Agenda

West Dunbartonshire
Health & Social Care Partnership

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

Date:	Tuesday, 15 November 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 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: 8 November 2022

Audio Streaming

Please note the sound from this meeting will be recorded for live and subsequent audio streaming. All of this meeting will be audio streamed and will be published on West Dunbartonshire Council's host's webcast/audio stream platform.

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

TUESDAY, 15 NOVEMBER 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 27 September 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 ANNUAL AUDIT REPORT 2021 -2022 – WEST DUNBARTONSHIRE INTEGRATED JOINT BOARD 15 - 65

Submit report by Julie Slavin, Chief Financial Officer presenting the Annual Audit Report and Auditor's letter, for the audit of the financial year 2021/22, as prepared by the Health and Social Care Partnership Board's external auditors, Audit Scotland.

6/

6 WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) QUARTERLY PERFORMANCE REPORT 2022/23 QUARTER TWO **67 – 83**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation ensuring the 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.

7 STRATEGIC RISK REGISTER SIX MONTH REVIEW **85 – 96**

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

8 INTERNAL AUDIT REPORT – PERFORMANCE MANAGEMENT ARRANGEMENTS **97 - 106**

Submit report by Alistair Handley, Systems, Digital and Information Governance Manager providing an update on the findings of the recent internal audit review of high level processes and procedures in relation to the HSCP Board's Performance Management Arrangements.

9 CARE INSPECTORATE INSPECTION REPORT FOR TWO OLDER PEOPLE'S CARE HOMES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE **107 - 134**

Submit report by Val Tierney, Chief Nurse providing an update on Care Inspectorate inspection reports for Balquidder House Nursing Care Home and Strathleven Residential Care Home. Both are independent sector Care Homes located within West Dunbartonshire.

10 INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE **135 - 148**

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

11/

11	**INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE**	**149 - 166**

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

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

At a Hybrid Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee held in the Civic Space, 16 Church Street, Dumbarton on Tuesday, 27 September 2022 at 1.00 p.m.

Present: Rona Sweeney, Lesley Rousselet and Michelle Wailes*, NHS Greater Glasgow and Clyde Health Authority; Michelle McGinty, Martin Rooney and Clare Steel, West Dunbartonshire Council and lay member Mrs Anne MacDougall, Chair of the Locality Engagement Network, Clydebank.

***** Arrived later in the meeting

Attending: Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Sylvia Chatfield, Head of Service for Mental Health, Addictions and Learning Disabilities; Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Work Officer; Fiona Taylor, Interim Head of Health and Community Care; Val Tierney, Chief Nurse; Jennifer Ogilvie, HSCP Finance Manager; Andi Priestman, Chief Internal Auditor; Nigel Ettles, Principal Solicitor* and Ashley MacIntyre and Lynn Straker, Committee Officers.

* Arrived later in the meeting

Also Attending: Christopher Gardner and Jack Kerr, Auditors, Audit Scotland; Selina Ross, Chief Officer – West Dunbartonshire CVS; Dr Saied Pourghazi, Clinical Director and Barbara Barnes, Chair of the Locality Engagement Network, Alexandria and Dumbarton*.

* Arrived later in the meeting

Apologies: Apologies for absence were intimated on behalf of Margaret-Jane Cardno, Head of Strategy and Transformation; Audrey Slater, Head of People and Change and Lynn Ratcliff, Police Scotland.

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 MEETING

The Minutes of Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee held on 27 June 2022 were submitted and approved as a correct record.

Note: Michelle Wailes joined the meeting during consideration of this item.

ROLLING ACTION LIST

A Rolling Action list for the Committee was submitted for information and relevant updates were noted and agreed.

QUARTERLY PERFORMANCE REPORT FOR QUARTER ONE

A report was submitted 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 delivery of services and on the programme of work as set out in the West Dunbartonshire HSCPs Strategic Plan.

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

(1) to note the content of the HSCP Quarterly Performance Report 2022/23 Quarter One and performance against the Strategic Plan 2019 - 2023 by exception;

(2) to note that due to timing issues the report presents partial Quarter One data; and

(3) to note that Quarter Four information previously unavailable to the Committee is presented in the report and that full year data is contained within the Annual Performance Report 2021/22.

Note: Nigel Ettles joined the meeting during consideration of this item.

AUDIT PLAN PROGRESS

A report was submitted by Andi Priestman, Chief Internal Auditor enabling Members to monitor the performance of Internal Audit and gain an overview of the West Dunbartonshire HSCP Board's overall control environment.

After discussion and having heard Andi Priestman, Chief Internal Auditor in further explanation of the report and in answer to a Member's questions, the Committee agreed to note the progress made in relation to the Internal Audit Annual Plans for 2021/22 and 2022/23.

CLINICAL AND CARE GOVERNANCE ANNUAL REPORT 2021

A report was submitted by Val Tierney, Chief Nurse providing detail on the Clinical and Care Governance (C&CG) Annual Report 2021 which described the C&CG oversight arrangements in West Dunbartonshire HSCP and the progress made in assuring and improving the quality of health and social care.

After discussion and having heard Val Tierney, Chief Nurse and relevant officers in further explanation of the report and in answer to Members' questions, the Committee agreed that the report be sent to NHS Greater Glasgow and Clyde as all Health and Social Care Partnerships are requested to provide an Annual Report covering the role and remit of the group and any future plans for review and evaluation of care quality.

ANNUAL PERFORMANCE REPORT

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation providing an overview of the HSCP's performance in planning and carrying out integrated functions. The Annual Performance Report is produced for the benefit of Partnerships and their communities including a complaints management overview for the year 2021/22.

After discussion and having heard Beth Culshaw, Chief Officer and relevant officers in further explanation of the report and in answer to Members' questions, the Committee agreed to recommend to the HSCP Board that the West Dunbartonshire HSCP Annual Performance Report 2021/22 and the Annual Complaints Report 2021/22 be approved for publication.

ALCOHOL AND DRUG PARTNERSHIP UPDATE

A report was submitted by Sylvia Chatfield, Head of Mental Health, Addictions and Learning Disability providing an update on the progress in relation to the Scottish Government Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs in relation to the expectations of local governance arrangements for Alcohol and Drug Partnerships.

After discussion and having heard Sylvia Chatfield, Head of Mental Health, Addictions and Learning Disability in further explanation of the report and in answer to a Member's questions, the Committee agreed to note the progress in relation to section 4 of the report.

Note: Barbara Barnes joined the meeting during consideration of this item.

IMPLEMENTATION OF DIRECTIONS POLICY AND REVIEW OF DIRECTIONS LOG

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation providing an update on the implementation of the Directions Policy, which was approved by the HSCP Board on the 23 September 2020 alongside an opportunity to review the implementation of Directions issued between the 30 September 2020 and 31 March 2022.

After discussion and having heard Julie Slavin, Chief Financial Officer and relevant officers in further explanation of the report and in answer to a Member's questions, the Committee agreed:-

(1) to note the progress made in respect of the implementation of the Directions Policy;

(2) to note that no changes to the Directions Policy will be recommended to the HSCP Board as part of a recent review as the Policy remains compliant with the most recent Scottish Government Guidance;

(3) to note the implementation of Directions issued from 30 September 2020 until 31 March 2022; and

(4) to recommend to the HSCP Board that it seek a further report on the work of the Carers Development Group for presentation at its meeting in November 2022.

INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE

Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Work Officer provided a verbal update on the progress of the improvement work in relation to the Care Inspectorate inspection of Adoption Services in West Dunbartonshire 2022.

After discussion and having heard Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Work Officer in further explanation and in answer to Members' questions, the Committee agreed that a written update be provided to the meeting of the HSCP Audit and Performance Committee in November.

INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE

Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Work Officer provided a verbal update on the progress of the improvement work in relation to the Care Inspectorate inspection of Adoption Services in West Dunbartonshire 2022.

After discussion and having heard Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Work Officer in further explanation and in answer to Members' questions, the Committee agreed that a written update be provided to the meeting of the HSCP Audit and Performance Committee in November.

The meeting closed at 3.05 p.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	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 Revised: February 2023	CIPFA has just released new guidance for local authority bodies audit committees. This will be considered in the ToR review along with some suggested improvements from the members development session"	
STRATEGIC RISK REGISTER	That the Head of Strategy and Transformation would provide an interim update report to the August and Performance Committee on Monday, 27 June 2022.	Margaret-Jane Cardno	June 2022		Complete
2021-22 ANNUAL ACCOUNTS AUDIT PROCESS	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	Julie Slavin	October 2022		

	process extends beyond the end of September.				
INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE	That the improvement plan would remain as a standing item on the agenda for West Dunbartonshire HSCP Audit & Performance meetings enabling progress to be monitored.	Lesley James	Ongoing		
INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE	That the improvement plan would remain as a standing item on the agenda for West Dunbartonshire HSCP Audit & Performance meetings enabling progress to be monitored.	Lesley James	Ongoing		
2021/22 LOCAL CODE OF GOOD GOVERNANCE AND GOVERNANCE STATEMENT	Initial due dates and revised due dates to be made visible.	Julie Slavin			
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	Developed action plan to be circulated to all Committee Members.	Lesley James			

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP AUDIT AND PERFORMANCE COMMITTEE

Report by Julie Slavin, Chief Financial Officer

15 November 2022

Subject: Annual Audit Report 2021/22 – West Dunbartonshire Integrated Joint Board

1. Purpose

1.1 To present the Annual Audit Report and Auditor's letter, for the audit of the financial year 2021/22, as prepared by the Health and Social Care Partnership Board's external auditors, Audit Scotland.

2. Recommendations

2.1 It is recommended that the HSCP Board's Audit and Performance Committee:

a) Consider the contents of the Annual Audit Report to the Board and the Controller of Audit for the financial year ended 31 March 2022;

b) Note the achievement of an unqualified audit opinion;

c) Consider the key messages, the recommendations and agreed management actions contained in the attached appendices relating to the audited Annual Accounts;

d) Provide assurance to the HSCP Board that after consideration of both this annual audit report and management's letter of representation to external audit, the 2021/22 final audited accounts can be approved for final sign-off by the HSCP Board.

3. Background

3.1 It is a statutory requirement of the accounts closure process (ISA 260) that those charged with the governance of the HSCP Board's financial affairs receives a report from the appointed external auditors, highlighting the main matters arising in respect of their audit of the financial statements.

3.2 The ISA 260 and Annual Audit Report covers the nature and scope of the audit, details any qualifications, any unadjusted misstatements, any material weaknesses in the accounting and internal control systems, gives a view on the qualitative aspects around accounting practices and any other matters specifically required to be communicated to the HSCP Board.

3.3 The letter containing Independent Auditor's Opinion to the HSCP Board and a copy of the letter of Representation from the Chief Financial Officer (ISA 580) are attached at Appendix 1 (A & B). The ISA 580 provides external auditors with assurance around the key accounting requirements and judgements made by the Chief Financial Officer when closing the 2021/22 Accounts. The proposed Annual Audit Report is attached at Appendix 2.

4. Main Issues

4.1 It is the auditor's opinion that the financial statements give a true and fair view of the HSCP Board's financial position for the year ended 31 March 2022. The unqualified independent auditor's report is attached at Appendix 1 (A).

4.2 The 2021/22 Annual Audit Report, attached at Appendix 2 sets out the findings and main judgements arising from the audit and makes a number of recommendations covering the audit dimensions of:

a) Financial management and sustainability; and
b) Governance, transparency and best value.

4.3 The main judgements and findings conclude that the Board has:

a) The financial statements give a true and fair view of transactions and were properly prepared in accordance with the financial reporting framework;
b) Effective budget monitoring arrangements in place;
c) Financial systems of internal control operated effectively;
d) The IJB has updated its medium to long-term financial plan to reflect the impact of Covid-19 and the wider challenges it faces;
e) Governance arrangements are appropriate and operate effectively;
f) The IJB demonstrates aspects of Best Value, but arrangements could be enhanced through the introduction of a formal review of Best Value;
g) The IJB holds a significant balance in reserves. Covid-19 funding received late in the financial year contributed to an underspend of £12.753 million;
h) There are significant workforce pressures within both partner organisations; and
i) There have been no material misstatements identified and therefore no change to the £12.753m reported surplus presented in the draft accounts.

4.4 This surplus has allowed the HSCP Board to exceed the 2% target for unearmarked reserves as set out in the Reserves Policy. For the year ended 31 March 2022 the target was £3.956m and the unearmarked reserves balance stands at £4.579 million.

4.5 The audit identified one main risk/issue and recommendation and this is included within an agreed action plan (Appendix 1 of the main Annual Audit Report):

- Sustainability of Services - The joint board's financial plans forecast significant budget gaps in future years. The IJB should further develop financial and service redesign plans to ensure that services are financially sustainable in the future.

4.6 The annual audit report's scope extends beyond the audit of the 2021/22 report and accounts and provides commentary and observations of "live" issues for the IJB in 2022/23. These include two main statements that could have a direct impact on the sustainability of health and social care services in 2022/23 and future years:

a) West Dunbartonshire Council is negotiating with the IJB to change the funding split of residential care costs; and
b) The council intends to abolish charges for non-residential care, and has proposed that the IJB covers the lost income through its reserves.

4.7 The potential financial implications of these current proposals are set out within the regular financial performance reports to the Board and where appropriate, standalone reports.

4.8 As stated in section 3.3 above the ISA580 or management's letter of representation to external audit (Appendix 2) provides assurances on the key accounting requirements and judgements made by the Chief Financial Officer when closing the 2021/22 Accounts and that the IJB has fulfilled its statutory responsibilities in the preparation of the accounts.

4.9 As set-out within the Terms of Reference for this committee, it is the responsibility of members to consider both the Annual Audit Report and ISA580. After consideration and agreement on the proposed management actions contained within the annual report, the audited annual accounts will be presented to the HSCP Board for final approval and sign-off.

5. Options Appraisal

5.1 None required

6. People Implications

6.1 None associated with this report.

7. Financial and Procurement Implications

7.1 The HSCP Board achieved a surplus of £12.753m in 2021/22, which will be retained in accordance with the Integration Scheme and Reserves Policy.

7.2 The Section 95 officer (Chief Financial Officer) has provided written representations on aspects of the annual accounts, including the judgement and estimates made.

8. Risk Analysis

8.1 Detailed within the Annual Audit Report Action Plan.

9. Equalities Impact Assessment (EIA)

9.1 None required.

10. Environmental Sustainability

10.1 None required.

11. Consultation

11.1 This report has been completed in consultation with the HSCP Board's external auditor's Audit Scotland.

12. Strategic Assessment

12.1 This report is in relation to a statutory function and as such does not directly affect any of the strategic priorities.

13. Directions

13.1 None required.

Julie Slavin – Chief Financial Officer
Date: 4 November 2022

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

Appendices: Appendix 1 A: ISA 260 – Independent Auditors Report
Appendix 1 B**:** ISA 580 - Letter of Representation

Appendix 2: Annual Audit Report 2021/22

Background Papers: HSCP Audit and Performance Committee June 2022 – Unaudited Annual Report and Accounts 2021/22

Localities Affected: All

8 Nelson Mandela Place
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AUDIT SCOTLAND

Audit and Performance Committee

27 October 2022

West Dunbartonshire Integration Joint Board
Audit of 2021/22 annual accounts

Independent auditor's report

1. Our audit work on the 2021/22 annual accounts is now substantially complete. Subject to receipt of a revised set of annual accounts for final review, we anticipate being able to issue unqualified audit opinions in the independent auditor's report on 15 November 2022 (the proposed report is attached at **Appendix A**).

Annual audit report

2. Under International Standards on Auditing in the UK, we report specific matters arising from the audit of the financial statements to those charged with governance of a body in sufficient time to enable appropriate action. We present for the Audit and Performance Committee's consideration our draft annual report on the 2021/22 audit. The section headed "Significant findings from the audit in accordance with ISA 260" sets out the issues identified in respect of the annual accounts.

3. The report also sets out conclusions from our consideration of the four audit dimensions that frame the wider scope of public audit as set out in the Code of Audit Practice.

4. This report will be issued in final form after the annual accounts have been certified.

Unadjusted misstatements

5. We also report to those charged with governance all unadjusted misstatements which we have identified during the course of our audit, other than those of a trivial nature and request that these misstatements be corrected.

6. We have no unadjusted misstatements to be corrected in the annual accounts. In accordance with normal audit practice, a number of presentational and disclosure amendments were discussed and agreed with management.

Fraud, subsequent events and compliance with laws and regulations

7. In presenting this report to the Audit Committee we seek confirmation from those charged with governance of any instances of any actual, suspected, or alleged fraud; any subsequent events that have occurred since the date of the financial statements; or material non-compliance with laws and regulations affecting the entity that should be brought to our attention.

Representations from Section 95 Officer

8. As part of the completion of our audit, we are seeking written representations from the Chief Finance Officer on aspects of the annual accounts, including the judgements and estimates made.

9. A draft letter of representation is attached at **Appendix B**. This should be signed and returned to us by the Section 95 Officer with the signed annual accounts prior to the independent auditor's report being certified.

Appendix A: Proposed Independent Auditor's Report

Independent auditor's report to the members of West Dunbartonshire Integration Joint Board and the Accounts Commission

Reporting on the audit of the financial statements

Opinion on financial statements

I certify that I have audited the financial statements in the annual accounts of West Dunbartonshire Integration Joint Board for the year ended 31 March 2022 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Comprehensive Income and Expenditure Statement, Movement in Reserves Statement, Balance Sheet, and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2021/22 (the 2021/22 Code).

In my opinion the accompanying financial statements:

- give a true and fair view in accordance with applicable law and the 2021/22 Code of the state of affairs of the West Dunbartonshire Integration Joint Board as at 31 March 2022 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the 2021/22 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing (UK) (ISAs (UK)), as required by the Code of Audit Practice approved by the Accounts Commission for Scotland. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I was appointed under arrangements approved by the Accounts Commission on 18 July 2016. The period of total uninterrupted appointment is 6 years. I am independent of the body in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. Non-audit services prohibited by the Ethical Standard were not provided. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern basis of accounting

I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's

ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

These conclusions are not intended to, nor do they, provide assurance on the body's current or future financial sustainability. However, I report on the body's arrangements for financial sustainability in a separate Annual Audit Report available from the Audit Scotland website.

Risks of material misstatement

I report in my Annual Audit Report the most significant assessed risks of material misstatement that I identified and my judgements thereon.

Responsibilities of the Chief Financial Officer and West Dunbartonshire Integration Joint Board for the financial statements

As explained more fully in the Statement of Responsibilities, the Chief Financial Officer is responsible for the preparation of financial statements that give a true and fair view in accordance with the financial reporting framework, and for such internal control as the Chief Financial Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Chief Financial Officer is responsible for assessing the West Dunbartonshire Integration Joint Board's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless there is an intention to discontinue the body's operations.

The West Dunbartonshire Integration Joint Board audit and performance committee is responsible for overseeing the financial reporting process.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities outlined above to detect material misstatements in respect of irregularities, including fraud. Procedures include:

- obtaining an understanding of the applicable legal and regulatory framework and how the body is complying with that framework;
- identifying which laws and regulations are significant in the context of the body;
- assessing the susceptibility of the financial statements to material misstatement, including how fraud might occur; and
- considering whether the audit team collectively has the appropriate competence and capabilities to identify or recognise non-compliance with laws and regulations.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the body's controls, and the nature, timing and extent of the audit procedures performed.

