and tracking.
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.	**Annie Ritchie Service Manager** **Paul Kyle Service Manager** **Mark Mulvenna Team Leader (Under 12's)** **Scott Barclay Team Leader (Under 12's)** **Elaine Kelly, Team Leader (Youth Services)** **Legal Services**	**30/4/22**	**Amber**	Permanence Tracking and Review Meetings will take place bi-monthly that will address monitoring of drift and delay. Colleagues from Legal Department will contribute to meetings. Permanence Tracking Review Meeting will be solution focussed and discuss problems moving forward, a timescale of review will be provided reducing drift. Additional resourcing will be investigated. Business object report set up from Care first which will identify any drift in delay.
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**	Aims and objectives to be shared with all staff members. Staff members must be clear and understand the 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 service aims to provide and how.	The adoption 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.	**Kathy Currie Senior Social Worker (adoption Team)** **Adoption Team**	**Completed 30/4/21**	**Green** Aims and Obj April 2022.doc	The statement around aims and objectives has been updated to be shared with all staff members and carers. Staff members and carers must be clear and understand the aims and objectives. Aims and objectives will be updated online.
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.	**Lesley James, Chief Social Work Officer** **Paul Kyle, Senior Manager** **Care First Team** **Kathy Currie**	**30/4/22**	**amber** Imporvement Planning sessions.d	3rd February 2022, meeting took place with Care First regarding the gathering of data and how best to make use of Care First. We are currently identifying gaps in data and how to address this. Staff have been advised and encouraged to attend Planning Session being delivered by the

	This will provide a significant emphasis on the oversight arrangements for managers.	**Senior Social Worker Adoption** **Monica Bristow Senior Social Worker Fostering Care First**		TRAINING LOG.docx	Care Inspectorate between the 24th May to 24th June 2022. Training records and opportunities have been provided to carers. Dates scheduled for Fostering and Adoption Team to attend Area Social Work Team meetings.
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.	**Lesley James, Chief Social Work Officer** **Eric Brown Independent Auditor**	**30/4/22**	**Amber**	Eric Brown Independent Auditor has been completed audits across children's services using the CI evaluation Tool (I CAN'T FIND THIS ON THE WEBSITE) Funding has been agreed to identify Independent Chair's for Fostering & Permanence Panels. External agencies have been contacted and we are now waiting for the contract to be confirmed and concluded by June. Funding for one year has been approved for employment of four Independent Chair's for LAAC Review and Foster Carer Reviews. These post have been through job evaluation and progressing to advert with a completion date of June 22.
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 time frames 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. Every looked after child in foster and adoptive placements to have a copy of their Child's plan and this will be followed up with a home visit by the allocated Social Worker to go over the plan with the child.

					UPDATE AT MEETING ON 3rd MAY RE PROGRESS
a) An audit of children's plans is undertaken to ensure they are outcome focused and SMART.	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. 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. On the 3rd May 22 it was agreed that six children would be identified (2 from each team) to have their care plans audited. An evaluation of the business support model is required to meet the expectations surrounding the recording of associated meetings and reviews.	**Lesley James, Chief Social Work Officer.** **Mark Mulvenna Team Leader Under 12's** **Scott Barclay, Team Leader Under 12's** **Elaine Kelly, Youth Services** **Eric Brown Independent Auditor**	**30/04/2022**	**Amber** Imporvement Planning sessions.d	Work group to be established by June 22 involving staff across the whole service. A process for LAAC and permanence has been completed and procedures to align with this to be drawn up by the working group. Every looked after child and their adopters will have a copy of their care plan. An independent auditor, Eric Brown, has been contracted to undertake an audit across children's services of children's assessments and care plans using the care inspectorate tool. Staff will be provided with training opportunities and a champion will be identified to lead with audits across children's services. Pilot of Viewpoint is being undertaken as a tool to ensure that children's voices are being taken in to account in the development of plans. Care Inspectorate Audit tool to be utilised added Business support arrangements reviewed an agreed systems of tracking and minuiting of LAAC reviews are in place. Use of MS teams is being expanded to ensure more options are available for face to face attendance of young people at their meetings.
b) Statutory timeframes are included as part of the planning and review process.	To be addressed via workgroup.	**Senior Managers, Team Leaders, Senior Social Workers, Legal services**	**30/4/22**	**Amber**	Permanence Review Tracking Meeting (PRTM) chaired by senior managers and be solution focused attendance of Legal reps too.