Irregularities that result from fraud are inherently more difficult to detect than irregularities that result from error as fraud may involve collusion, intentional omissions, misrepresentations, or the override of internal control. The capability of the audit to detect fraud and other irregularities depends on factors such as the skilfulness of the perpetrator, the frequency and extent of manipulation, the degree of collusion involved, the relative size of individual amounts manipulated, and the seniority of those individuals involved.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Reporting on other requirements

Opinion prescribed by the Accounts Commission on the audited part of the Remuneration Report

I have audited the part of the Remuneration Report described as audited. In my opinion, the audited part of the Remuneration Report has been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014.

Other information

The Chief Financial Officer is responsible for other information in the annual accounts. The other information comprises the Management Commentary, Annual Governance Statement, Statement of Responsibilities and the unaudited part of the Remuneration Report.

My responsibility is to read all the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon except on the Management Commentary and Annual Governance Statement to the extent explicitly stated in the following opinions prescribed by the Accounts Commission.

Opinions prescribed by the Accounts Commission on the Management Commentary and Annual Governance Statement

In my opinion, based on the work undertaken in the course of the audit:

- the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with statutory guidance issued under the Local Government in Scotland Act 2003; and

- the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is

consistent with the financial statements and that report has been prepared in accordance with the Delivering Good Governance in Local Government: Framework (2016).

Matters on which I am required to report by exception

I am required by the Accounts Commission to report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the audited part of the Remuneration Report are not in agreement with the accounting records; or
- I have not received all the information and explanations I require for my audit.

I have nothing to report in respect of these matters.

Conclusions on wider scope responsibilities

In addition to my responsibilities for the annual accounts, my conclusions on the wider scope responsibilities specified in the Code of Audit Practice, including those in respect of Best Value, are set out in my Annual Audit Report.

Use of my report

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 120 of the Code of Audit Practice, I do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Fiona Mitchell-Knight FCA

Audit Director

Audit Scotland

4th Floor, South Suite

The Athenaeum Building

8 Nelson Mandela Place

Glasgow

G2 1BT

West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire Health & Social Care Partnership

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Dumbarton
G82 1QL

Date: 15 November 2022
Direct Line: 07773934377
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Dear Fiona,

West Dunbartonshire Integration Joint Board Annual Accounts 2021/22

1. This representation letter is provided in connection with your audit of the annual accounts of West Dunbartonshire Integration Joint Board for the year ended 31 March 2022 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the financial reporting framework, and for expressing other opinions on the remuneration report, management commentary and annual governance statement.

2. I confirm to the best of my knowledge and belief and having made enquiries as I consider necessary, the following representations given to you in connection with your audit of West Dunbartonshire Integration Joint Board's annual accounts for the year ended 31 March 2022.

General

3. West Dunbartonshire Integration Joint Board and I have fulfilled our statutory responsibilities for the preparation of the 2021/22 annual accounts. All the accounting records, documentation and other matters which I am aware are relevant to the preparation of the annual accounts have been made available to you for the purposes of your audit. All transactions undertaken by West Dunbartonshire Integration Joint Board have been recorded in the accounting records and are properly reflected in the financial statements.

4. I confirm that the effects of uncorrected misstatements are immaterial, individually and in aggregate, to the financial statements as a whole. I am not aware of any uncorrected misstatements other than those reported by you.

Financial Reporting Framework

5. The annual accounts have been prepared in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom 2021/22 (2021/22 accounting code), mandatory guidance from LASAAC, and the requirements of the Local

Government (Scotland) Act 1973, the Local Government in Scotland Act 2003 and The Local Authority Accounts (Scotland) Regulations 2014.

6. In accordance with the 2014 regulations, I have ensured that the financial statements give a true and fair view of the financial position of the West Dunbartonshire Integration Joint Board at 31 March 2022 and the transactions for 2021/22.

Accounting Policies & Estimates

7. All significant accounting policies applied are as shown in the notes to the financial statements. The accounting policies are determined by the 2021/22 accounting code, where applicable. Where the code does not specifically apply, I have used judgement in developing and applying an accounting policy that results in information that is relevant and reliable. All accounting policies applied are appropriate to West Dunbartonshire Integration Joint Board circumstances and have been consistently applied.

8. The significant assumptions used in making accounting estimates are reasonable and properly reflected in the financial statements. Judgements used in making estimates have been based on the latest available, reliable information. Estimates have been revised where there are changes in the circumstances on which the original estimate was based or as a result of new information or experience.

Going Concern Basis of Accounting

9. I have assessed West Dunbartonshire Integration Joint Board's ability to continue to use the going concern basis of accounting and have concluded that it is appropriate. I am not aware of any material uncertainties that may cast significant doubt on West Dunbartonshire Integration Joint Board's ability to continue as a going concern.

Liabilities

10. All liabilities at 31 March 2022 of which I am aware have been recognised in the annual accounts.

11. Provisions have been recognised in the financial statements for all liabilities of uncertain timing or amount at 31 March 2022 of which I am aware where the conditions specified in the 2021/22 accounting code have been met. The amount recognised as a provision is the best estimate of the expenditure likely to be required to settle the obligation at 31 March 2022. Where the effect of the time value of money is material, the amount of the provision has been discounted to the present value of the expected payments.

12. Provisions recognised in previous years have been reviewed and adjusted, where appropriate, to reflect the best estimate at 31 March 2022 or to reflect material changes in the assumptions underlying the calculations of the cash flows.

13. There are no plans or intentions that are likely to affect the carrying value or classification of the liabilities recognised in the financial statements.

Fraud

14. I have provided you with all information in relation to

- my assessment of the risk that the financial statements may be materially misstated as a result of fraud
- any allegations of fraud or suspected fraud affecting the financial statements
- fraud or suspected fraud that I am aware of involving management, employees who have a significant role in internal control, or others that could have a material effect on the financial statements.

Laws and Regulations

15. I have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

Related Party Transactions

16. All material transactions with related parties have been appropriately accounted for and disclosed in the financial statements in accordance with the 2021/22 accounting code. I have made available to you the identity of all the West Dunbartonshire Integration Joint Board's related parties and all the related party relationships and transactions of which I am aware.

Remuneration Report

17. The Remuneration Report has been prepared in accordance with the Local Authority Accounts (Scotland) Regulations 2014, and all required information of which I am aware has been provided to you.

Management commentary

18. I confirm that the Management Commentary has been prepared in accordance with the statutory guidance and the information is consistent with the financial statements.

Corporate Governance

19. I confirm that the West Dunbartonshire Integration Joint Board has undertaken a review of the system of internal control during 2021/22 to establish the extent to which it complies with proper practices set out in the Delivering Good Governance in Local Government: Framework 2016. I have disclosed to you all deficiencies in internal control identified from this review or of which I am otherwise aware.

20. I confirm that the Annual Governance Statement has been prepared in accordance with the Delivering Good Governance in Local Government: Framework

2016 and the information is consistent with the financial statements. There have been no changes in the corporate governance arrangements or issues identified, since 31 March 2022, which require to be reflected.

Balance Sheet

21. All events subsequent to 31 March 2022 for which the 2021/22 accounting code requires adjustment or disclosure have been adjusted or disclosed.

Yours sincerely

Julie Slavin CPFA
Chief Financial Officer

West Dunbartonshire Integration Joint Board

Proposed 2021/22 Annual Audit Report

AUDIT SCOTLAND

Prepared for West Dunbartonshire Integration Joint Board and the Controller of Audit
November 2022

Contents

Key messages

2021/22 annual accounts

1 Our audit opinions on the annual accounts of West Dunbartonshire Integration Joint Board are unmodified. The financial statements give a true and fair view of transactions and were properly prepared in accordance with the financial reporting framework.

2 The management commentary, the audited part of the remuneration report and the annual governance statement were consistent with the financial statements and prepared in accordance with proper accounting practices

Financial management and sustainability

3 Joint Board's across Scotland were operating in a volatile and challenging environment in 2021/22. The Integration Joint Board (IJB) had to prioritise its health and social care response to the Covid-19 pandemic against the backdrop of workforce and financial challenges.

4 Covid-19 had a significant impact on the 2021/22 year-end outturn. The joint board received £14.980 million of Covid-19 related funding, of which £8.893 million was received late in the financial year. Unspent Covid-19 funding of £9.213 million significantly contributed to an overall underspend of £12.753 million for 2021/22.

5 The joint board has effective budget monitoring arrangements in place.

6 The medium to long-term financial plan was updated to reflect the impact of Covid-19 and the wider challenges facing the joint board. In the worst-case scenario, a budget deficit of £18.725 million is forecast by 2026/27.

7 Unspent Covid-19 funding has significantly increased the joint board's reserves. As at 31 March 2022, it holds total reserves of £34.560 million, of which £29.981 million is earmarked for specific purposes.

8 There are significant workforce pressures within both partner organisations.

Governance, Transparency and Best Value

9 The governance arrangements are appropriate and operate effectively.

10 The joint board is progressing approval of the revised integration scheme.

11 The IJB demonstrates some aspects of Best Value, but arrangements could be enhanced through the introduction of a formal Best Value review.

12 Overall, key performance indicators in 2021/22 show similar levels of performance when compared to 2020/21. There are significant challenges in reducing delayed discharges.

Introduction

1. This report summarises the findings arising from the 2021/22 audit of West Dunbartonshire Integration Joint Board (the IJB).

2. The scope of the audit was set out in our Annual Audit Plan presented to the 7 March 2022 meeting of the Audit and Performance Committee.

3. This report comprises the findings from:

- the audit of the West Dunbartonshire Integration Joint Board's 2021/22 annual accounts
- consideration of the four audit dimensions that frame the wider scope of public audit set out in the Code of Audit Practice 2016

Adding value through the audit

4. We add value to the IJB, through audit, by:

- identifying and providing insight on significant risks, and making clear and relevant recommendations
- sharing intelligence and good practice through our national reports (Appendix 3) and good practice guides
- providing clear and focused conclusions on the appropriateness, effectiveness and impact of corporate governance, performance management arrangements and financial sustainability.

Responsibilities and reporting

5. The IJB has primary responsibility for ensuring the proper financial stewardship of public funds. This includes preparing annual accounts that are in accordance with proper accounting practices. The IJB is also responsible for compliance with legislation and putting arrangements in place for governance and propriety that enable it to successfully deliver its objectives.

6. Our responsibilities as independent auditor appointed by the Accounts Commission are established by the Local Government in Scotland Act 1973, the Code of Audit Practice 2016 and supplementary guidance, and International Standards on Auditing in the UK.

7. As public sector auditors we give independent opinions on the annual accounts. Additionally, we conclude on:

- the appropriateness and effectiveness of the IJB's performance management arrangements,
- the suitability and effectiveness of corporate governance arrangements, and
- the financial position and arrangements for securing financial sustainability.

8. Further details of the respective responsibilities of management and the auditor can be found in the Code of Audit Practice 2016 and supplementary guidance.

9. This report raises matters from our audit. Weaknesses or risks identified are only those which have come to our attention during our normal audit work and may not be all that exist. Communicating these does not absolve management from its responsibility to address the issues we raise and to maintain adequate systems of control.

10. Our annual audit report contains an agreed action plan at Appendix 1 setting out specific recommendations, responsible officers and dates for implementation. It also includes outstanding actions from previous years and the progress made.

Audit appointment from 2022/23

11. The Accounts Commission is responsible for the appointment of external auditors to local government bodies. 2021/22 is the last year of the current appointment round.

12. The procurement process for the new round of audit appointments was completed in May 2022. For the period 2022/23 to 2026/27, Mazars will be the appointed auditor for the IJB. We are working with the new auditors to ensure a well-managed transition.

New Code of Audit Practice

13. A new Code of Audit Practice applies to public sector audits for financial years starting on or after 1 April 2022. It replaces the Code issued in May 2016.

14. The Code outlines the objectives and principles to be followed by all auditors. The audit of financial statements is covered by auditing standards, so the Code focuses more on the wider dimension objectives and responsibilities of public sector auditors. It is a condition of their appointment by the Auditor General for Scotland or the Accounts Commission that auditors adhere to the requirements of the Code.

Auditor Independence

15. Auditors appointed by the Accounts Commission or Auditor General must comply with the Code of Audit Practice and relevant supporting guidance. When auditing the financial statements auditors must comply with professional

standards issued by the Financial Reporting Council and those of the professional accountancy bodies.

16. We can confirm that we comply with the Financial Reporting Council's Ethical Standard. We can also confirm that we have not undertaken any non-audit related services and therefore the 2021/22 audit fee of £27,960, as set out in our Annual Audit Plan, remains unchanged. We are not aware of any relationships that could compromise our objectivity and independence.

17. This report is addressed to both the West Dunbartonshire Integration Joint Board and the Controller of Audit and will be published on Audit Scotland's website www.audit-scotland.gov.uk in due course. We would like to thank the management and staff who have been involved in our work for their co-operation and assistance during the audit.

1. Audit of 2021/22 annual accounts

The principal means of accounting for the stewardship of resources and performance

Main judgement

Our audit opinions on the annual accounts of West Dunbartonshire Integration Joint Board are unmodified. The financial statements give a true and fair view of transactions and were properly prepared in accordance with the financial reporting framework.

The management commentary, the audited part of the remuneration report and the annual governance statement were consistent with the financial statements and prepared in accordance with proper accounting practices.

Our audit opinions on the annual accounts are unmodified

18. The IJB's annual accounts for the year ended 31 March 2022 were approved by the joint board on 15 November 2022. As reported in the independent auditor's report:

- the financial statements give a true and fair view and were properly prepared in accordance with the financial reporting framework
- the audited part of the Remuneration Report, Management Commentary and the Annual Governance Statement were all consistent with the financial statements and properly prepared in accordance with the relevant regulations and guidance.

The unaudited annual accounts were submitted for audit in line with the agreed timetable

19. We received the unaudited annual accounts on 30 June 2022 in line with the agreed audit timetable. The working papers provided to support the accounts were of a good standard. Finance staff provided good support to the audit team which helped ensure the final accounts audit process ran smoothly.

There were no objections raised to the annual accounts

20. The Local Authority Accounts (Scotland) Regulations 2014 require local government bodies to publish a public notice on its website that includes details

of the period for inspecting and objecting to the accounts. This must remain on the website throughout the inspection period. The IJB complied with the regulations. There were no objections to the 2021/22 annual accounts.

Our audit testing reflected the calculated materiality levels

21. We apply the concept of materiality in both planning and performing the audit and in evaluating the effect of identified misstatements on the audit and in forming the opinion in the auditor's report. We identify a benchmark on which to base overall materiality, such as gross expenditure, and apply what we judge to be the most appropriate percentage level for calculating materiality values.

22. The determination of materiality is based on professional judgement and is informed by our understanding of the entity and what users are likely to be most concerned about in the annual accounts. In assessing performance materiality, we have considered factors such as our findings from previous audits, any changes in business processes and the entity's control environment including fraud risks.

23. Our initial assessment of materiality for the annual accounts was carried out during the planning phase of the audit. This was reviewed and revised on receipt of the unaudited annual accounts and is summarised in Exhibit 1.

Exhibit 1
Materiality values

Materiality level	Amount
Overall materiality: This is the figure we use in assessing the overall impact of potential adjustments on the financial statements. It has been set at 1.5% of gross expenditure for the year ended 31 March 2022.	£3.478 million
Performance materiality: This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality this would indicate that further audit procedures should be considered. Using our professional judgement, we calculated performance materiality at 70% of planning materiality.	£2.435 million
Reporting threshold: We are required to report to those charged with governance on all unadjusted misstatements more than the 'reporting threshold' amount.	£0.105 million

Source: Audit Scotland

We have a significant finding to report on the audited annual accounts

24. International Standard on Auditing (UK) 260 requires us to communicate significant findings from the audit to those charged with governance, including our view about the qualitative aspects of the body's accounting practices. We have one significant finding detailed in Exhibit 2.

Exhibit 2
Significant finding from the audit of the annual accounts

Issue	Resolution
1. Significant balance in reserves The balance held in reserves for future spending amounted to £34.560 million as at 31 March 2022. This represents an increase of £12.753 million in 2021/22. The significant increase is mostly attributable to £8.893 million Covid-19 related funding received from the Scottish Government late in the financial year. This has been carried forward for use in 2022/23 in an earmarked ring-fenced reserve, and there are conditions on how this money can be spent. This funding is included as an underspend against budget in the annual accounts. In September 2022, the Scottish Government commenced discussions with all IJBs regarding the possible clawback of reserves, although these discussions are at an early stage.	**For information only.** IJBs across Scotland have recorded large increases to their reserves position in 2021/22. We recognise that the board has received regular updates on the reserves position and there are plans for their use. Further comment on the reserves position is detailed in paragraphs 49. to 54.

Source: Audit Scotland

25. In addition to our finding in Exhibit 2, we identified one further less significant issue, detailed below:

- **Hospital acute services (set-aside)**: In the unaudited accounts, the prior year set aside expenditure figure for hospital acute services, and corresponding NHS Greater Glasgow and Clyde income contribution, had been restated in the comprehensive income and expenditure statement. Both figures were increased by £0.096 million. This was due to prior year set aside data incorrectly including activity related to the Royal Hospital for Children. As the restatement was not material, a restatement was not required, in accordance with International Accounting Standard (IAS) 8. This has been adjusted in the audited accounts.

26. We have obtained audit assurances over the identified significant risks of material misstatement to the financial statements, identified in our 2021/22 Annual Audit Plan. Exhibit 3 summarises the audit procedures we performed during the year to obtain assurances over the risks and conclusions from the work completed.

Exhibit 3

Significant risk of material misstatement in the financial statements

Audit risk	Assurance procedure	Results and conclusions
1. Risk of material misstatement due to fraud caused by the management override of controls As stated in International Standard on Auditing (UK) 240, management is in a unique position to perpetrate fraud because of management's ability to override controls that otherwise appear to be operating effectively.	Assurances obtained from the external auditors of West Dunbartonshire Council and NHS Greater Glasgow and Clyde over the completeness, accuracy and allocation of income and expenditure. Evaluated any unusual material transactions identified through our audit testing for any evidence of management override of controls.	**Results & Significant Judgements:** Testing of income and expenditure transactions was carried out by the external auditors of the IJB's partner bodies. No issues were reported in the assurances obtained which would have an impact on the processing of IJB transactions or our audit approach. There were also no unusual material transactions identified. **Conclusion:** There was no evidence of management override of controls from the work performed.
2. Hospital acute services (set-aside) The "set-aside" is the Joint Board's share of the delegated acute services provided by NHSGGC hospitals on behalf of the Joint Boards. It reflects actual cost and activity data. In 2020/21, audit testing identified a material error in the IJB's set-aside figure. This error was due to a change in the formatting of the central Health Board spreadsheet. The accounts were amended to show the correct figures. Due to the	Review and testing of the calculation of the set aside figure in the accounts.	**Results & Significant Judgements:** The set aside figure for delegated services provided in large hospitals was £36.346 million. The detailed working paper supporting the calculation was subject to review and audit testing. No errors were identified. **Conclusion:** There were no errors identified in the 2021/22 set aside figure.

Audit risk	Assurance procedure	Results and conclusions
error, this will be an area for audit focus in 2021/22.		

There were no material misstatements identified in the annual accounts

27. There were no misstatements identified in the annual accounts. In accordance with normal audit practice, a number of presentational and disclosure amendments were discussed and agreed with management.

Financial and performance reporting in the management commentary has improved

28. The management commentary that accompanies the annual accounts should clearly explain how the IJB has performed against its budget and how this is reconciled to the financial statements.

29. In previous years, we reported that the overall presentation and accessibility of information in the accounts could be enhanced through greater use of infographics and trend analysis over time.

30. Improvements have been made to the management commentary in 2021/22 by introducing infographics, which present highlights from the joint board's performance over the year. There remains scope to further enhance how information is presented in the annual report, focusing on key messages and summarising information. This would improve the readability of the report and give a more accessible picture of performance.

Our audit work addressed the wider dimension risks identified in our 2021/22 Annual Audit Plan

31. The Code of Audit Practice 2016 requires auditors to consider the wider dimensions of public sector audit (financial management, financial sustainability, governance and transparency and value for money). Within our 2021/22 Annual Audit Plan, under this responsibility, we identified wider dimension risks in relation to:

- Planning for financial sustainability
- Service pressures
- Workforce sustainability
- Governance arrangements
- Integration scheme

32. Appendix 2 summarises the audit procedures we performed during the year to obtain assurances over these risks and the conclusions from the work

completed. Further details of our work in relation to the audit dimensions is included in sections 2 to 5 of this report.

Reasonable progress was made on prior year recommendations

33. The joint board has made reasonable progress in implementing our prior year audit recommendations made in our 2020/21 Annual Audit Report. This includes actions brought forward from previous years. For actions not yet implemented, revised responses and timescales have been agreed with management, and are set out in Appendix 1.

2. Financial management and sustainability

Financial management is about financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively.

Main judgements

Joint Board's across Scotland were operating in a volatile and challenging environment in 2021/22. The Integration Joint Board (IJB) had to prioritise its health and social care response to the Covid-19 pandemic against the backdrop of workforce and financial challenges.

Covid-19 had a significant impact on the 2021/22 year-end outturn. The joint board received £14.980 million of Covid-19 related funding, of which £8.893 million was received late in the financial year. Unspent Covid-19 funding of £9.213 million significantly contributed to an overall underspend of £12.753 million for 2021/22.

The joint board has effective budget monitoring arrangements in place.

The medium to long-term financial plan was updated to reflect the impact of Covid-19 and the wider challenges facing the joint board. In the worst-case scenario, a budget deficit of £18.725 million is forecast by 2026/27.

Unspent Covid-19 funding has significantly increased the joint board's reserves. As at 31 March 2022, it holds total reserves of £34.560 million, of which £29.981 million is earmarked for specific purposes.

There are significant workforce pressures within both partner organisations.

Covid-19 funding received late in the financial year contributed to an underspend of £12.753 million

34. The joint board does not hold assets, nor does it directly incur expenditure or employ staff, other than the Chief Officer and Chief Finance Officer. All funding and expenditure for the IJB is incurred by partner bodies and processed in their accounting records.

35. The Covid-19 pandemic had a significant impact on the IJB's 2021/22 budget. In 2021/22, the IJB had £14.980 million of Covid-19 related funds available (including income carried forward from the previous year), with £8.893 million of this received late in the financial year. The IJB utilised £5.767 million of this funding with the remaining £9.213 million transferred to an earmarked ring-fenced reserve, and there are conditions on how this money can be spent.

36. The late receipt of Covid-19 funding significantly contributed to the IJB returning an overall underspend of £12.753 million against a budgeted breakeven position, as shown in Exhibit 4. The IJB has earmarked £12.541 million of this underspend for specific purposes with the remaining £0.212 million unearmarked.

Exhibit 4
Performance against budget

IJB budget summary	Budget £m	Actual £m	Variance £m
Net Expenditure on Services Directly Managed by WDIJB	170.097	178.232	8.135
Funded by			
Contribution from NHS Greater Glasgow & Clyde Health Board	(97.853)	(116.060)	(18.207)
Contribution from West Dunbartonshire Council	(71.921)	(74.925)	(3.004)
Use of Earmarked Reserves	(0.323)	0	0.323
Surplus of Income over Expenditure	0	(12.753)	(12.753)

Source: Audit Scotland

There are effective budget monitoring arrangements in place

37. Detailed budget monitoring reports were submitted to meetings of the joint board throughout the year. The reports included the year to date and forecast year-end outturn position, including detailed information on additional Covid-19 related funding and expenditure. Progress towards meeting agreed savings targets were also monitored as part of these reports.

38. The budget reports provided members with a comprehensive overview of the IJB's financial position. To support effective scrutiny by members, the Chief Financial Officer has presented a summarised dashboard view of key figures, alongside the standard budget reports, at key points during the financial year. This has improved the budget reporting arrangements in place.

39. We observed that senior management and members receive detailed and timeous financial information on the IJB's financial position and have concluded the IJB has effective budget monitoring arrangements in place.

£2.372 million savings and service redesign efficiencies, were planned but only £0.892 million was achieved

40. As part of the 2021/22 budget, the joint board approved £2.372 million of savings and service redesign efficiencies. The final outturn report presented to the June 2022 Board reported that £0.892m of savings were achieved as planned. £1.084 million was covered by Covid-19 funding and the remaining £0.396 million was covered by other IJB underspends and earmarked reserves.

41. Where possible, the IJB should aim to identify where recurring savings can be made to address the forecast future year budgets gaps in Exhibit 5. The achievement of budgeted savings and service redesign efficiencies will be important for services to be financially sustainable in the future.

Financial systems of internal control operated effectively

42. The IJB does not have its own financial systems and instead relies on partner bodies' financial systems. All financial transactions are processed under the partner bodies' internal controls.

43. As part of our audit approach, we sought assurances from the external auditor of NHS Greater Glasgow & Clyde. We are also the auditor of West Dunbartonshire Council. The audits of the health board and council identified no significant weaknesses that could result in a risk to the annual accounts of the IJB.

44. The IJB also received their own assurances from the Section 95 Officer of the council and Chief Financial Officer of the health board. These assurances provided confirmation that the charges for services commissioned by the IJB accurately reflect the income and expenditure recorded in the partner' bodies financial systems in 2021/22.

The IJB has updated its medium to long-term financial plan to reflect the impact of Covid-19 and the wider challenges it faces

45. Financial sustainability looks forward to the medium and longer term to consider whether the body is planning effectively to continue to deliver its services or the way in which they should be delivered. We previously reported that the medium to long-term financial plan should be updated to reflect the longer-term financial impact of Covid-19 on health and social care services.

46. In March 2022, the Board approved a revised medium-term financial plan covering the period 2022/23 to 2026/27. This sets out anticipated income and expenditure based on assumptions around pay inflation, service demand, demographic changes and pressures resulting from the impact of Covid-19. Scenario planning has been used to project potential future budget gaps based on the likely, worst case and best-case

scenarios, Exhibit 5. The plan also includes indicative financial data for the period to 2031/32.

47. All IJBs are operating in an environment of significant uncertainty which constrains longer term financial planning. The Scottish Government's plans to introduce a new National Care Service, the funding share of pay awards, and single year funding settlements make future income difficult to forecast.

48. The financial plan contains five broad themes setting out the IJB's plans to address the budget gaps: better ways of working, community empowerment, prioritise our services, equity and consistency of approach, and service redesign and transformation. Through the use of reserves, the IJB has appointed three service improvement leads to progress service redesign.. It is important that the joint board further develops financial and service redesign plans to ensure its resources are aligned to agreed priorities and the necessary service redesign and transformational changes are progressed. The extent of the challenges faced by the IJB means that services will need to change if they are to be sustainable in the future.

Recommendation 1

The joint board's financial plans forecast significant budget gaps in future years. The IJB should further develop financial and service redesign plans to ensure that services are financially sustainable in the future.

Exhibit 5

Scenario planning to project potential future budget gaps

Indicative budget gap	2023/24 £m	2024/25 £m	2025/26 £m	2026/27 £m
Best	0.833	3.562	7.522	10.435
Likely	2.815	5.623	9.652	12.635
Worst	8.492	11.445	15.602	18.725

Source: West Dunbartonshire Integration Joint Board Medium Term Financial Plan 2022/23–2026/27

The IJB has total reserves of £34.560 million as at 31 March 2022. Covid-related funding has significantly increased the reserves position in the past two financial years.

49. The joint board holds two types of reserves, earmarked and unearmarked reserves. Earmarked reserves are held for a known commitment or for a

specific purpose in the future. Unearmarked reserves provide a contingency fund to manage the impact of unexpected events or emergencies. The IJB holds £4.579m of unearmarked reserves, £0.623 million above the two per cent of net expenditure (excluding Family Health Services) target set in the IJB's reserves policy.

50. At 31 March 2022, the earmarked reserves balance amounted to £29.981 million compared to £17.440 million at 31 March 2021. The substantial increase in 2021/22 is primarily due to an underspend of Covid-19 funding received by the Scottish Government, to be spent in future years. As is the case in many other integration joint boards, this year's reserves balance is significantly higher than at any other point in the joint board's history, Exhibit 6.

Exhibit 6

West Dunbartonshire IJB's reserves, 2017/18 to 2021/22

	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m
Total Unearmarked Reserves	1.705	2.457	2.809	4.367	4.579
Total Earmarked Reserves	4.43	4.723	5.254	17.440	29.981
Total Reserves	**6.142**	**7.180**	**8.063**	**21.807**	**34.560**

Source: West Dunbartonshire Integrated Joint Board annual accounts 2017/18 to 2021/22

51. Of the earmarked reserves held, 65% is for Scottish Government policy initiatives such as Covid-19 funding. These funds are largely ring-fenced which restricts their use. This ring-fenced funding contains non-recurring elements.

52. There are ongoing sustainability challenges of using non-recurring income, held in reserves, to fund recurring expenditure. The non-recurring nature of this funding means that, for example, the IJB is generally advertising for fixed-term, rather than permanent posts which can be more difficult to fill. Difficulties in recruiting staff has been a significant factor in the joint board drawing down £7.832 million of the £8.968 million it forecast to use from earmarked reserves in 2021/22.

53. An additional challenge arises from the fact that, in September 2022, the Scottish Government commenced discussions with IJBs regarding the possible clawback of reserves to meet future funding pressures. These discussions are at an early stage so further information will be required to support the IJB in making informed decisions on the use of reserves.

54. Proposals which would utilise £1.489 million of reserves were presented to the August 2022 Board by the Chief Financial Officer, however these proposals were not agreed by members. There is a risk this impacts on the delivery of the IJB's strategic priorities. The IJB has earmarked £29.891 million of its reserves

although delivery of these plans may be constrained by national recruitment challenges. Members will be required to take difficult decisions in the future, recognising that a clear plan and effective management of the IJB's reserves will be key to maintaining financial sustainability and ensuring the effective delivery of services.

West Dunbartonshire Council is negotiating with the IJB to change the funding split of residential care costs

55. As part of West Dunbartonshire Council's 2022/23 budget, a proposal was agreed to negotiate the funding split of residential child placements with the IJB. The council's budgeted assumptions would increase the IJB's share of costs from 50% to 80%, resulting in a £1.365 million cost increase for the IJB in addition to a further £0.725 million of budget pressure to be met by the joint board's Covid reserves. Since then, the Scottish Government has indicated that Covid reserves should not be used for this particular purpose by the IJB. In October 2022, West Dunbartonshire Council further amended its proposals for these costs to be allocated on a 72% HSCP and 28% council basis in 2022/23, on a recurring basis.

56. The council's proposals were considered as part of the IJB's 2022/23 budget-setting process, but were not agreed by the joint board in March 2022 as a full review of the costs split had not yet been undertaken. The budgetary implications of these proposals require the agreement of the IJB, health board and council, and agreement has not been reached.

The council intends to abolish charges for non-residential care, and has proposed that the IJB covers the lost income through its reserves.

57. At the June 2022 West Dunbartonshire Council meeting, a motion was passed with an intention to abolish £1.510 million of non-residential care charges. The power to set or abolish these charges lies with the local authority. The council's aim was that the IJB would cover this loss of income through its unearmarked reserves. At the August 2022 meeting of the IJB, members did not agree to fund this with unearmarked reserves. The council has not formally abolished charges, and the implications of any future decisions would need to be reflected in the budgetary requirements of the council and the IJB.

There are significant workforce pressures within both partner organisations

58. There are significant workforce pressures within both the NHS and social care. In its February 2022 NHS in Scotland 2021 report, in the context of the scale and pace of remobilisation, Audit Scotland noted the risk of workforce issues in the NHS. This included concerns about staff wellbeing, sustainability because of retirals, recruitment challenges, and the need to ensure the appropriate skills mix. From a social care perspective, Audit Scotland's 2022 Social Care briefing highlighted that the social care workforce has high vacancy rates with many services facing recruitment problems. Together with the

increasing demand for social care, this presents a risk to the capacity and quality of social care services.

59. The workforce challenges experienced nationally are replicated within both West Dunbartonshire IJB partner organisations. These issues have the potential to impact on the delivery of the IJB's Strategic Plan and plans to redesign services. The IJB's Strategic Risk Register reflects the significance of the workforce sustainability risk with this risk assessed as unacceptable, the highest rating. Actions are being undertaken to address this risk with internal audit due to complete a review of workforce planning arrangements as part of its 2022/23 internal audit plan.

The Scottish Government's proposals for a new National Care Service have the potential to significantly change the way that IJBs are structured and operate

60. Following the publication of the Independent Review of Adult Social Care in February 2021, work is currently under way nationally to develop and implement a new National Care Service (NCS). The Scottish Government expects the new NCS to be operational by 2026. These proposals have the potential to significantly change the way that IJBs are structured and operate.

61. In its January 2022 Social Care briefing, Audit Scotland noted stakeholders concerns about the extent of the proposals for reform and the time it will take to implement them. Many of the current issues experienced by the social care sector, for example the workforce pressures, cannot wait for the Scottish Government to implement a new NCS.

62. Members have been kept informed on the potential impact of the new NCS through a series of joint board papers and two informal board sessions. Following board approval, the IJB provided a formal response to the consultation on a NCS for Scotland. The response, agreed in November 2021, noted that "whilst supportive of many of the ambitions within the consultation document, [the IJB] would wish further detail to allow reflection on whether the time and resources required to create an entirely new structure is best value".

4. Governance, transparency and Best Value

The effectiveness of scrutiny and oversight and transparent reporting of information. Using resources effectively and continually improving services.

Main Judgements

The governance arrangements are appropriate and operate effectively.

The joint board is progressing approval of the revised integration scheme

The IJB demonstrates some aspects of Best Value, but arrangements could be enhanced through the introduction of a formal Best Value review.

Overall, key performance indicators in 2021/22 show similar levels of performance when compared to 2020/21. There are significant challenges in reducing delayed discharges.

Governance arrangements are appropriate and operate effectively overall

63. The IJB's governance framework has been adapted as a result of the Covid-19 pandemic. Meetings of the Audit and Performance Committee and the Board have continued as planned but have taken place remotely throughout 2021/22. Since June 2022, meetings have been delivered through a hybrid model with some members and officers attending in person while others contribute remotely.

64. The joint board operates in a difficult and uncertain strategic context and faces significant financial pressures, a lack of certainty and flexibility over long-term funding, and the prospect of major service reforms. Collaborative leadership was critical to the pandemic response by harnessing the resources of the community and partners.

65. The current financial outlook will inevitably place strain on the ability of the joint board to make funding decisions collaboratively to support recovery and improve outcomes for residents. Complex problems need a 'whole systems approach', so it is vital that members and partners promote open, collaborative and partnership working.

66. We reported in our 2021/22 Annual Audit Plan, based on our attendance at a recent Board meeting, that the length of a Board meeting we attended provided limited opportunities for members to discuss and scrutinise agenda items. During the course of our audit, we have observed that members have been provided with sufficient time and opportunities to properly scrutinise officers' reports and challenge decisions made. We can conclude that this particular board meeting was not representative of the overall governance environment throughout 2021/22.

67. We consider that governance arrangements are appropriate and support effective scrutiny, challenge and decision-making. We can conclude that effective governance has been demonstrated in 2021/22.

The IJB audio streams meetings to improve the openness and transparency of its activities and decision making

68. There continues to be an increasing focus on demonstrating the best use of public money. Openness and transparency in how a body operates and makes decisions is key to supporting understanding and scrutiny. Transparency means that the public has access to understandable, relevant, and timely information about how the body is taking decisions and using resources.

69. The IJB has its own website which includes the schedule of meetings and the agenda, reports, and minutes for each meeting of the Integration Joint Board and Audit and Performance Committee. Agenda and papers are posted in advance of meetings to allow members of the public access to these.

70. The IJB have improved the openness and transparency of its activities and decision making. The August 2022 meeting of the Board was the first to be audio streamed. All future meetings of the Board and Audit and Performance Committee will be audio streamed, with recordings available on the West Dunbartonshire Council website. Including the audio streamed meetings on the IJB website, or including a link to the recordings, would enhance arrangements further.

71. We conclude that the IJB demonstrates a commitment to openness and transparency.

Internal audit provided a reasonable level of assurance over the adequacy and effectiveness of the systems of governance, risk management and internal control

72. Internal audit provides the joint board with independent assurance on the organisation’s overall risk management, internal control and corporate governance processes. The internal audit function for the IJB is provided by West Dunbartonshire Council, overseen by the Shared Service Manager – Audit and Fraud.

73. Public Sector Internal Audit Standards require the “chief audit executive”, which for the IJB is the Shared Service Manager – Audit and Fraud, to provide an internal audit opinion to inform the annual governance statement. Internal audit issued its Annual Assurance Report to the IJB in June 2022 which

included the opinion that “reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control for the year ending 31 March 2022”.

The joint board is progressing approval of the revised integration scheme

74. The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the partner bodies carry out a review of the integration scheme within five years of establishment. While the IJB approved a revised scheme in February 2020, the necessary approvals required by the health board were delayed by the Covid-19 pandemic.

75. A consistent integration scheme has been developed across the six integration joint boards which make up the Greater Glasgow and Clyde Health Board area. Following public consultation, final approval of the revised scheme of integration by Scottish Ministers is expected by March 2023. We have been advised that a review of the Board’s Standing Orders and Scheme of Officer Delegation will be concluded following the approval of the integration scheme.

The joint board has extended its strategic plan by a further year due to the disruption caused by the pandemic

76. The Public Bodies (Joint Working) (Scotland) Act 2014 requires IJBs to review their strategic plans every three years. Given the significant period of disruption caused by Covid-19, the board agreed in November 2021 to extend the Strategic Plan by a period of 12 months to March 2023.

77. The Strategic Plan should set out how resources will be directed to secure better health and wellbeing outcomes. The IJB’s Strategic Planning Group is progressing an action plan and we understand the IJB remain on track to present its updated Strategic Plan 2023 – 2026 to the Board by March 2023. Work already undertaken includes the completion of strategic needs assessments (SNA’s) for adults and children’s services. The IJB should use the data from the SNA’s, alongside the feedback from the planned consultation with the public and strategic partners, to inform the future strategic plan.