c) Where timeframes have been delayed there are clear actions and resources identified to remedy this.	To be addressed via workgroup.	**Senior Managers, Team Leaders, Senior Social Workers, Legal services**	**30/4/22**	**Amber**	The service is working in a more joined up integrated way to improve timescales in relation to identified drift and delay. Additional resources has been identified to strengthen in reviewing children's plan and chairing foster and adoption panels via independent chair.
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.	**Senior Managers, Team Leaders, Senior Social Workers, Legal services**	**30/4/22**	**Amber**  LAAC & Perm Process May 21 A3.v  PERMANENCE PLANNING FLOW CH	The adoption team will be part of the bi monthly meetings work alongside legal part of solution focused discussions. In terms of individual children family's we will continue to identify a worker within the family placement team to progress children's plans. Support to staff to enable them to undertake identified assessments in a timely manner. Staff supervision to support and identify gaps in leaning. Changes to legal advice chairing meetings now Team Leaders which will help reduce drift and delay ensure they are sighted which will link to the LAAC and permanence process. This will be implemented by June 2022. Management meeting monthly shared across team lead group to strengthen communication across service areas.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Head of Children's, Health, Care and Justice Services, Chief Social Work Officer

27th June 2022

Subject: Inspection of Fostering Services in West Dunbartonshire

1. Purpose

1.1 To provide an update to committee on the improvement work undertaken in response to the inspection of Fostering Services in West Dunbartonshire.

2. Recommendations

2.1 To note the contents of this report with particular regard to financial considerations 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 the 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?

How well do we support people's wellbeing? - Evaluated 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. Complete.

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. Partially complete.

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

How good is our Leadership? – Evaluated Weak

Requirement
By 31 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. Complete.

How well is our care and support planned? – Adequate

Requirement
1. By 31st April 2022, the provider must ensure a clear, outcome focussed child's plan is in place and accessible to children using the fostering service. Complete.

4. Main Issues for Improvement

4.1 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.

4.2 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.

4.3 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.

4.4 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.

4.5 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. A lack of independent chairing contributed to lack of independent oversight, scrutiny and challenge.

4.6 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.

4.7 Clarity of the aims and objectives of the service that is both understood by staff and carers requires to be further developed.

4.8 The lack of a clear continuing care policy had resulted in young people with care placements who are 18 years or over with continuing care relationships not being fully recognised in relation to their right to sustained support

5. Options Appraisal

5.1 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

6.1 Comprehensive training in relation to Child Protection for all Foster Carers - 4.1

Training has been developed and delivered to the majority of Foster carers there remain 2 further scheduled dates. Daytime and evening online sessions have been developed to support the many demands on carers. All carers will be trained in this area by the end of June 2022. Carers training logs have been updated and there will be a requirement to refresh this training every three years. This will be monitored through our yearly Foster Care Reviews and will conform to the statutory training requirements required of the service. Additionally, each Supervising Social Worker has been requested to ensure child protection matters and updates are informed by their supervision of carers and that these discussions are reflected in the CAREFIRST record and annual review reports.

6.2 Relationships with professionals for children and young people were not maintained as well as they could be- 4.2

The transition points between service teams requires further review. Enhanced communication and detailed planning arrangement will support improved communication and shared understanding between team keeping the focus of young people at the centre. Work is underway to consider the current structure and resource alignment and this feedback form a small number of young people as part of this care inspectorate inspection of fostering services will be further considered in any re- service design. The current structure of over 12s and under 12s teams remains, however it is anticipated that this will feature in the work of our newly appointed Promise Lead who will be focussed on how we can achieve relationship based practice and learn from the feedback of young people's experience of the services through wider consultation. The frequency of Social Worker visits to children in placement were noted to be a concern. Regular visiting had been reduced

due to pandemic and at time non-essential visits halted. Service expectation of regular maintained contact with children and young people has fully resumed.

6.3 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 - 4.3

Improved processes have been created to ensure greater management oversight of key systems. This has included the development of tracking processes that will enable managers to oversee and address drift and delay in children's planning arrangements. A permanence tracking group has been created to ensure scrutiny and progression of actions required to achieve permanence outcomes and chaired by senior managers.