The IJB demonstrates aspects of Best Value, but arrangements could be enhanced through the introduction of a formal review of Best Value

78. IJBs have a statutory duty to have arrangements to secure Best Value. To achieve this, IJBs should have effective processes for scrutinising performance, monitoring progress towards their strategic objectives and holding partners to account.

79. There are effective performance management arrangements in place. The Audit and Performance Committee has continued to monitor the key performance targets in the existing strategic plan through quarterly performance reporting. Clear and measurable performance targets are in place which provide an indication of the IJB’s progress against its strategic objectives.

80. Internal audit conducted a review of the IJB's performance management arrangements focussing on the high-level processes and procedures in place. Areas of best practice were identified in the layout, timing and presentation of quarterly performance information. Two low risk issues were identified in relation to key processes and cross-referencing of exception reporting to relevant performance indicators.

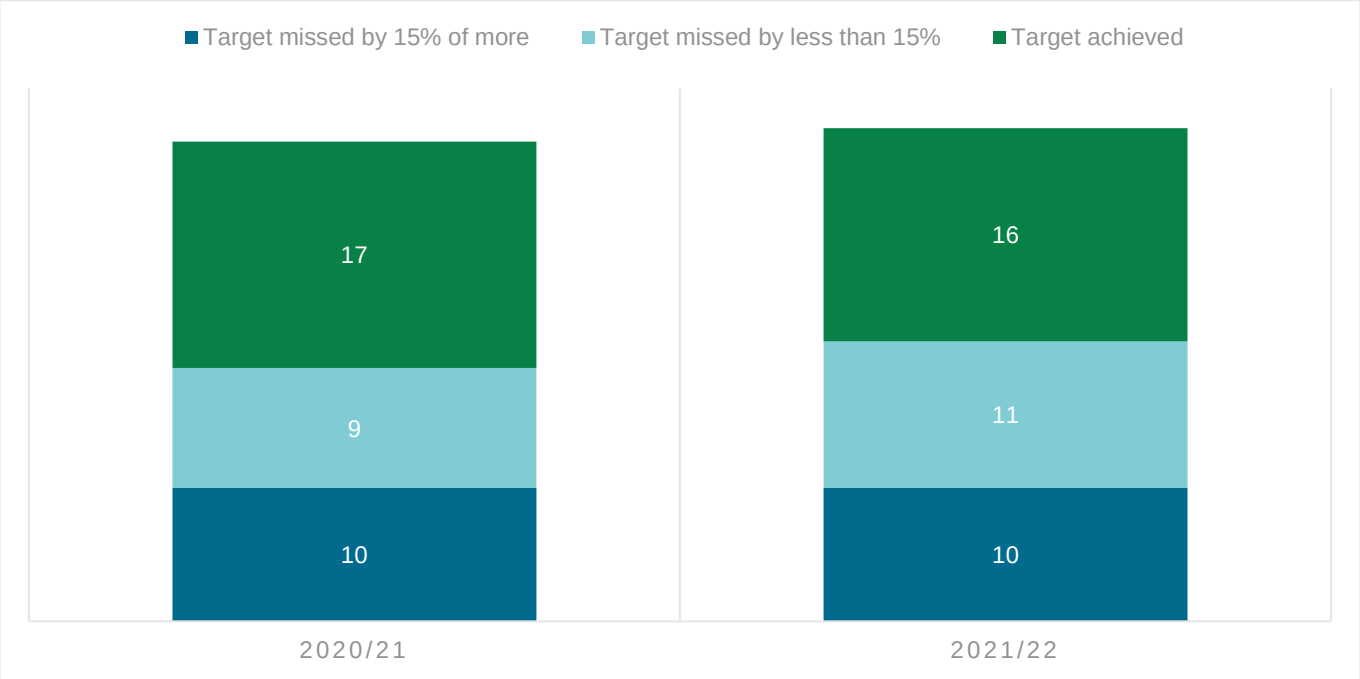
81. We have previously recommended that the IJB should agree a mechanism for undertaking a periodic and evidenced formal review of how it is achieving Best Value. This is still to be established as we have reported in Appendix 2. There is an opportunity for the IJB to develop a Best Value review mechanism which complements and supports the implementation of the new strategic plan.

Overall, key performance indicators in 2021/22 show similar levels of performance when compared to 2020/21. There are significant challenges in reducing delayed discharges.

82. The Public Bodies (Joint Working) (Scotland) Act 2014 requires IJB's to produce an annual performance report covering areas such as: assessing performance in relation to national health and wellbeing outcomes, financial performance and best value, reporting on localities, and the inspection of services.

83. The 2021/22 Annual Performance Report was approved by the IJB ahead of the extended 30 September 2022 deadline. Overall, key performance indicators in 2021/22 show similar levels of performance compared to 2020/21, Exhibit 7. In 2021/22, 57% of targets were missed. This compares to 53% of targets missed in 2020/21.

Exhibit 7
Key Performance Indicators



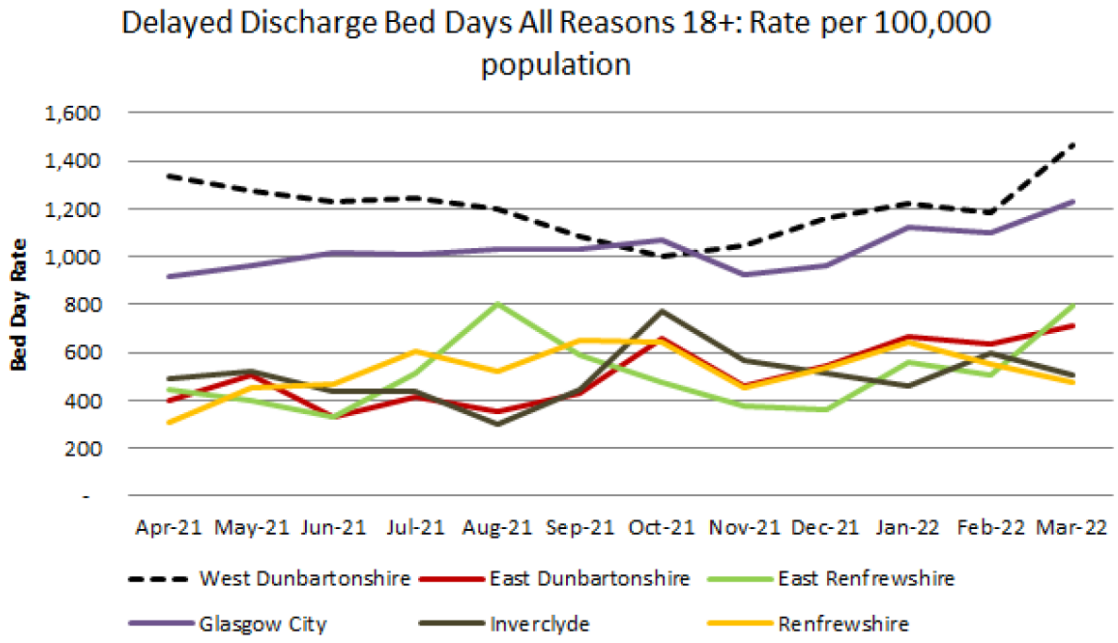
Source: West Dunbartonshire Integrated Joint Board Annual Performance Reports 2020/21 & 2021/22

84. The Covid-19 pandemic has had a substantial impact on performance measures, particularly for services which were temporarily suspended or required to operate at a reduced level. All services had to adapt quickly to new ways of working. It is therefore important to consider the IJB's performance in the context of the pandemic which has created significant pressures on services.

85. There are significant challenges in reducing delayed discharges. A delayed discharge is where a person has been deemed medically fit for discharge from hospital back home or to a care home, but a discharge is unable to take place. Delayed discharges are indicative of other pressures being experienced in the health and social care system, for example lack of services within the community or availability of appropriate care home placements. West Dunbartonshire IJB has the highest rate of adult delayed discharge in the NHS Greater Glasgow and Clyde health board area, Exhibit 8.

Exhibit 8

Delayed Discharge Bed Days All Reasons 18+: Rate per 100,000 population



Source: West Dunbartonshire Integration Joint Board Annual Performance Report 2021/22

86. The IJB has introduced targeted improvement actions with the aim of improving delayed discharge performance. Daily meetings are in place within the West Dunbartonshire discharge team and there is evidence of data being analysed to understand the reasons for delays and identify areas for improvement. These measures showed some signs of early progress in quarter two and three of 2021/22, but performance has since declined.

87. Further work is required by the IJB to ensure key performance targets are being met. The impact of the pandemic has been significant, with West Dunbartonshire having the highest death rate from Covid-19 in Scotland up until June 2022. It is recognised that the IJB is operating in a challenging environment with staffing pressures, increased demand for services, and the ongoing impact of the pandemic. It is essential that there is a clear focus on shaping services that support the IJB and its partner bodies in meeting the needs of the people of West Dunbartonshire.

National performance audit reports

88. Audit Scotland carries out a national performance audit programme on behalf of the Accounts Commission and the Auditor General for Scotland. During 2021/22 we published some reports which may be of direct interest to the IJB as outlined in Appendix 3.

89. During 2021/22 we noted that relevant national reports were considered by members. Findings and recommendations in national reports relevant to the IJB were included in papers of the Audit and Performance Committee. We welcome this positive response to the national reports.

Appendix 1. Action plan 2021/22

2021/22 recommendations

Issue/risk	Recommendation	Agreed management action/timing
1. Sustainability of services The medium to long-term financial plan projects significant budget gaps in future years. While the financial plan contains broad themes setting out how budget gaps will be addressed, transformation and service redesign plans require further development. **Risk:** Services are not financially sustainable in the future.	The joint board's financial plans forecast significant budget gaps in future years. The IJB should further develop financial and service redesign plans to ensure that services are financially sustainable in the future. Paragraph 48	In 2020/21 the IJB invested (through reserves) in the creation of 3 Service Improvement Leads. They have been supporting Heads of Service, including redesign plans for Care at Home (advanced), Learning Disability (just commenced) and Children & Families (being scoped). For the HSCP to progress redesign effectively improvement capacity needs substantiated. The IJB in approving the new Strategic Plan 2023-2026, will set clear priorities to address the demand for services that can be safely and effectively delivered within the financial resources available. **Responsible officer:** Operational Heads of Service. **Agreed Date:** Service redesigns will cover a 3-to-5-year period with key target dates incorporated.

Follow-up of prior year recommendations

Issue/risk	Recommendation	Agreed management action/timing
PY 1. Management Commentary The 2020/21 management commentary included a significant amount of detailed narrative. This can obscure the key messages for the reader. **Risk:** The accounts are not readily accessible to users.	Management should review the format and content of the 2021/22 management commentary to make it more accessible for readers of the accounts. Officers should consider the appropriate use of infographics and trend analysis	**Complete** Financial and performance reporting in the management commentary has been improved. Infographics have been introduced which has improved the accessibility of information. This action will be ongoing as reporting develops further, but it is appropriate to close this action point based on the progress made.
PY 2. Review of Standing Orders Standing orders are in place to regulate the procedures and business of the Joint Board. Current standing orders were reviewed in 2015. The review of the standing orders is currently dependent on when the revised Integration Scheme is approved by the Health Board and the Scottish Government. **Risk:** The current standing orders do not reflect the arrangements of the IJB.	The IJB should undertake a prompt review of the standing orders following the Health Board and Scottish Government approval of the revised Integration Scheme	**Outstanding** Revisions to the integration scheme are yet to be concluded. Final approval of the revised scheme of integration is expected by March 2023. **Revised management action:** A pan-GGC working group has concluded the review and revision of the February 2020 version of the schemes. These will now be consulted on across local authority areas and NHSGGC. It is anticipated that the revised schemes will be approved by the end of March 2023. A full review of standing orders will follow this approval. **Responsible Officer:** Head of Strategy and Transformation and Chief Financial Officer. **Revised Date:** June 2023

Issue/risk	Recommendation	Agreed management action/timing
PY 3 (2019/20). Revised financial plans to reflect Covid-19 Both the 2020/21 budget and the medium-term financial plan were developed prior to the Covid-19 pandemic. There remains a risk that the additional funding may not be sufficient to cover all the additional costs, and lost income, incurred by the IJB.	The Board should ensure that that 2020/21 budget and medium-term financial plan are revisited as there is more certainty around the short, medium and longer-term financial impact of Covid-19 on health and social care services. Contingency plans should also be developed to assist it in responding to any potential shortfall in Scottish Government funding for Covid-19 costs.	**Complete** A revised medium-long term financial plan was approved by the Board in March 2022. This reflects the impact of Covid-19 and the wider challenges faced by the IJB. We have recommended in 2021/22 that the joint board should further develop financial and service redesign plans
PY4 (2019/20). Use of outcome data to shape future plans As the IJB continues to gather more data on care pathways and outcomes, it is important to harness this information to drive further progress in shifting the balance of care. There is also the opportunity to share and exchange this data with other IJBs across Scotland to learn from experiences elsewhere.	When developing future plans, the IJB should ensure they consider all available data to inform where they can best direct resources to deliver the improved outcomes for residents.	**Partially complete** Detailed strategic needs assessments (SNA), which draw on a significant amount of data, have been prepared for adults and children's services. It will be important that the SNA findings are appropriately reflected in the ambitions of the new strategic plan. **Revised management action:** This action is well advanced. A recent internal audit of the performance management framework has been positive. Best practice events have been undertaken with the Strategic Planning Group (SPG) supported by Healthcare Improvement Scotland. The data captured by the SNAs has been analysed and considered by the SPG and used to draft the Strategic Plan 2023-2026. The IJB will consider this draft at the November board. This will be followed by a

Issue/risk	Recommendation	Agreed management action/timing
		period of engagement before final approval is sought in March 2023. **Responsible Officer:** Head of Strategy and Transformation **Revised date:** 31 March 2023
PY5 (2018/19). Savings Targets The IJB was expected to make savings of £1.216 million in 2018/19. An update on progress against these savings was presented to the August 2018 Board, showing a projected saving of £0.960 million for the year-end. However, no further individual updates were reported throughout the year or at year-end other than within the projected outturn position. There is a risk that the IJB is not achieving its 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.	**Complete** The Board received updates on progress against planned savings throughout 2021/22 as part of financial performance reports. The final savings position was reported to the June 2022 Board.
PY6 (2018/19). Best Value While there is evidence of elements of Best value being demonstrated by the IJB, there is no mechanism for formal review, and it is not being reported through the Annual Performance Report. **Risk:** Non-compliance with requirements outlining the content of the Annual Performance Report. Opportunities for continuous improvement are being missed.	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.	**Partially Complete** We have reported in prior years that improvements have been made to the Annual Performance Report to better demonstrate how the IJB is delivering Best Value. A mechanism for undertaking a formal, and regular, review of Best Value is not yet in place. **Revised management action:** The HSCP has drafted a Quality Improvement Framework based on the public sector

Issue/risk	Recommendation	Agreed management action/timing
		improvement framework. Once implemented this this will support a formal review of Best Value arrangements. **Responsible Officer:** Head of Strategy and Transformation **Revised date:** September 2023

Appendix 2: Audit dimension risks

The table below sets out the audit dimension risks that we identified in our 2021/22 annual audit plan together with a summary of the audit procedures we performed during the year to obtain assurances over these risks and the conclusions from the work completed.

Audit dimension risks

Description of risk	Audit response to risk	Results and conclusions
1. Planning for financial sustainability There remains uncertainty around financial sustainability as the wider impact of Covid-19 is not yet known. The IJB's medium-term financial plan was last updated prior to the onset of the Covid-19 pandemic in March 2020. Further updates were delayed as a result of its impact. **Risk:** Without a revised financial plan, the Joint Board may not effectively plan the financial sustainability of its service.	Monitor progress in developing a revised medium-term financial plan. Assess the revised financial plan and conclude whether this includes appropriate scenario planning to address identified budget gaps and service pressures. Consider budget monitoring reports, including progress in realising efficiency savings. Review of the Joint Board's year-end reserves position, including the earmarking of reserves.	**Results:** The IJB updated it's medium to long-term financial plan in March 2022. Under the worst-case scenario, a budget gap of £18.725 million would arise in 2026/27. The IJB has effective budget monitoring arrangements in place. Of £2.372 million of budgeted savings and service redesign efficiencies, £0.892 million was achieved as planned. The IJB reserves have increased in 2021/22 by £12.753 million to £34.560 million as at 31 March 2022. The significant increase is mostly attributable to £8.893 million Covid-19 related funding received from the Scottish Government late in the financial year. **Conclusion:** Further work is required to ensure the financial sustainability of services, refer Recommendation 1.

Description of risk	Audit response to risk	Results and conclusions
2. Service pressures The Covid-19 pandemic continues to place significant pressure on the health and social care services commissioned by all Joint Boards and delivered by their partners. Unprecedented demand reflects the significant backlog of service users and patients seeking health and social care services. As a result some key performance targets, for example in delayed discharges have not been met. **Risk:** Covid-19 pressures may exceed the Joint Board's commissioning ability and also each partner's ability to meet the levels of service user and patient demand in West Dunbartonshire.	Review progress against strategic objectives reported within the IJB's Annual Performance Report. Review quarterly performance reports to assess the extent the Board is meeting service performance targets. Monitor progress in development of operational delivery and improvement plans which reflect learning from the pandemic and the shift to the balance of care.	**Results:** Service pressures, and the impact on performance, has been detailed in paragraphs 82 to 87 of this report. **Conclusion:** Overall, key performance indicators show similar levels of performance when compared to 2020/21. The Covid-19 pandemic has had a substantial impact on performance measures.
3. Workforce sustainability An appropriately resourced and skilled workforce is fundamental to the Joint Board's ability to meet service demands. In common with other health and social care bodies, the Joint Board is facing significant workforce pressures. This is due to a combination of unfilled vacancies in both health and social care, but also high levels of staff absence due to the direct impact of Covid-19, or increasingly, wellbeing issues and individual health concerns that may have been	Monitor reports taken to the Joint Board and the Performance and Audit Sub-Committee in respect of workforce sustainability Review financial monitoring and performance reports to identify issues arising due to workforce sustainability	**Results:** Refer paragraph 58 and 59. **Conclusion:** There are significant workforce pressures within both partner organisations. The IJB's Strategic Risk Register reflects the significance of the workforce sustainability risk. Internal Audit is due to complete a review of workforce planning arrangements as part of its 2022/23 Internal Audit Plan.

Description of risk	Audit response to risk	Results and conclusions
exacerbated during the pandemic. **Risk:** The Joint Board is unable to sustain services due to significant workforce pressures.		
4. Governance arrangements It is essential that the Board provides effective scrutiny and oversight of the IJB's operations. We observed the most recent Board meeting. It was a very short meeting and, in our opinion, provided limited opportunities for members to discuss and scrutinise the agenda items. **Risk:** Meetings of the IJB do not provide adequate opportunity for members to scrutinise and challenge decisions.	We will continue to attend Board meeting to assess if effective governance is demonstrated.	**Results:** See paragraph 63 onwards. **Conclusion:** Governance arrangements are appropriate and operate effectively. Subsequent board meetings have provided members with greater opportunity to scrutinise and challenge decisions made at the Board.
5. Integration scheme It is a statutory requirement that the local authority and health board carry out a review of the integration scheme within five years of the establishment of the Joint Board. While a revised scheme was considered by the Joint Board in February 2020, this has not been subject to approval by the health board or Scottish Ministers. When approved, changes to the integration scheme will need to be reflected in the Joint Board's standing orders. **Risk:** The Integration Scheme and Standing Orders	Monitor progress in the approval and implementation of the revised integration scheme. Review updated standing orders and assess whether they accurately reflect the terms of the revised integration scheme.	**Results:** See paragraphs 74 to 75. **Conclusion:** Final approval of the revised scheme of integration is expected by March 2023.

Description of risk	Audit response to risk	Results and conclusions
do not reflect the current operation of the Joint Board.		

Appendix 3. Summary of 2021/22 national performance reports and briefing papers

May

Local government in Scotland Overview 2021

June

Covid 19: Personal protective equipment

July

Community justice: Sustainable alternatives to custody

September

Covid 19: Vaccination programme

January

Planning for skills

Social care briefing

February

NHS in Scotland 2021

March

Local government in Scotland: Financial Overview 20/21

Drug and alcohol: An update

Scotland's economy: Supporting businesses through the Covid 19 pandemic

West Dunbartonshire Integration Joint Board

Proposed 2021/22 Annual Audit Report

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

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

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

15 November 2022

Subject: West Dunbartonshire Health and Social Care Partnership (HSCP) Quarterly Performance Report 2022/23 Quarter Two

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 July 2022 to September 2022 (Appendix I) for the Committee's 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 2022/23 Quarter Two and performance against the Strategic Plan 2019 - 2023 by exception.

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

2.3 Note that Quarter One information previously unavailable to the Committee is also presented in this report.

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 Two data. This is reflective of a similar position in terms of previous reporting on Quarter One 2022/23. However, the indicators which were incomplete in Quarter One are presented in this report.

4.4 The HSCP have 45 performance indicators. Of the 28 reported on in Quarter One, 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.

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.

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Designation: Head of Strategy and Transformation

Date: 15 November 2022

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Appendices: West Dunbartonshire HSCP Performance Report 2022/23: Quarter Two July - September 2022

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership Performance Report 2022/23: Quarter 2 July - September 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. Targets for 2022/23 are currently under review.

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	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
1	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	Published late December	95%	Not yet available	Not yet available	93.9%	
2	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	Published late December	95%	Not yet available	Not yet available	98.3%	
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	69.6%	95%			70%	
5	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on non-offence (care and protection) ground	Not yet available	N/A		Not yet available	119	
6	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on offence grounds	Not yet available	N/A		Not yet available	34	
7	Number of delayed discharges over 3 days (72 hours) non-complex cases	Published November	0	Not yet available	Not yet available	15	
8	Number of bed days lost to delayed discharge 18+ All reasons	Not yet available	1,460	Not yet available	Not yet available	2,924	
9	Number of bed days lost to delayed discharge 18+ Complex Codes	Not yet available	N/A		Not yet available	1,506	
10	Number of acute bed days lost to delayed	2,676	1,104			2,195	

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
	discharges (inc Adults With Incapacity) Age 65 years & over						
11	Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	1,030	N/A			1,135	
12	Number of emergency admissions 18+	Not yet available	2,295	Not yet available	Not yet available	2,211	
13	Number of emergency admissions aged 65+	Not yet available	1,134	Not yet available	Not yet available	1,190	
14	Emergency admissions aged 65+ as a rate per 1,000 population	Not yet available	67	Not yet available	Not yet available	70.5	
15	Number of unscheduled bed days 18+	Not yet available	17,735	Not yet available	Not yet available	20,873	
16	Unplanned acute bed days (aged 65+)	Not yet available	12,156	Not yet available	Not yet available	15,137	
17	Unplanned acute bed days (aged 65+) as a rate per 1,000 population	Not yet available	726	Not yet available	Not yet available	897.4	
18	Number of Attendances at Accident and Emergency 18+	Not yet available	4,720	Not yet available	Not yet available	5,750	
19	Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	17.4%	24%			17.8%	
20	Number of clients receiving Home Care Pharmacy Team support	280	258			300	
21	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	30%	90%			26%	
22	Percentage of carers who feel supported to continue in their caring role when asked through their Adult Carer Support Plan	91.8%	95%			100%	
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 December	90%	Not yet available	Not yet available	96.1%	
24	Percentage of Adult Support and Protection clients who have current risk assessments and care plan/protection plan	67%	100%			71%	
25	Number of people receiving Telecare/Community Alarm service - All ages	1,912	2,200			1,888	
26	Number of patients with an eKIS record	20,205	N/A			20,357	

Access

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
27	Number of people receiving homecare - All ages	1,454	N/A			1,443	
28	Number of weekly hours of homecare - All ages	10,637	N/A			10,854	
29	Total number of homecare hours provided as a rate per 1,000 population aged 65+	526.5	570			538	

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
30	Percentage of people aged 65 and over who receive 20 or more interventions per week	41.9%	35%			40.9%	
31	Percentage of homecare clients aged 65+ receiving personal care	99.3%	95%			99%	
32	Number of people aged 75+ in receipt of Telecare - Crude rate per 100,000 population	18,426	20,945			18,145	
33	Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	30%	30%			37.5%	
34	Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	57.8%	32%			46.2%	
35	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	79.7%	98%			75.5%	
36	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	75.3%	80%			81.6%	
37	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	3.3%	80%			20.5%	

Resilience

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
38	Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	98.9%	90%			97.5%	
39	Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	8	18			10	
40	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	49.6%	90%			37.4%*	

*Amended from 59.8% - error in spreadsheet formula

Assets

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
41	Prescribing cost per weighted patient (Annualised)	Not yet available	GGC average	Not yet available	Not yet available	£167.00	
42	Compliance with Formulary Preferred List	Not yet available	78%	Not yet available	Not yet available	77.17%	

Inequalities

Ref	Performance Indicator	Q2 2022/23	Q1 2022/23	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	89.5%	90%			90%	
44	Percentage of looked after children being looked after in the community who are from BME communities	81.8%	N/A			76.5%	
45	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	100%	75%			100%	

Please find April to June 2022 data below for those indicators we were unable to report on in our Quarter 1 2022/23 Performance Report.

Early Intervention

Ref	Performance Indicator	Q1 2022/23				Q4 2021/22	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
1	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	93.9%	95%			94%	
2	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	98.3%	95%			95.7%	
12	Number of emergency admissions 18+	2,211	2,295			2,049	
13	Number of emergency admissions aged 65+	1,190	1,134			1,056	
14	Emergency admissions aged 65+ as a rate per 1,000 population	70.5	67			62.6	
15	Number of unscheduled bed days 18+	20,873	17,735			18,753	
16	Unplanned acute bed days (aged 65+)	15,137	12,156			13,555	
17	Unplanned acute bed days (aged 65+) as a rate per 1,000 population	897.4	726			803.6	
19	Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	17.8%	24%			25.1%	
23	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	96.1%	90%			88.1%	

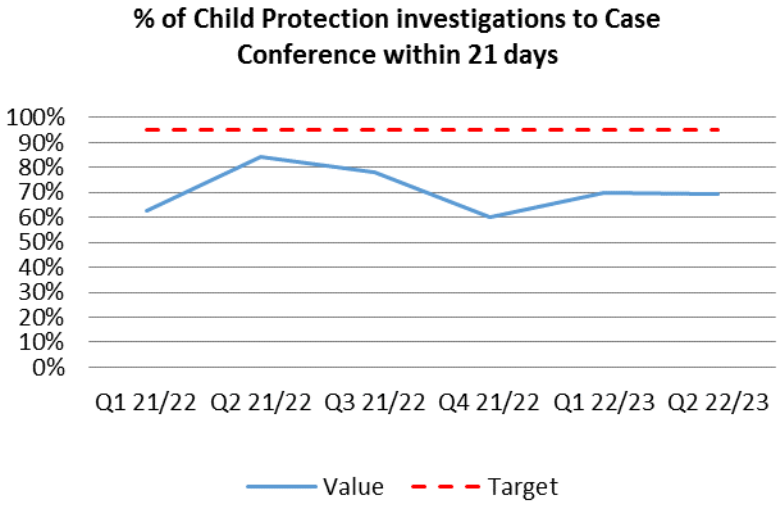
Resilience

Ref	Performance Indicator	Q1 2022/23				Q4 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	97.5%	90%			96%	

Performance Area: Child Protection

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
4	Percentage of child protection investigations to case conference within 21 days	69.6%	95%			70%	

Quarter	Value	Target
Q1 21/22	62.5%	95%
Q2 21/22	84.2%	95%
Q3 21/22	78.1%	95%
Q4 21/22	60.0%	95%
Q1 22/23	70.0%	95%
Q2 22/23	69.6%	95%



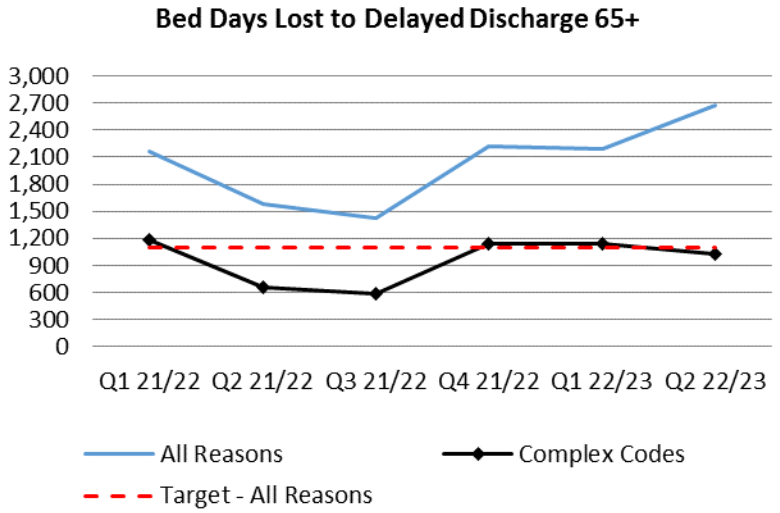
Key Points:
Of the 23 case conferences due to take place during July to September, 16 were carried out within the 21 day timescale. The 7 investigations outwith the timescale involved a small number of family groups.

Improvement Actions:
We are continuing to monitor timescales for a number of key stages in the Child Protection journey through 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.

Performance Area: Delayed Discharge

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
10	Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over	2,676	1,104			2,195	
11	Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	1,030	N/A			1,135	

Quarter	All Reasons	Complex Codes
Q1 21/22	2163	1180
Q2 21/22	1575	662
Q3 21/22	1429	584
Q4 21/22	2225	1138
Q1 22/23	2195	1135
Q2 22/23	2676	1030



Key Points:
Focused efforts to facilitate hospital discharges in a safe and timely way have continued however delays have remained high throughout the quarter peaking at 45 at the end of September. There were 94 new delays in the quarter: an increase of 32 (52%) on the previous quarter. While the numbers of delayed discharges were high, the majority are shorter delays.

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.

Daily 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.

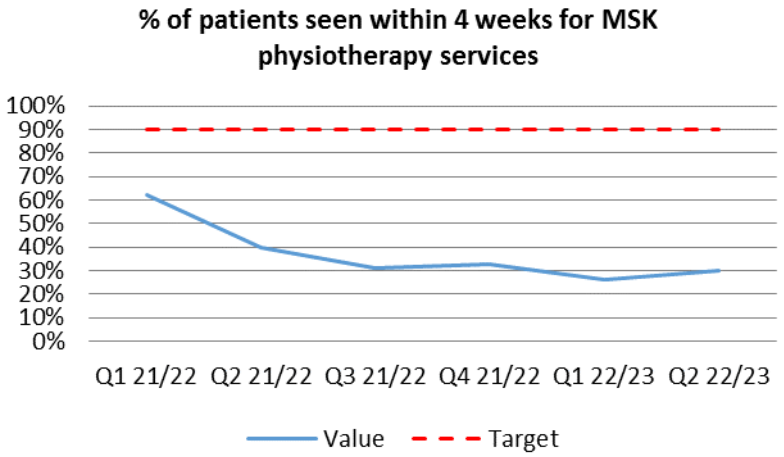
Local data is continually monitored and analysed to identify areas for improvement.

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 Physiotherapy

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
21	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	30%	90%			26%	

Quarter	Value	Target
Q1 21/22	62%	90%
Q2 21/22	40%	90%
Q3 21/22	31%	90%
Q4 21/22	33%	90%
Q1 22/23	26%	90%
Q2 22/23	30%	90%



Key Points:
All patients categorised as urgent continue to be seen within 4 weeks.

Improvement Actions
Due to a focused project to try and address recruitment challenges, general capacity has increased across the service during July to September. As a consequence both new and return appointments saw an increase of 29% on the previous quarter.

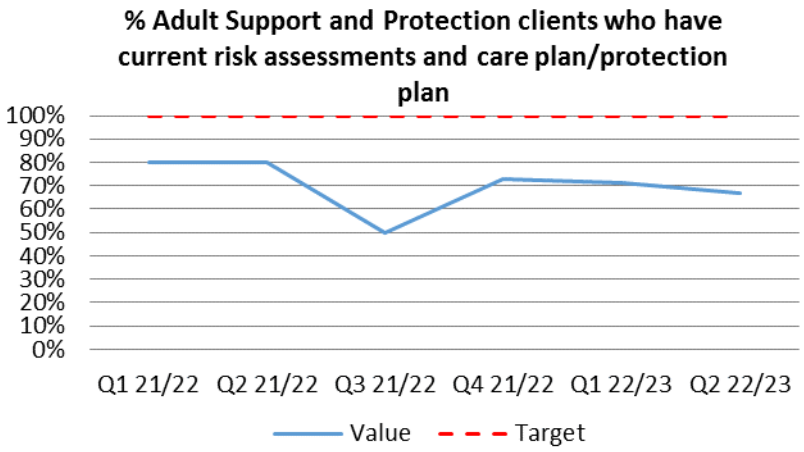
Priority project work is also being done within the service to try and address routine waiting times and the number of patients waiting for a routine appointment.

Performance Area: Adult Support and Protection

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
24	Percentage of Adult Support and Protection clients who have current risk assessments and care plan/protection plan	67%	100%			71%	

Quarter	Value	Target

Q1 21/22	80%	100%
Q2 21/22	80%	100%
Q3 21/22	50%	100%
Q4 21/22	73%	100%
Q1 22/23	71%	100%
Q2 22/23	67%	100%



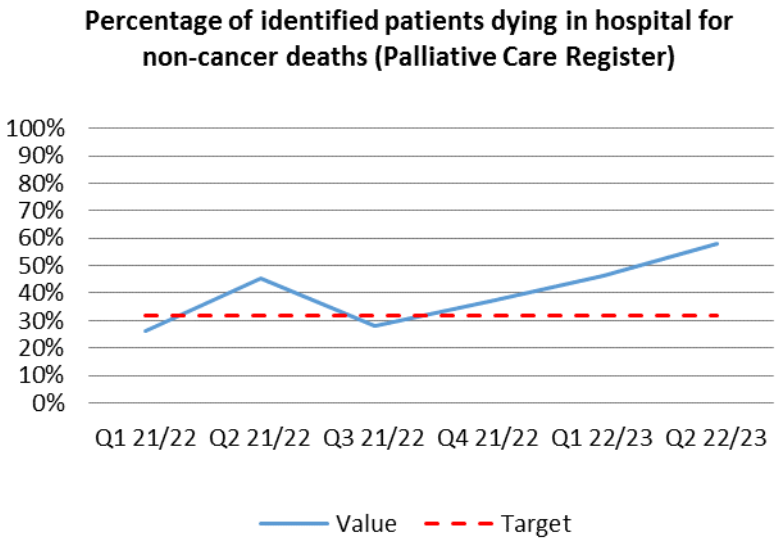
Key Points:
There were a very small number of Adult Support and Protection clients in the period July to September. These small numbers mean percentages will fluctuate more significantly.

Improvement Actions:
Increased levels of scrutiny continue and processes are being put in place to highlight any gaps to workers involved.

Performance Area: Palliative Care Deaths in Hospital

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
34	Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	57.8%	32%			46.2%	

Quarter	Value	Target
Q1 21/22	26.0%	32%
Q2 21/22	45.5%	32%
Q3 21/22	28.1%	32%
Q4 21/22	36.8%	32%
Q1 22/23	46.2%	32%
Q2 22/23	57.8%	32%



Key Points:
The District Nursing service strive to ensure people die in their chosen place of care, and most of our patients choose to die at home. However, due to the range of potential and unexpected complexities of non-cancer deaths, it is inevitable that sometimes hospital is the safest place to manage a person's care.

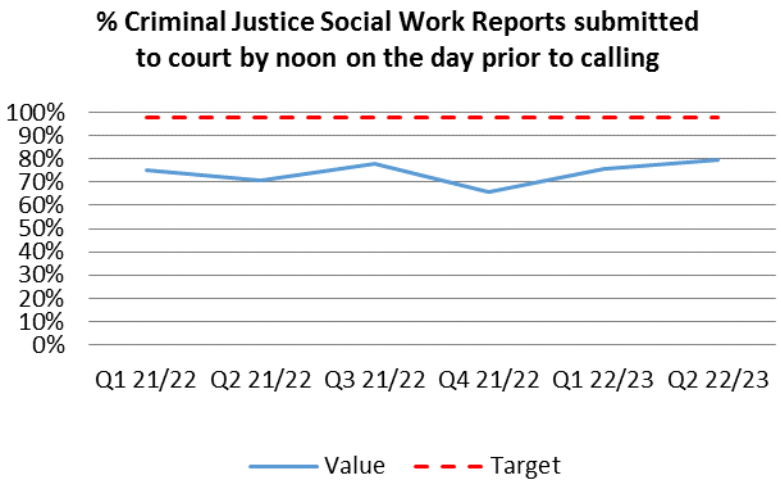
Another contributing factor in this complex category is the need to also care for carers, and occasionally admissions can happen due to the sense they may have of being overwhelmed by their role at such an emotional time, particularly if the symptoms their loved one is experiencing are significant.

Improvement Actions:
We will continue to strive to ensure people die in their chosen place of care and we will continue to monitor how effectively we have been able to do this while acknowledging the complexities above.

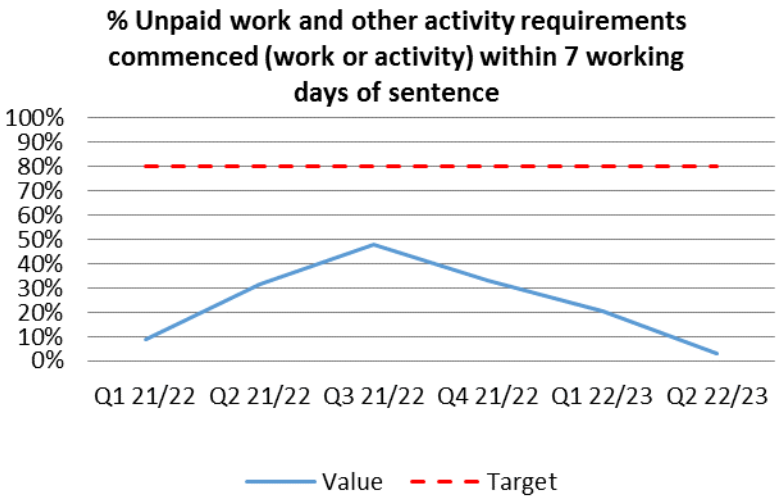
Performance Area: Criminal Justice

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
35	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	79.7%	98%			75.5%	
37	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	3.3%	80%			20.5%	

Quarter	Value	Target
Q1 21/22	75.0%	98%
Q2 21/22	70.5%	98%
Q3 21/22	78.0%	98%
Q4 21/22	65.9%	98%
Q1 22/23	75.5%	98%
Q2 22/23	79.7%	98%



Quarter	Value	Target
Q1 21/22	9.0%	80%
Q2 21/22	31.3%	80%
Q3 21/22	47.6%	80%
Q4 21/22	32.9%	80%
Q1 22/23	20.5%	80%
Q2 22/23	3.3%	80%



Key Points:
Long term sickness is impacting on the ability to start Unpaid Work Orders within 7 working days. Delays in recruitment have compromised existing staff supporting the induction of unpaid work. The decrease in commencing orders has also been created by lack of availability of squad placements with high demand for weekends where there is a waiting list.