Operational Team Leaders who have an oversight and quality assurance role will now be responsible for the Chairing of the Legal Advice Meeting for children who may require permanent care out with their own home. Scheduled audit of Looked after Children's case records is being progressed by a recently appointed 0.5 independent audit post holder to support quality assurance and embed self-evaluation approaches

6.4 The lack of evidence of clear planning or clarity about the Child's Plan is an identified area for improvement - 4.4

A review of all looked after children in care placements was carried out to ensure children' and young people's plans were in place. The numbers identified without child plans was small and all children in placements now have an active plan in place. Each child, where possible, has been made aware of their plan and have a copy of this written document systems to ensure this is routinely in place have been reinstated.

Appointment of Independent Chairs for each child's review meetings across our LAAC and Kinship population will significantly enhance the scrutiny around child's plans to ensure children's and parents views are heard and services are accountable for timely delivery of a child plan.

6.6 ''A lack of independent chairing contributed to lack of independent oversight, scrutiny and challenge – 4.5

Independent chairing of the Fostering and Adoption Panel have been recognised and has been commissioned to allow us to employ an external Chairperson. An Independent Chair from Adoption Fostering Association, Scotland (AFA) has been identified and independent scrutiny will commence at the end of June 2022 for children's plans and independent reviews of foster carers, this will further enhance our oversight, scrutiny and challenge in this area of practice.

The proposed introduction of Independent Chairs for each child's meetings across our LAAC and Kinship population will significantly enhance the scrutiny around child's plans to ensure children's and parents views are heard and services are accountable for timely delivery of a child plan.

6.7 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 – 4.6

The service has reinstated minute taking for all review meetings which had been reduced during pandemic. Evidence and recording of decision making around any child in care is a statutory requirement.

The appointment of independent reviewing officers has been progressed on a fixed term basis subject to funding approval by the Board.

6.8 Clarity of the aims and objectives of the service that is both understood by staff and carers requires to be further developed – 4.7

The service has now updated its vision values and objectives and provided updated information to carers and on the fostering website

6.9 The lack of a clear continuing care policy had resulted in young people with care placements who are 18 years or over with continuing care relationships not being fully recognised in relation to their right to sustained support – 4.8

A draft policy has been developed in relation to continuing care to provide clarity about young people rights who opt into continuing care arrangement where they are no longer looked after and wish to remain in placement, embedding rights based approaches to services. The final document will be presented to HSCP Senior Management Team in July 2022.

7. People Implications

7.1 In order to strengthen scrutiny, management oversight and collaborative leadership, additional fixed term posts have been proposed and job evaluated and approved by SMT. This includes:

- Four Independent Review Co-ordinators to enhance scrutiny of Looked after Children's planning arrangements and to ensure children are at the centre with their views being sought and heard.
- Integrated Children Services Lead to support the Nurture DIG and the work of integrated children's services planning across the Community Planning Partnership.

8. Financial and Procurement Implications

8.1 The preparation of the annual financial statements includes a comprehensive review of HSCP reserves. This review covers existing reserves (both un-earmarked and earmarked) and the evaluation of any new reserve proposals. The appointment of four independent Fostering and Adoption Panel Chair are being progressed subject to approval of the HSCP Board.

8.2 The Chief Financial Officer will present to the HSCP Audit and Performance Committee the draft unaudited accounts which will include a new earmarked reserve of circa. 0.530m to support the Action Plan and associated posts. The position will also be reflected in the 2021/22 Financial Outrun report for the HSCP Board's consideration at the 27th June 2022 meeting. It is anticipated that the posts will be fixed term for the period of two years, subject to review as part of the Children and Families Service Review.

9. Risk Analysis

9.1 Failure to deliver on the requirement and improvement areas identified within this report will result in statutory functions not being adequately fulfilled and may impact negatively on vulnerable children a young people in West Dunbartonshire. This could cause reputational damage to the HSCP and wider corporate parents.

10. Equalities Impact Assessment (EIA)

10.1 No equalities impact assessment required at this time.

11. Environmental Sustainability

11.1 No current issues.

12. Consultation

12.1 No formal consultation is required at present.

13. Strategic Assessment

13.1 No strategic assessment is currently required.

Name	Lesley James
Designation	Head of Children's Health, Care and Justice Services Chief Social Work Officer
Date	1st June 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.			Foster Carer have your say minutes.do Foster Carer Training Record.do Training Letter Carers.doc	Discussion at Quarterly Meeting 26th & 27th January 2022 re importance of training and CP in particularly following inspections 23rd February 2022- Consultation Have Your Say About Your Training took place. Action to introduce Mandatory Core training for Child Protection, Safer Caring & First Aid. 31st March 2022 – Letter to Carer to explain the introduction of Mandatory Core Training as above. Also Training Record Provided to all foster carers to complete.