Improvement Actions:
With additional government funding received, we are now recruiting staff to enable us to tackle the backlog of orders created by the pandemic and ensuing restrictions placed on the service.

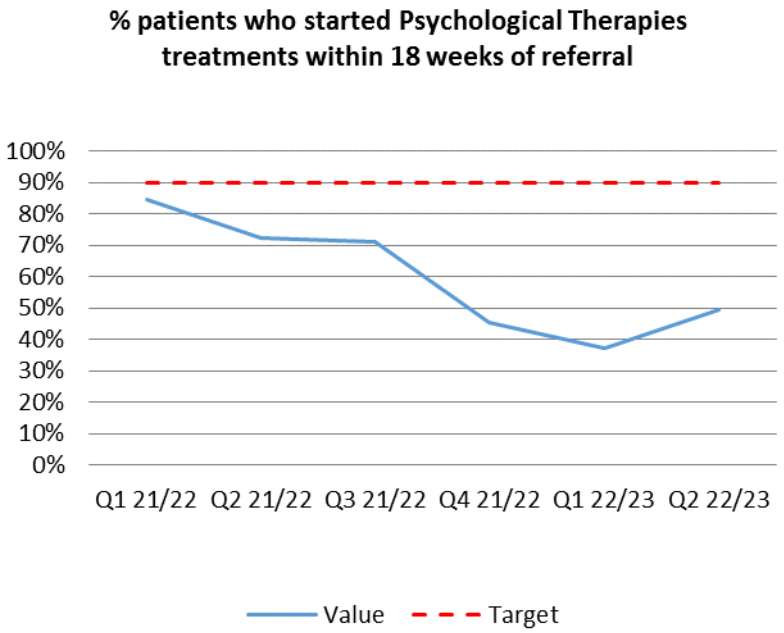
We continue to have commissioned third sector colleagues providing virtual workshops and addressing digital poverty to enable service users to complete their unpaid work hours within timescales.

Performance Area: Psychological Therapies

Ref	Performance Indicator	Q2 2022/23				Q1 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
40	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	49.6%	90%			37.4%*	

*Amended from 59.8% - error in spreadsheet formula

Quarter	Value	Target
Q1 21/22	84.8%	90%
Q2 21/22	72.4%	90%
Q3 21/22	71.3%	90%
Q4 21/22	45.6%	90%
Q1 22/23	37.4%	90%
Q2 22/23	49.6%	90%



Key Points:
127 people started Psychological Therapies treatments between July and September: 63 waited less than 18 weeks from the point of referral.

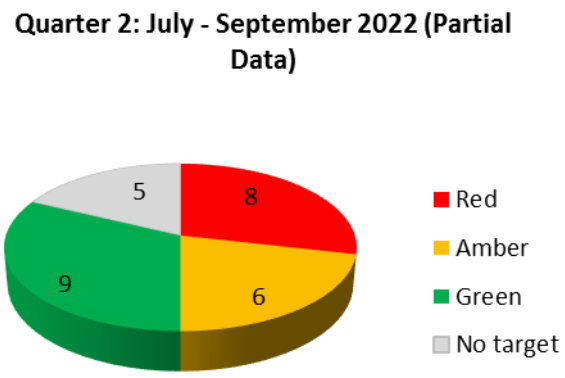
There are a number of vacancies across the teams which is impacting on caseload capacities.

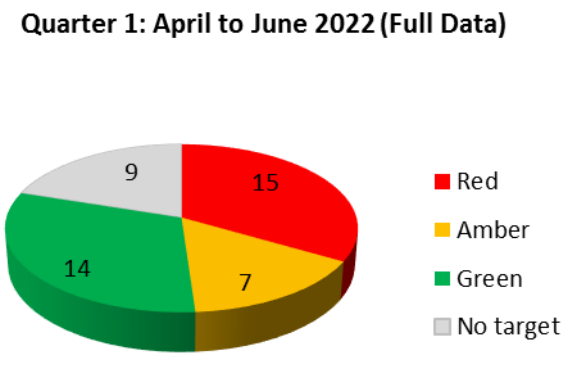
Improvement Actions:
Staff vacancies are being processed as quickly as possible to minimise the impact on waiting times.

Those people waiting longest are being offered appointments across the area as appropriate.

The Community Mental Health Teams are maximising usage of NHS Greater Glasgow and Clyde's Psychological Therapy Group Service as appropriate.

Summary of Strategic Plan Key Performance Indicators





West Dunbartonshire Health and Social Care Partnership
Complaints Reporting: Quarter 2 July - September 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 identifying good practice and areas for improvement on a local and national basis.

During July to September 2022 the following learning points or actions were identified through the investigation of complaints received by the HSCP.

Service Area	Lessons Learned/Actions Taken
MSK Physiotherapy	• Change to orthopaedic plan to be highlighted to physiotherapy directly rather than patient advised to rearrange appointment with provided time frame. • If a member or staff is met with aggressive behaviour to remove themselves from the situation but stating clearly to the patients that this is being done and that someone else will come to speak to them. Alternatively patient asked to leave the department. • Member of staff feeling intimidated to remove themselves to a private area not open reception.
District Nursing	Learning Event took place with all team members involved to review case and investigate what when wrong and future steps to be taken to reduce future occurrence. Future steps: • Agreement that in the absence of a Band 6, caseload to be reassigned in full to another Band 6 staff member. • Staff to ensure care plans updated at time of any changes being identified. • Staff to take ownership of changes and not to pass on or have expectation other team members will follow up. • Staff to raise any concerns regards workload to a Band 6, Team Lead or Senior Nurse.

SPSO Indicator	Measure	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23
2	Number of Stage 1 complaints (whether escalated to Stage 2 or not)	16	21	13	16	13	23
	Number of complaints direct to Stage 2	8	7	6	10	7	11
	Total number of complaints	24	28	19	26	20	34
3	% closed within timescale - Stage 1	Not yet available*					
	% closed within timescale - direct to Stage 2	25%	29%	33%	20%	43%	36%
	% closed within timescale - escalated to Stage 2	100%	N/A	N/A	N/A	N/A	N/A
4	Average response time - Stage 1	Not yet available*					
	Average response time - direct to Stage 2	25	23	23	24	29	22
	Average response time - escalated to Stage 2	18	N/A	N/A	N/A	N/A	N/A

*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 2 2022/23

	Model Complaints Handling Procedure		
Outcome	NHSGGC	WDC*	% of total
Fully Upheld	2	0	22%
Partially Upheld	2	0	22%
Not Upheld	4	1	56%
Unsubstantiated	0	0	0%
Total	8	1	9

*2 complaints are still ongoing

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP AUDIT AND PERFORMANCE COMMITTEE

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

15 November 2022

Subject: Strategic Risk Register Six Month Review

1. Purpose

1.1 The purpose of this report is to present the updated Strategic Risk Register to the West Dunbartonshire Health and Social Care Partnership Audit and Performance Committee.

2. Recommendations

2.1 It is recommended that the HSCP Committee:

2.1.1 Consider the recommendation of the Senior Management Team that the Financial Sustainability risk should be increased from 12 (Issue) to 16 (Unacceptable); and

2.1.2 Agree recommendations in respect of the updated Strategic Risk Register (Appendix A) for consideration of the HSCP Board on the 15 November 2022.

3. Background

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) states that an Integration Joint Board (IJB) must have effective governance arrangements in place, which includes systems for managing strategic risks.

3.2 The Integration Scheme confirms that a key element of the required risk management process is the preparation, scrutiny, approval and then annual review of the strategic risk register for the Health and Social Care Partnership.

3.3 The Chief Officer is responsible for ensuring that suitable and effective arrangements are in place to manage both strategic and operational risks relating to the Health and Social Care Partnership.

3.4 The HSCP Board's Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group which confirms the responsibility of the Chief Officer to develop a West Dunbartonshire Health and Social are Partnership Risk Management policy and strategy. The current Risk Management Policy and Strategy was approved by the HSCP Board on the 20 September 2021.

4. Main Issues

4.1 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that beneficial and defensible decisions are made.

4.2 The attached Strategic Risk Register (Appendix A) has been prepared in accordance with the Risk Management Policy and Strategy, approved by the HSCP Board on the 20 September 2021. Similarly, in accordance with that Policy and Strategy, standard procedures are applied across all areas of activity within the Health and Social Care Partnership in order to achieve consistent and effective implementation of good risk management.

4.3 Strategic risks represent the potential for the HSCP Board to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk. These are distinct from operational risks, which represent the potential for impact (opportunity or threat) within or arising from the activities of an individual service area or team operating within the scope of the Health and Social Care Partnership's activities.

4.4 The Chief Officer has responsibility for managing operational risks as those are more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Operational risk registers are maintained by Heads of Service on behalf of the Chief Officer; and are the "building blocks" for the Strategic Risk Register.

4.5 Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the HSCP Board. The HSCP Senior Management Team (SMT) reviewed all operational risk registers on 12 October 2022 and agreed that in respect of the risk pertaining to Financial Sustainability/Resource Allocation and Savings Targets, this be escalated to Unacceptable.

4.6 It was the view of SMT that despite a range of agreed mitigating actions, the post-mitigation assessment for the Financial Sustainability risk should be increased from 12 (Issue) to 16 (Unacceptable). This reflects the ongoing uncertainty over the final cost of health and social care pay awards coupled with no guaranteed additional funding and the proposed additional transfer of costs to the HSCP from WDC for children and young people's residential placements. The publication of the Scottish's Government's Emergency Budget Review on the 2 November 2022 highlights the financial pressure of current and future public sector pay deals against a climate of a real term

reduction in UK Government funding and predicts a period of financial austerity.

5. Options Appraisal

5.1 Not required for this report.

6. People Implications

6.1 Key people implications associated with the identified strategic risks are addressed within the mitigating actions of the Strategic Risk Register.

6.2 The Risk Management Policy and supporting strategy affirms that risk management needs to be integrated into daily activities, with everyone involved in identifying current and potential risks where they work.

6.3 Individuals have a responsibility to make every effort to be aware of situations, which place them, or others at risk, report identified hazards and implement safe working practices developed within their service areas

7. Financial and Procurement Implications

7.1 Key financial implications associated with the identified strategic risks are addressed within the mitigating actions of the Strategic Risk Register.

7.2 The Risk Management Policy and supporting strategy affirms that financial decisions in respect of these risk management arrangements rest with the Chief Financial Officer.

8. Risk Analysis

8.1 Failure to comply with the legislative requirement in respect of risk management would place the HSCP Board in breach of its statutory duties.

8.2 The Chief Officer and Senior Management Team reviewed the Operational Risk Registers and the Strategic Risk Register on the 12 October 2022.

9. Equalities Impact Assessment (EIA)

9.1 An equality impact assessment is not required as the HSCP Board as the recommendations within this report will not have a differential impact on any of the 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.

11.2 Relevant Monitoring Officers, including internal auditors, 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. Direction

13.1 A direction is not required for this report, as it is an update on the Strategic Risk Register.

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Designation: Head of Strategy and Transformation
Date: 3 November 2022

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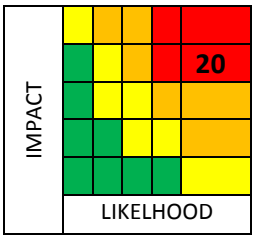
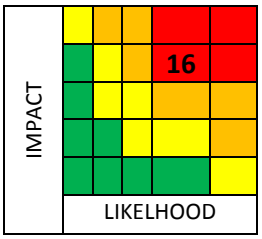
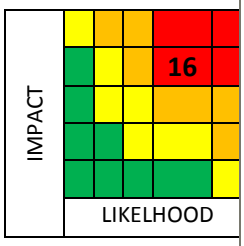
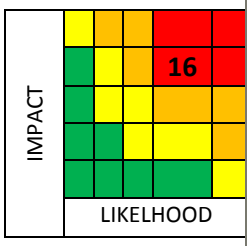
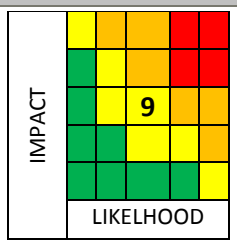
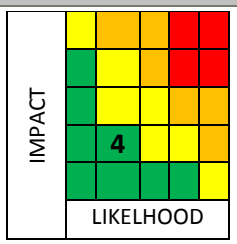
Appendices: Strategic Risk Register (Appendix A)

West Dunbartonshire Health and Social Care Partnership Strategic Risk Register 2022 – 2023

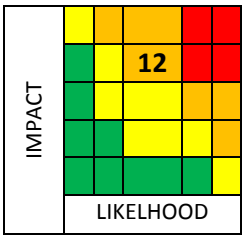
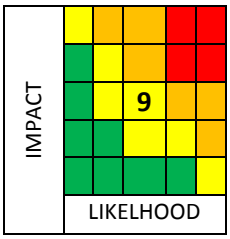
Financial Sustainability/Resource Allocation and Savings Targets	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Miti Risk**
Failure to deliver HSCP Board priorities within approved budget incorporating allocated savings targets. Failure to operate within financial parameters in context of continuing and new demand; there is a risk of not being able to (safely) deliver on the Strategic Plan priorities, impact on quality or reduction of service; failure to meet statutory requirements; and potential impact on staff resilience. Failure to deliver efficiency savings targets, as approved by HSCP Board, including as a consequence of savings programmes implemented by other service/divisions of WDC or NHSGGC.	Beth Culshaw; Julie Slavin		Almost Certain - Major **Unacceptable**		Probably Moderate **Unaccep**
Mitigating Actions					
A process of managing and reviewing budget by the Senior Management Team (SMT) is in place including: application of earmarked reserves; analysis of monthly monitoring reports; securing recurring efficiencies; vacancy management; turnover targets and overtim restrictions.					
Financial position monitored through regular reporting to Health and Social Care Partnership (HSCP) Board and HSCP Audit and Performance Committee as set out in the Financial Regulations, Terms of Reference and the Integration Scheme. Including the prep of the Annual Accounts in line with all statutory requirements and the implementation of any recommended actions identified by exter auditors.					
A recovery plan will be implemented to address areas of significant in-year overspend across all service areas. HSCP SMT and all bu managers/commissioners of services work closely with WDC and NHSGGC procurement teams on the priorities identified within the procurement pipeline, to ensure that externally purchased services are delivering Best Value.					
Active engagement with Partner Bodies in budget planning process: Scottish Government, WDC and NHSGGC including identifying dependencies and risks on any organisational savings programme and ensure that, where appropriate, HSCP budget managers imp initiatives e.g. FIP (Financial Improvement Programme).					
To continue to engage with forums/groups to identify proposals and consolidate approved policies including: eligibility criteria; asses charging and financial savings and/or service redesign that may have a negative impact on HSCP services and/or budgets.					
As required by the Ministerial Steering Group, continue to work with Scottish Government, West Dunbartonshire Council, NHS Great Glasgow and Clyde & Greater Glasgow and Clyde Board-wide Integrated Joint Boards to bring forward notification and approval of b allocation before the start of the financial year to allow for early identification of actual funding gap to be filled by efficiency savings, s transformation or withdrawal of service.					

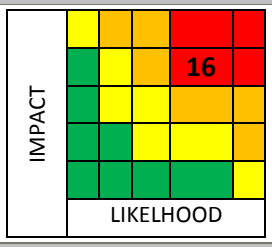
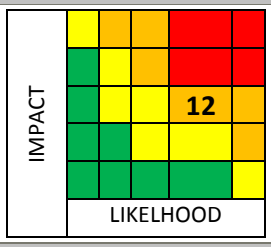
A continued commitment to due diligence in all roles; communication and consideration within and between all areas of service; cons and communication with the public; staff groups and representatives; Health and Social Care Partnership Board members including E Members.
The delivery of a medium to long term budget strategy for the HSCP, refreshed on an annual basis, to reflect the impact of new budg settlements on the delivery of strategic priorities and agreed service improvement programmes.
A mechanism has been agreed for calculation of set aside budgets this must now be aligned with the draft unscheduled care commis plan.

Procurement and Commissioning	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
Failure to deliver contract monitoring and management of commissioned services; creates a risk to the financial management of the HSCP and there is a risk to delivery of high quality services and the delivery of quality assurance across all areas of service delivery Failure to manage contracting arrangements; there is a risk that the HSCP has commissioned services which may be out-with contract or contracts are not fit for purpose. Failure to manage contracting arrangements; there is a risk that the HSCP is unable to demonstrate Best Value. Failure to adhere to Financial Regulations and Standing Financial Instructions when commissioning services from external providers.	Margaret-Jane Cardno		Probably - Major **Unacceptable**		Probably – Major **Unacceptable**
Mitigating Actions					
Regular Care Inspectorate reports on independent and third sector providers are presented to the HSCP Audit and Performance Committee and HSCP Clinical and Care governance Forum.					
Regular Complaints reports are presented to the HSCP Audit and Performance Committee, following scrutiny at SMT and HSCP Clinical and Care Governance Forum. Quarterly performance reports have been enhanced to include complaint data and these reports are more effectively aligned with the HSCP strategic planning periorities.					
Continued commitment by Heads of Service and Integrated Operations Managers to work with procurement partners to progress the Procurement pipeline work, linking procurement and commissioning of internal and external services. Regular procurement reports will be presented to the HSCP Board jointly by Chief Finance Officer after presentation at WDC Tendering Committee.					
Continued commitment by Heads of Service and Integrated Operations Managers to ensure robust contract monitoring, service review and management as part of the procurement pipeline work linked to the development and review of service led service specifications, reporting mechanisms and the agreed terms and conditions of all contracts.					
The HSCP is in the process of recruiting additional capacity in to this service with a view to further improving commissioning, quality and contract management processes. The service will re-advertise the post of Commissioning Manager in February 2022.					
All budget managers and commissioners of services to attend procurement training and have procurement progress as standing item on HOS team meetings.					
7.6% improvement in compliance in the first half of financial year 2020/21. Improvement from 80.2% in 19/20 – 87.8% in 20/21.					
A growth bid has been developed for the IJB to be considered as part of the March 2022 budget setting process. If successful this would enable the appointment of a WTE Commissioning Officer.					

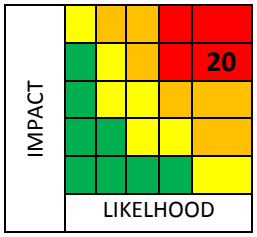
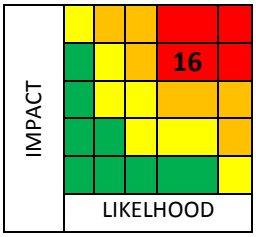
Performance Management Information	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
Failure to review and scrutinise performance management information; creates a risk of the HSCP being unable to manage demand analysis, service planning and budget management across totality of the organisational responsibilities.	Margaret-Jane Cardno		Possible - Moderate **Adequate**		Unlikely - Minor **Acceptable**
Mitigating Actions					

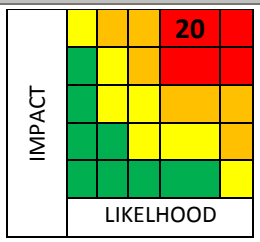
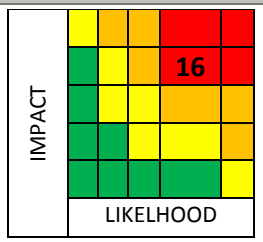
Regular performance reports are presented to the HSCP Chief Officer and Heads of Services for their specific areas of responsibility; this ensures data and information can be considered in terms of legislative developments, financial reporting/governance and the need to prioritise use of resources effectively and anticipate demand.
Improved performance management reporting presentation, including detailed analyses of those performance indicators that are red and underperforming. Focused scrutiny and challenge
Regular Organisational Performance Review meetings are held with Chief Executives of WDC and NHSGGC.
Development of robust management information available at service level for frontline staff for ongoing demand management, quality control and assurance and to support transformational change.
The Commissioning Plan will support the links between finance and planning to meet demand and service delivery within the current financial envelope.
Regular performance reports are presented to the HSCP Board by Chief Officer and Heads of Services; providing members of the Board with a range of data and performance information collated from across health and social care systems; this supports governance and accountability; as outlined within the requirements of the Act.
Additional performance reports have been introduced to support the recovery and renewal process.
Quarterly and Annual Performance reporting has been more closely aligned with HSCP Performance and Audit and HSCP Board meeting schedules to improve the timeous updates on performance across the Partnership, strengthening scrutiny and challenge by members.
NHSGGC has established a monthly performance board in order to further scrutinise high risk areas in relation to waiting time directives.

Information and Communication	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
Failure to maintain a secure information management network; there is a risk for the HSCP that the confidentiality of information is not protected from unauthorised disclosures or losses. Failure to maintain a secure information management network; there is a risk for the HSCP if this is unmanaged of breaches as a result of a GDPR breach; power/system failure; cyber-attack; lack of shared IT/recording platforms; as such being unable to manage and deliver services. Inability to provide service.	Margaret-Jane Cardno		Possible - Major **Issue**		Possible - Moderate **Adequate**
Mitigating Action					
Continued commitment to information management by the Chief Officer and Heads of Service; Integrated Operational Managers and their direct reports must demonstrate adherence to both NHS and Council policies for ICT and data management and procedures; regular learning session on breaches if they occur by individual service areas.					
Confirmation of the appointment of Data Protection Officer for the HSCP Board to support governance arrangements.					
Continued training available for staff groups from both NHS and Council to reflect changes in Data Protection Legislation in May 2018; staff must demonstrate their attendance at Data Protection awareness sessions. Staff are supported to safeguard the data and information which is collected and stored in the course of delivering services and support; there are continued reminders of the need safeguard and manage information.					
Continued training available for staff groups from both NHS and Council with online courses available which staff must demonstrate they have completed via the Council's iLearn or NHS Learn-Pro courses. Staff within the HSCP will complete the course of their employing authority on either an annual (Council) or bi-annually (NHS) basis.					
Autocomplete email address option has been disabled for West Dunbartonshire Council staff, this is an additional safeguard introduced to mitigate data breaches.					
Records Management Plan in place and lodged with National Records of Scotland.					
In order to enhance capacity recruitment of a Systems, Digital and Information Governance Manager is underway.					

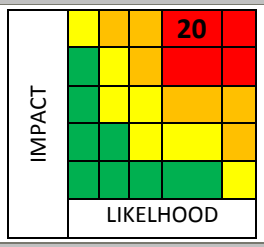
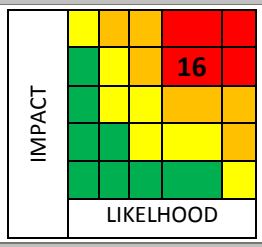
Outcomes of external scrutiny: Inspection recommendations	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
Failure to deliver on recommendations within reports by Care Inspectorate and other relevant scrutiny bodies.	Chief Social Work Officer		Probably - Major **Unacceptable**		Probably - Moderate **Issue**
Mitigating Action					

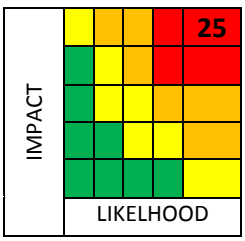
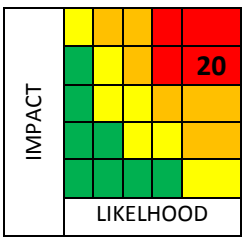
Improvement action plans for Self Directed Support and Community Payback Orders are being implemented, reflecting findings and recommendations from inspections including specific actions linked to improvement.
Steps have been taken to recruit an SDS Lead in order to embed SDS activity across the HSCP (closing date 27/02/22).
The My Life Assessment tool has been fully implemented and is subject to ongoing evaluation.
Review groups for SDS and CPO improvement activity monitor achievement of objectives and service improvements.
Regular performance and monitoring reports are presented to the HSCP Board/Audit and Performance Committee/Clinical and Care Governance Group as appropriate to support governance and continued scrutiny.
Staff development and training reflects learning from each inspection report to ensure consistent understanding of duties around delivery of SDS and CPOs.
Additional external scrutiny has been introduced in response to Covid 19 – reporting to HSCP board and ongoing monitoring through the internal quality assurance team and external bodies.
The HSCP Board has agreed additional investment from reserves to support operational managers to deliver on improvement action plans.
ADDITION 14/03/22: Steps have been taken to build capacity within the wider public protection team, this includes the use of reserves to enhance audit and performance capacity which will be linked to a wider learning and development post. The HSCP is adopting an enhanced approach to quality assurance (including audit) this will be reported directly to the clinical and care governance group on a regular basis.

Delayed Discharge and Unscheduled Care	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
Failure to support timely discharge and minimise delayed discharge; creates risk for the HSCP to effectively manage patient, client and carer care. Failure to plan and adopt a balanced approach to manage the unscheduled care pressures and related business continuity challenges that are faced in winter; creates risk for the HSCP to effectively manage patient, client and carer care.	Jo Gibson		Almost Certain - Major **Unacceptable**		Probably - Major **Unacceptable**
Mitigating Action					
A Management Action Plan has been developed to review activity and manage specific actions linked to improvement of planning for delayed discharge.					
A weekly performance report is provided to the Integrated Operations Managers and Senior Management Team; this includes updates on the early assessment model of care and support; effective use of the NHS acute Dashboard; delivery of rehabilitation in-reach within ward settings; provision and usage of Red bags; promotion of Power of Attorney arrangements; commissioning of services linked to free personal care for those under 65 years old and Adult with Incapacity requirements and; delivery of an integrated approach to mental health services.					
An NHS GGC Corporate Vaccination Plan is in place supported by a local vaccination group alongside the local Flu Management and Covid Vaccination Plan; this reflects the HSCP unscheduled care plan for community services which addresses the critical areas outlined in the national Preparing for Winter Guidance.					
A Primary Care Improvement Plan has been developed to review activity and manage specific actions linked to improvement of planning for GP contracting arrangements; this supports effective multi-disciplinary team working within primary care and as part of management of delayed discharge.					
An Improvement Plan to deliver actions linked to Action 15 mental health monies has been developed to review activity and manage specific actions linked to improvement of planning for localised mental health arrangements; this supports effective multi-disciplinary team working within primary care and as part of management of delayed discharge.					
Formal and regular formal scrutiny by SMT and reported to joint NHS and HSCP scrutiny and planning groups linked to UC and winter planning.					
NHSGGC has established a monthly performance board in order to further scrutinise high risk areas in relation to waiting time directives.					

Workforce Sustainability	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
Failure to have an appropriately resourced workforce to meet service demands, caused by the inability to recruit, retain or deploy the workforce with necessary skills, which could potentially lead to disruption of services .	Audrey Slater		Probably- Catastrophic **Unacceptable**		Probably - Major **Unacceptable**
Mitigating Action					

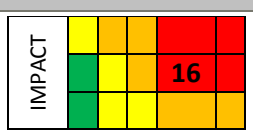
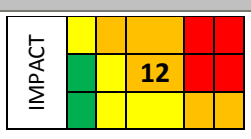
Continued commitment to the implementation of HSCP Workforce and Organisational Development Strategy and Support Plan.
Robust Operational Management Structures in place and Business Continuity Plans to support service delivery.
HR policies which reflect best practice and relevant employment legislation to support manager and staff development needs.
Attendance Management Polices and Staff Health and Well Being Strategies in place. Initiatives accessible to all staff such as Healthy Working Lives, Occupational Health Services and Counselling Services.
Staff Engagement and feedback through I Matter Survey and action planning.
Agreed processes for revalidation of medical and nursing workforce and Professional Registration. Policies and procedures in place to ensure staff are meeting professional bodies and organisational requirements for registration.
Sickness absence reporting available to service managers through HR21, Micro strategy, SSTS and Workforce Information Departments.
The production and scrutiny of agency and overtime reports.
Measures in place to provide additional emotional and psychological support to help HSCP staff through stressful times. This includes the information and resources which can be accessed via the National Wellbeing Hub.
HR reports provided to SMT and Joint Staff Forum on HR metrics.
Workforce reporting integrated into HSCP Performance reports.
Production and scrutiny of statutory and mandatory Training reports.
Production, implementation and monitoring of I Matter action plans and scrutiny of associated reports.
KSF/ PDP and Be the Best Conversations.

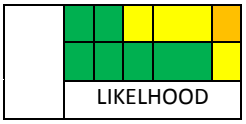
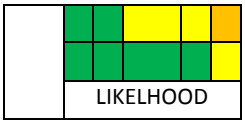
Waiting Times	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
Failure to meet waiting times targets e.g. MSK Physiotherapy, Psychological Therapies, Child and Adolescent Mental Health Services and Drug and Alcohol Treatment.	Beth Culshaw		Probably - Catastrophic **Unacceptable**		Probably - Major **Unacceptable**
Mitigating Action					
Regular performance reports are presented to the HSCP Chief Officer and Heads of Services for their specific areas of responsibility; to review activity and manage specific actions linked to improvement of planning for localised arrangements.					
Promotion of self-management and co-productive community services including access to online supports and advice					
Implementation of effective triage processes in place for patients across all areas.					
Regular performance data collection and monitoring is scrutinised to ensure effective and robust performance management and demand management.					
Consistent workforce and attendance management across all service areas.					
The HSCP Board has approved dedicated earmarked reserves to support activity in relation to waiting times initiatives.					

Risk of future Pandemic – Covid 19 variations	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
New 20/21 Risks across services from a future pandemic include difficulty in resourcing medications, medical devices (instruments and equipment in Hospital) and clinical consumables including PPE, disposable and short life goods. There will be an impact on patients and service users and on recruitment to and workforce. Financial Impact – rapid response, prescribing costs, commissioning and procurement impact. Human diseases can take a variety of forms and consequently their impacts can vary	Beth Culshaw		Almost Certain - Catastrophic **Unacceptable**		Almost Certain - Major **Unacceptable**

considerably both in scale and nature. The main types of human disease that represent new or additional risks to the UK are outlined below. The examples have been chosen to give an impression of the range of possible diseases that would have a significant disruptive effect, but are by no means exhaustive. Pandemic - Influenza pandemics are natural phenomena that have occurred from time to time for centuries. Including Covid 19, this has happen four times in the last century. The symptoms are similar to those of seasonal influenza but may be significantly more severe. Influenza pandemics arise as a result of a new influenza virus that is markedly different from recently circulating influenza viruses and therefore to which few people, if any, have immunity. As a result of rapid spread from person to person, pandemics have significant global human health consequences. In addition to the severe health effects, a pandemic is also likely to cause significant wider social and economic damage and disruption.					

Mitigating Action
Develop, implement and monitor recovery plans for each service – reported to HSCP Board on a regular basis throughout pandemic.
Develop and monitor pandemic risk framework based on reflection, experience and learning from Covid 19.
Pandemic objectives that focus on service continuity - workforce health, workforce effectiveness, essential service delivery continuity, citizen/community engagement, financial continuity, partner continuity (both commissioned and third sector), security – physical and digital, reputational monitoring community, workgroups and stakeholder (are the framework elements effective).
Agile response to monitor continuity of operations and relationships including decision logs and resilience plans.
Normal life is likely to face wider social and economic disruption, significant threats to the continuity of essential services, lower production levels, shortages and distribution difficulties. The strategic planning group will aim to capture and respond to this data.
Individual organisations may suffer from the pandemic's impact on staff absenteeism therefore reducing the services available.
The post- pandemic years provide a very important opportunity to develop and strengthen preparations for the potentially serious impact of an influenza pandemic. The Government is collaborating actively with international partners on prevention, detection and research, and is taking every practical step to ensure that the UK is prepared to limit the internal spread of a pandemic and to minimise health, economic and social harm as far as possible. This includes purchasing and stockpiling appropriate medical countermeasures.
Apply and comply with Scottish Government and Public Health Scotland guidance and advice – for example Covid-19 the Scottish Government Covid19 Advisory Group, Scientific Advisory Group for Emergencies (SAGE).
Follow NHS and Social Care mobilisation and planning guidance in Scotland and link this to funding requirements.
Apply integrated emergency management principles, develop flexible and adaptable arrangements for dealing with emergencies, whether foreseen or unforeseen. This will be informed in future by Covid 19 reflection and recovery work.
The delivery of Risk Management table top exercises in order to ensure preparedness for further major incidents.

Public Protection – Legislation and Service Risk	**Risk Lead**	**Pre-Mitigation Assessment**	**Pre-Mitigation Risk**	**Post-Mitigation Assessment**	**Post-Mitigation Risk**
1. Legislative requirements Failure to meet legislative duties in relation to child protection, adult support & protection and multi-agency public protection arrangements (MAPPA).	Chief Social Work Officer		Probable - Major **Unacceptable**		Possible - Major **Issue**

Failure to ensure that Guardianship cases are appropriately monitored, supported and reviewed by social workers. 2. Service risk and delivery requirements Public Protection Co-ordinator post provides limited resilience to ensure continuity of public protection functions across West Dunbartonshire HSCP and other responsible agencies Failure to ensure compliance with relevant risk assessments and evidence-based interventions. Failure to ensure that staff are appropriately trained and adhere to standards for risk assessment and risk management across child, adult and public protection work. Failure to monitor commissioned and other partnership services which could impact on an individual's safety or risk to themselves or others. Failure to monitor and ensure the wellbeing of adults in independent or WDC residential care facilities. Failure of staff to recognise, report and manage risk.					
Mitigating Action					
Review of interim and longer-term arrangements to support child protection and adult protection activity and multi-agency practice arising from vacant Public Protection Coordinator post.					
West Dunbartonshire's Child Protection and Adult Support and Protection Committees ensure child and adult protection procedures are followed and have a scrutiny role over compliance linked to implementation of relevant policies and procedures.					
Chief Social Work Officer attends the North Strathclyde MAPPA Strategic Oversight Group; responsible manager attends the Management Oversight Group which monitors local compliance with national standards and legislative duties.					
Chief Social Work Officer and Heads of Service ensure that child and adult protection plans as well as MAPPA risk management plans are regularly reviewed; themes and trends from local audit activity are reported to clinical and care governance structures, the Child and Adult Protection Committees and the MAPPA Strategic Oversight Group.					
West Dunbartonshire Nurtured Delivery Improvement Group (DIG) – which includes the Chief Social Work Officer – continues to review progress to achieve the recommendations from the joint strategic inspection of children and young people's services.					
Chief Social Work Officer and Heads of Service ensure appropriate systems and processes are in place to ensure that findings of external scrutiny (e.g.: Care Inspectorate) processes are acted upon timeously and appropriately, including the recent inspection of adult support and protection and the forthcoming inspection of Children at Risk of Harm					
Chief Social Work Officer oversees compliance with the PVG scheme.					
Operational teams regularly review their training and development needs, Business Continuity plans and operational risk registers.					
Reviews of children and families and criminal justice social work services reflects actions to reduce risk and uphold professional practice standards.					
Ensure staff are aware that whistleblowing policies and procedures are in place to ensure concerns can be raised and investigated.					

IMPACT						
	(5) Catastrophic	5 Adequate	10 Issue	15 Issue	20 Unacceptable	25 Unacceptable
	(4) Major	4 Acceptable	8 Adequate	12 Issue	16 Unacceptable	20 Unacceptable
	(3) Moderate	3 Acceptable	6 Adequate	9 Adequate	12 Issue	15 Issue
	(2) Minor	2 Acceptable	4 Acceptable	6 Adequate	8 Adequate	10 Issue

	(1) Insignificant	1 Acceptable	2 Acceptable	3 Acceptable	4 Acceptable	5 Adequate
	Risk Appetite	(1) Rare	(2) Unlikely	(3) Possible	(4) Probably	(5) Almost Certain
	LIKELIHOOD OF RISK					

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
AUDIT AND PERFORMANCE COMMITTEE

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

15 November 2022

Subject: Internal Audit Report – Performance Management Arrangements

1. Purpose

1.1 The purpose of this report is to provide the HSCP Audit and Performance Committee with an update on the findings of the recent internal audit review of high level processes and procedures in relation to the HSCP Board's Performance Management Arrangements

2. Recommendations

It is recommended that the HSCP Audit and Performance Committee:

2.1 Note the findings of the Audit report.

2.2 Note the actions taken to meet one of the audit requirements and plans to meet the other within defined timescales.

3. Background

3.1 West Dunbartonshire HSCP is required to publish an annual performance report detailing planning and performance of the HSCP functions.

3.2 Performance Management arrangements are in place to ensure effective monitoring and reporting is in place to support effective monitoring and reporting on service delivery and progress around West Dunbartonshire HSCP Board's Strategic Plan.

4. Main Issues

4.1 Between January and June 2022 Internal Audit conducted an audit of Performance Management arrangements. This was in accordance with the 2021/22 Internal Audit Plan, as agreed by the West Dunbartonshire HSCP Audit and Performance Committee.

4.2 The audit objective was to provide the HSCP Board with an assessment of the adequacy and effectiveness of the governance, risk management and controls surrounding the key risks in relation to Performance Management.

4.3 The report, published in June 2022, evaluated the overall control environment as Satisfactory, with areas of best practice identified in terms of revisions to

the Performance Management processes introduced in 2020 particularly around layout, timing and presentation of the Quarterly Performance information.

4.4 Two GREEN issues were identified concerning improvements that could be made to documentation of key processes and cross referencing exception reporting to performance indications. Actions were agreed which if implemented by management would enhance the control environment. The full report can be found in Appendix I of this report.

4.5 The first highlighted action, concerning the production of procedures and guidance within the Information Team in relation to the process for data collection, collation and reporting, will be completed by the end of the current Financial Year. An update will be provided at a future HSCP Board meeting to confirm completion of the action.