	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.				27th & 28th April & 5th May – CP training being delivered. CP Training adapted and put together by staff in Fostering Team. Collated dates for this 3 times a year. Online CP training identified via Kate Cairns, offered as an alternative to virtual/face to face group training.
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.			FOSTER CARERS HANDBOOK DRAFT	Fostering Handbook reviewed, reduced and updated. Final draft emailed to Senior Managers 31.3.22 (NEEDS TO BE QA AND EMAILED TO ALL CARERS)
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.				Spreadsheet provided by KC and emailed to Senior Manager & TL's TL's / Managers to review cases team by team
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.	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.				Permanence Tracking Review Meetings have been set up bi monthly to track and monitor cases and agree actions to progress plans.

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.				Permanence Tracking Review Meetings will monitor and review assessments in line with timescales. New processes being developed for all children post 30th April to prevent ongoing drift and delay.
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.				Link in with throughcare re Supported Lodgings type assessment
b) How best to assess young	Working group to be re-established to generate				Linking with Throughcare to explore adapting Pathways Assessment

	people to ensure that continuing care is in their best interests.	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.				Jean to confirm with Link Inspector if we need to be registered Adult Placement Provider. Explore training for foster carers re Continuing Care
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**	**31/04/2022**	**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.				These have been developed by Fostering Team and emailed to Senior Manager/TL 31st March
b) **Management systems are developed to ensure appropriate oversight of key systems,**	Interrogation of our current systems within the context of the fostering team has commenced, with local systems being re-aligned and updated where required. This will provide a				3rd February meeting with Care First about gathering data and making use of the system.

processes and events.	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.				Currently exploring best use of CF and identifying gaps in data

c) **Appropriate independent scrutiny is in place to ensure professional challenge to the service aimed at improving practice.**	The findings of the working group will be presented to SMT via a management report, highlighting current provision and any challenges noted to allow appropriate scrutiny across the service to take place.				Authorisation in place for Independent Chair for F&A panels to cover sickness. Proposal for Independent Chair for F&A panels and for FCR & LAAC Review – awaiting confirmation of this.

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.	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.	**Paul Kyle,** **Senior Manager (LAAC)** **Clinical & Care Governance**	**31/04/2022**	**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.

As shown in A, B, C, D, E and F below.	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.				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.
a) **An audit of childs' plans is undertaken to ensure they are outcome focused and SMART**.	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				T/L, SSW & SW have been asked for a copy of the child's plan for every child in foster placement.

	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.				(I think Foster Carers should be asked for reports for all laac reviews)
c) A copy of the Child's Plan and any updates are received by foster carers.	Process to be addressed via workgroup.				These have been requested by SSW for every child in foster care.
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			.	LAAC Review's to be minute and Children's view should be sought consistently at all laac reviews.

f) Appropriate independent scrutiny is in place to ensure professional challenge to the service aimed at improving practice.	The findings of the working group will be presented to SMT via a management report, highlighting current provision and any challenges noted to allow appropriate scrutiny across the service to take place.				Exploring independent chairs as above

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Val Tierney - Chief Nurse

Audit and Performance Committee - 27 June 2022

Subject: Care Inspectorate Inspection Reports for Hillview Care Home

1. Purpose

To provide the Audit and Performance Committee with information regarding the most recent inspection report for Hillview Care Home. Hillview is a nursing care home with capacity for 150 older people including eight with physical disabilities. The care home is comprised of five single story units, each with thirty rooms all with en-suite facilities. The care home is operated by Advinia Care Homes Ltd. and was registered with the Care Inspectorate in 2017.

2. Recommendations

2.1 Members of the Audit and Performance Committee are asked to note the report.

3. Background

3.1 The Care Inspectorate conducted the inspection 01.04.22 which involved a detailed evaluation of the following areas. The Inspection report continues to evaluate and report the quality using a six point scale from **1- weak to 6 – excellent.**

How well do we support people's wellbeing?	3 - Adequate
1.1 People experience compassion, dignity and respect	4 - Good
1.2 People get the most out of life	4 - Good
1.3 People's health benefits from their care and support	3 - Adequate

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement is led well	3 - Adequate

How good is our care and support during the COVID-19 pandemic?	3 - Adequate
7.2 Infection control practices support a safe environment for people experiencing care and staff	3 - Adequate
7.3 Staffing arrangements are responsive to the changing needs of people experiencing care	4 - Good

4. Main Issues

4.1 This grading awarded represents a deterioration in grades across all areas evaluated.

4.2 The inspectors reported that family views were mixed. Some people were very positive and others were dissatisfied with the way the home communicated with them.

4.3 The inspectors observed some lovely interactions between residents and staff. Staff clearly knew the people well and were respectful. Residents were noted to enjoy the company of staff and trusted them. Residents were well presented and satisfied with being in the home

4.4 Two requirements were stipulated in the report and three areas for improvement.

4.5 The service had met five of ten areas for improvement made at or since the last inspection. Five areas for improvement were not met or fully implemented and were continued.

5. Requirements / Improvements

Two requirements were identified

5.1 By 10th July 2022 the provider must ensure that the approach to quality assurance including audits and observations is reviewed and improved. This must include the development of clear action plans detailing the areas for attention, staff responsible, and timescales for action and outcomes for people.

5.2 By 3rd June 2022 the provider must review and revise its procedures relating to infectious outbreaks. This action is complete. A review was undertaken with support from NHS Greater Glasgow and Clyde Care Home Hub Infection Protection Control Nurse on 19.04.22. A Care Assurance Visit was undertaken (as part of our ongoing programme of assurance visits) by a Senior Nurse and Senior Social Worker from the HSCP on the 06.05. The HSCP continues to work in collaboration with the care home to support ongoing improvements identified via quality assurance audits.

Areas for improvement

5.3 Three new improvements were identified which related to, strengthening care planning and review, adherence to guidance re visiting within the home and ensuring all staff understand the requirement to provide notification to the Care Inspectorate of concerns of people being at risk of harm.

Previous Area for Improvement

5.4 Met

- Robust systems in place to check staff registration with professional bodies
- Staff consistently work in a person centred way that respects people's rights, choices, privacy and dignity.
- A dedicated team is now in places to ensure a range of meaningful activities is offered that takes account of residents' abilities, preferences and choices.
- Appropriate continence care plans are in place.
- Staff are mindful of the environment that activities take place in and options for 1-1 and small group activity encourage participation.

5.5 Not Met and Continued

- Ensure Health monitoring tools are completed following guidance and complete regular management audit to secure consistency across the service
- Develop and implement a system to monitor and record compliance with infection protection control – identify actions to sustain and improve IPC practice.
- The service needs to implement a system of robust evaluation of how staff apply training to practice
- Further progress required to evidence person centred care planning, requires further development and needs to be outcome focussed.
- Records of care review meetings should reflect an outcome focussed approach and should be conducted timeously.

6. Options Appraisal

61 N/A

7. People Implications

7.1 There are no personnel issues associated with this report.

8. Financial and Procurement Implications

8.1 There are no financial implications associated with this report

9. Risk Analysis

9.1 Grades awarded to a service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within the time-scales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any Care Home or Day Service

would be of concern to the Audit Committee, particularly in relation to the continued placement of older people in such establishments.

Since the inspection, the care home has accepted support from NHS Greater Glasgow and Clyde Infection Prevention Control Team (IPCT) who undertook a visit on 19.04.22 and offered support and advice. The IPC Team also offered to revisit once the Care Inspectorate report was published and this will be arranged.

A routine multiagency care assurance visit was also undertaken by a Senior Nurse and Social Worker from the HSCP on 29.04.22. A collaborative approach to support the improvements identified in the action plan is underway, ensuring that the care home access the requisite support from the NHSGGC Care Home Hub Team to support the home to secure the requirements and improvements identified within the Care Inspectorate report, particularly in relation to the use of health monitoring tools.

The weekly multiagency care home oversight group will continue to monitor progress and work collaboratively with the care home to support them to achieve the required improvements.

10. Equalities Impact Assessment (EIA)

10.1 There are no Equalities Impact Assessments associated with this report.

11. Environmental Sustainability

11.1 N/A

12. Consultation

12.1 None required

13. Strategic Assessment

13.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan for 2016 – 19 priorities' are:

- To improve the health and wellbeing of West Dunbartonshire.
- 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.

14. Directions

14.1 N/A

Name:	Val Tierney
Designation:	Chief Nurse
Date:	30.05.22

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Appendices:	Appendix 1: Hillview Care Home Care Inspectorate Report