4.6 The second action from the audit is to include a cross-reference in the Exception Report to the Performance Indicators has been completed, with performance indicators included within the relevant Service Performance Area in the Exceptions section of the report.

5. Options Appraisal

5.1 An options appraisal is not required in respect of the recommendation within 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 or procurement implications arising from the recommendation within this report.

8. Risk Analysis

8.1 There are no risks arising from the recommendation within this report.

9. Equalities Impact Assessment (EIA)

9.1 An EIA is not required as the recommendation within this report does not impact on those with protected characteristics.

10. Environmental Sustainability

10.1 A Strategic Environmental Assessment is not required in respect of the recommendation within this report.

11. Consultation

11.1 The Chief Officer, Chief Finance Officer, Monitoring Solicitor, Chief Internal Auditor and the Senior Management Team have been consulted on this report.

12. Strategic Assessment

12.1 The recommendation within this report supports the HSCPs strategic priority pertaining to resilience, by ensuring clear Performance Management is provided and defined processes agreed to support care delivery.

13. Directions

13.1 A direction is not required in respect of the recommendation within this report.

Name	Margaret-Jane Cardno
Designation	Head of Strategy and Transformation West Dunbartonshire Health and Social Care Partnership
Date	26 October 2022

Person to Contact	Margaret-Jane Cardno Head of Strategy and Transformation West Dunbartonshire Health and Social Care Partnership Margaret-jane.cardno@west-dunbarton.gov.uk

Appendices:	Audit Report (Appendix 1)
Background Papers	

PRIVATE AND CONFIDENTIAL
INTERNAL AUDIT REPORT

HSCP BOARD PERFORMANCE MANAGEMENT ARRANGEMENTS

JULY 2022

FINAL

Control Environment Opinion:

SATISFACTORY
In our opinion ***isolated*** areas of control weakness were identified which, whilst not systemic, put some service objectives at risk.

	RED	AMBER	GREEN
FINDINGS	0	0	2

Final Distribution

To: **Beth Culshaw, Chief Officer, WD HSCP Board**
Margaret-Jane Cardno, Head of Strategy and Transformation

1. EXECUTIVE SUMMARY

Introduction

This audit was conducted between January and June 2022 in accordance with the 2021/22 Internal Audit Plan, as agreed by the West Dunbartonshire HSCP Audit and Performance Committee.

Background

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 ensure that performance is open and accountable, the 2014 Act obliges Partnerships to publish an annual performance report setting out an assessment of performance in planning and carrying out the integration functions for which they are responsible.

To facilitate this the HSCPB has Performance Management arrangements in place to ensure its 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 Board's Strategic Plan.

Objectives

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 effective Performance Management arrangements for monitoring and reporting on the delivery of services and on the programme of work as set out in the West Dunbartonshire HSCP Board's Strategic Plan.

Scope & Approach

The review focussed on the high level processes and procedures in relation to the HSCP Board's Performance Management Arrangements and concentrated on identified areas of perceived higher risk, such as not fully complying with the statutory requirement and not adequately reporting on the delivery of services and on the programme of work as set out in the West Dunbartonshire HSCP Board's Strategic Plan.

To facilitate this process it was planned that the scope of the audit focussed on the key risks outlined in the agreed Terms of Reference set out at Appendix 1.

The audit approach was planned to fall in line with the agreed Terms of Reference and included:

- Review of compliance with Policy & Statutory reporting requirements
- Review of HSCP Board and Audit & Performance Reporting Process
- Review of HSCP Audit & Performance Committee Terms of Reference

- Review of Performance Management Data sources and process of data collection
- Review of content of Performance Management Reports
- Review of Reporting and Challenge at HSCP Board and Audit & Performance Meetings

Summary Findings

There are two GREEN issues identified which if implemented by management would enhance the control environment. These are set out in more detail at Section 2 of this report. (The audit Grading Criteria is provided in Appendix 2).

Conclusions

The overall control environment opinion for this audit review was **Satisfactory**. Areas of best practice were identified in terms of revisions to the Performance Management processes introduced in 2020 in particular in relation to the layout, timing and presentation of the Quarterly Performance information; however it was recognised that improvements could be made to the documentation of key processes and cross-referencing of exceptions reporting to relevant performance indicators.

Acknowledgements

The co-operation and assistance of all staff during the audit was greatly appreciated.

Andi Priestman
Chief Internal Auditor

Sheila Bronson
Internal Audit

2 DETAILED FINDINGS

	FINDING	RISK	AGREED ACTION	RESPONSIBILITY DUE DATE
GREEN	**Procedures or Guidance for Statutory Reporting Process** No procedures or guidance are in place within the Information Team in relation to the process for data collection, collation and reporting. Although the team is highly experienced, this would be beneficial for any new member staff and for transparency of the process.	Lack of procedures or guidance for officers for the collection, collation and reporting of data could result in failure to comply with statutory reporting requirements.	Procedures or guidance will be produced for data collection, collation and reporting for all statutory reporting such as Annual and Quarterly reports by the end of the Financial Year.	Head of Strategy & Transformation HSCP 31 March 2023
GREEN	**Cross-Reference on Exception Reports** Quarterly Performance Reports meet statutory guidance for its contents. Reports are generally user friendly but would benefit from cross referencing between Exceptions reported and Performance Indicators reported.	If reports are not easily referenced, there is the risk that users do not fully consider the information within the report which could lead to a lack of robust scrutiny and challenge on performance.	Inclusion in the Quarterly Performance Report a cross-reference in the Exception Report to the Performance Indicators reported is expected to be in place for reporting to the September 2022 meeting of the Audit & Performance Committee.	Head of Strategy & Transformation HSCP 30 September 2022

Terms of Reference

Overall Audit Objective

To review the adequacy and effectiveness of the governance, risk management and controls surrounding the West Dunbartonshire Health & Social Care Partnership Board (HSCPB) Performance Management arrangements which mitigate the key risks detailed below.

Risks

1 Adequate performance management arrangements are not in place to completely and effectively monitor implementation of the HSCPB's strategic plan.

2 Adequate arrangements are not in place to provide key stakeholders with relevant, accurate and timely information regarding implementation of the HSCPB's strategic plan.

Internal Audit Report Findings – Risk/Impact Grading Criteria

Report Grading & Criteria / Business Risk/Impact (Actual or Potential)	**GREEN** • Process improvements/efficiencies may be actioned if it is cost-effective or at management's discretion – in consultation with IA. • To be managed by the appropriate service manager. • Low risk - can be prioritised to fit in with wider business activities and priorities (normally start within 6 months of audit) • Will not be reported in any Committee papers.	**AMBER** • Mandatory - corrective action must be taken (some exceptions agreed by IA) • To be overseen to completion by Head of Service. • Remedial action to address an amber issue should start within a "***reasonable***" timescale (normally within 3 months of audit) • Will be reported in Audit Committee papers.	**RED** • Mandatory – immediate corrective action must be taken. • To be overseen to completion by a member of the Corporate Mgmt Team. • Remedial action to address a red issue should start ***immediately.*** • Will be reported in Audit Committee papers.
Financial *Actual or potential loss which will impact either the Income & Expenditure Account or Balance Sheet within any twelve-month period (i.e. loss of profit or loss of asset)*	• Process improvement identified which will enhance operational efficiency. • Non-material control weakness.	• Material impact at Service level.	• Material impact at Corporate Level.
Reputation *Actual or potential impact to the reputation of the Council in the external environment. This includes the views held by the regulator.*	• Isolated, non-systemic, or restricted scope events that may have a limited impact on our standing with any of our business partners/stakeholders.	• Events that may tarnish our reputation with a specific customer, group or third parties. • Moderate impact on our standing with our key partners/stakeholders.	• Strong likelihood of or actual adverse comment in the national media. • Significant impact on our standing with any of our key partners/stakeholders
Legal & Regulatory *Actual or potential impact arising from operational/management failure that leads to a failure to comply with regulation or legislation.*	• Isolated, non-systemic, or limited scope events which statutory body would not consider the need for additional supervision activity.	• Events that may lead statutory body to consider increasing level of supervision activity; and damaging the ongoing relationship.	• Events/breaches resulting in the strong likelihood of increased levels of supervision from a statutory body.
Operational *Actual or potential impact arising from any operational/management failure that leads to an inability to maintain a quality service to any of the Council's stakeholders (staff, service users, customers, suppliers, regulators etc)*	Impact upon the delivery of a Service area's plan/objectives, such as: • Affecting a small number of stakeholders. • Small (non-systemic) errors, omissions or delays in operational plans, processes, projects or systems. • Non-material failure at Service level.	Impact upon the delivery of a Service area's plan/objectives, such as: • Affecting a moderate number of stakeholders. • Non-material systemic errors, omissions or delays in operational plans, processes, projects or systems. • Material Control failure impacting at Service level.	Impact upon the delivery of the Council's Corporate objectives: • Affecting a significant number of stakeholders. • Material systemic errors, omissions or delays in strategic or operational plans, processes, projects or systems. • Material control failure impacting at Corporate level.
Timescale for start of agreed action	**Discretionary (6 months)**	**Reasonable (3 months)**	**Immediate**

Internal Audit Report – Overall Environment Opinion

Strong	In our opinion there is a ***sound*** system of internal controls designed to ensure that the service is able to achieve its objectives.
Satisfactory	In our opinion ***isolated*** areas of control weakness were identified which, whilst not systemic, put some service objectives at risk.
Requires improvement	In our opinion ***systemic and/or material*** control weaknesses were identified such that some service objectives are put at significant risk.
Unsatisfactory	In our opinion the control environment was considered ***inadequate*** to ensure that the service is able to achieve its objectives.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP AUDIT AND PERFORMANCE COMMITTEE

Report by Head of Service - Val Tierney Chief Nurse

15 November 2022

Subject: Care Inspectorate Inspection report for two Older People's Care Homes operated by the Independent Sector in West Dunbartonshire

1. Purpose

1.1 To provide the Audit and Performance Committee with an up-date on Care Inspectorate inspection reports for Balquidder House Nursing Care Home and Stratheven Residential Care Home. Both are independent sector Care Homes located within West Dunbartonshire.

2. Recommendations

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

3. Background

3.1 The Care Inspectorate now use Key Questions rather than Quality Themes in their inspections. They still use the six point scale of 1 – Unsatisfactory to 6 – Excellent in grades awarded.

3.2 During the COVID-19 pandemic the Care Inspectorate amended the focus of their inspections. They focused only on how well Care Home residents were being supported during the COVID-19 pandemic rather than the full range of Key Questions.

3.3 They amended their quality framework for Care Homes to include a new Key Question; 'How good is our care and support during the COVID-19 pandemic?' This Key Question has 3 quality indicators:

- People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic;
- Infection control practices support a safe environment for both people experiencing care and staff; and
- Staffing arrangements are responsive to the changing needs of people experiencing care.

3.4 The Care Inspectorate have resumed looking at the Key Questions which now include elements from the Covid Key Question in their inspections.

3.5 The independent sector Care Homes reported within this report are:

- Balquhidder House;
- Strathleven Care Home

A copy of their inspection report has been published and can be accessed on the Care Inspectorate website: www.careinspectorate.com

4. Main Issues

Balquidder House

4.1 Balquhidder House is owned and managed by Balquhidder Care Ltd which is part of the Hansale Group who took over the service in February 2020. Balquidder House is registered with the Care Inspectorate for a maximum of 65 residents. At the time of inspection there were 62 residents being supported in Balquhidder House.

4.2 The Care Home was inspected between 30 May and 1 June 2022 and the report issued at end of June 2022. The table below summarises the grades awarded to Balquhidder House over their last 3 inspections:

4.3

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
07.06.22	3	3	3	Not Assessed	Not Assessed
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
07.08.19	5	Not Assessed	Not Assessed	Not Assessed	5
Inspection date	**Care & Support**	**Environment**	**Staffing**	**Management & Leadership**	
18.07.18	6	Not Assessed	Not Assessed	6	

The grade of '3 – Adequate' received for the Key Question 1 is a reduction from the last inspection. Key Question 2 and 3 were inspected for the first time. This was the services first inspection since the start of the COVID-19 pandemic. In this recent inspection report there were no requirements highlighted for remedial action by the service.

4.4 Management and staff continue to work to improve the service whilst dealing with the impact and changes to practice introduced as a result of COVID-19.

Strathleven Care Home

4.5 Strathleven Care Home is owned by Pelan Ltd. Strathleven Care Home is registered with the Care Inspectorate for a maximum of 21 residents. At the time of inspection there were 18 residents being supported in Strathleven Care Home.

4.2 The Care Home was inspected between 7 and 15 September 2022 and the report issued on 5 October 2022. The table below summarises the grades awarded to Strathleven Care Home over their last 3 inspections:

Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
16.09.22	2	2	2	Not Assessed	Not Assessed
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
18.07.19	4	Not Assessed	3	Not Assessed	4
Inspection date	**Care & Support**	**Environment**	**Staffing**	**Management & Leadership**	
27.04.18	5	Not Assessed	5	Not Assessed	

4.3 The grades awarded are lower than those in their previous inspections. The inspectors detailed 6 requirements in their report to be addressed. These were:

1. The provider must provide a varied programme of meaningful activities. To do this the provider must at a minimum provide:
   a) an activity plan developed from people's interests and hobbies
   b) a range of meaningful activities for people living in the service.
   c) opportunities for people to be physically active
   d) opportunities for people to be out in the community

2. The provider must improve the management of medication. To do this the provider must as a minimum provide:
   a) an effective system of recording the purpose and effectiveness of 'as required' medications.
   b) a robust system for auditing and reviewing the use of 'as required' medications and evidence of consideration of GP referrals for further management of these medications.

3. The provider must ensure that daily health charts are fully completed and the information is readily available to staff.
   To do this the provider must as a minimum provide:
   a) a mechanism for the daily recording of bowel movements, food and fluid intake and weight where this is indicated.
   b) ensure that this information is audited and evaluated regularly with consideration of GP referrals for further management of people's conditions, as appropriate.

4. The provider must ensure that the home is clean and free from avoidable intrusive smells.
   To do this the provider must as a minimum ensure:
   a) that the source of the unpleasant smell in the activity room is identified and eradicated.
   b) that all equipment, including bath chairs, are kept clean and hygienic.

5. The provider must have maintained a robust quality assurance system.
   In order to do this they must provide:
   a) systems that audit healthcare issues, including but not exclusive to bowel movements, weights, wounds, and falls risk
   b) records of spot checks of the environment
   c) records of spot checks of staff practice
   d) a SMART action plan to address any deficits or issues identified.

6. The provider must ensure that the skills mix, number and deployment of staff meets the needs of people.
   In order to do this they must provide:
   a) evidence of staff arrangements which allow for more than basic care needs to be met and which support people to get the most out of life.
   b) evidence that staff help each other by being flexible in response to changing situations to ensure care and support is consistent and stable.

4.4 The Home Manager has submitted a comprehensive action plan to the Care Inspectorate, which has been agreed with Inspectors, to address the requirements detailed.

4.5 The Home Manager is working with the HSCP and Care Home Collaborative to progress work to meet time the requirements within the specified timescale of 23 December 2022.

5. Options Appraisal

5.1 Not required for this report.

6. People Implications

6.1 There are no personnel issues associated with this report.

7. Financial and Procurement Implications

7.1 The enhanced quality payment awarded on top of the National Care Home Contract (NCHC) when a service receives grades of 5 in one or more of the Key Questions during an inspection. Strathleven care home was in receipt on a double enhancement (£2.50 per resident per week) having been awarded grades of 5 in a previous inspection. We would not normally remove the enhancement after one inspection that did not result in the service receiving a grade of 5. As this is the second inspection where the grade of 5 has not been reinstated this enhancement has been removed.

7.2 The National Care Home Contract clause 21.1 (iii) stipulates :- the Council may contractually suspend any future Placements to the Service where the Care Home has received a score of 2 or less in the themed area of 'Quality of Care and Support'. Having carefully considered the implications from all partners' perspectives the requirement to suspend admissions was not considered to be warranted. Close scrutiny, support and oversight of implementation of the improvement plan is in place and subject to regular review.

8. Risk Analysis

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

9. Equalities Impact Assessment (EIA)

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

10. Environmental Sustainability

10.1 Not required for this request.

11. Consultation

11.1 None required for this report.

12. Strategic Assessment

12.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan for 2019 – 22 priorities' are:

- Early Intervention;
- Access;

- Resilience;
- Assets;
- Inequalities.

12.2 The strategic priorities above emphasise the importance of quality assurance amongst providers of care and the HSCP's commitment to work with providers within an agreed assurance framework.

13. Directions

13.1 Not required for this report.

Name: Val Tierney
Designation: Chief Nurse West Dunbartonshire HSCP
Date: 17.10.2022

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Appendices: Appendix 1 - Balquhidder

Appendix 2 - Strathleven

Background Papers: All the inspection reports can be accessed from https://www.careinspectorate.com/

Wards Affected: All

Care Home Service

1 Charleston Way
Alexandria
G83 0TD

Telephone: 01389 488 777

Type of inspection:
Unannounced

Completed on:
7 June 2022

Service provided by:
Balquhidder Care Ltd

Service provider number:
SP2014012387

Service no:
CS2014332915

About the service

Balquhidder House has been registered with the Care Inspectorate since 7 July 2015 to provide care for up to 65 older people some of whom will be living with dementia. The provider is Balquhidder Care Ltd, a part of the Handsale group. There were 62 residents at the time of the inspection.

There are four separate units within the home. Downstairs there is a unit for people living with dementia and another for frail older people. Upstairs both units are for frail older people. All bedrooms are single bedrooms with en-suite shower facilities and some bedrooms have direct access to the garden area with an individual patio area.

There are lounge areas and separate dining areas in each unit. There is a self service café at reception which is open to all residents and visitors. The home has extensive well- maintained secure garden areas. There are good transport links and limited parking at the care home.

The aims of the service include:

To measure our success against residents, and their loved one's feelings, opinions, and experiences.
To nurture a family feel and cared for staff culture.
To use latest technologies , digital systems and innovation to benefit residents lives.
To continually work in partnership with our regulatory and business partners to ensure that people in our care receive safe and outstanding care.

About the inspection

This was an initial inspection that took place on 30 May 2022, 31 May 2022 and 01 June 2022 . The inspection was carried out by two inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. In making our evaluations of the service we spoke with ten people using the service and seven family members. We spoke with seven staff including management. We observed practice and daily life. We reviewed documents.

Key messages

The service has a history of excellent and very good evaluations.

Residents told us they were happy living at the home.

Staff were kind and caring and provided good care.

There was a lack of opportunities for residents to participate in meaningful experiences.

Improvement was needed in the areas of increasing opportunities for socialisation for people.

Improvement was needed in the areas of conducting audits, staff support and developing the service following the covid-19 pandemic and the associated isolation of people coupled with staffing shortages.

A new provider has been in place since February 2020 and they continue to work with the management team on improvement work.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	3 - Adequate
How good is our leadership?	3 - Adequate
How good is our staff team?	5 - Very Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 3 - Adequate

We gave a rating of adequate for this key question as we found that there were weaknesses in activity provision which detracted from the strengths in the area of supporting people's wellbeing.

Feedback from people who resided in the home and their family overall indicated that people were treated well by staff members who were aware of their needs, wishes and preferences. Interactions between staff and people residing in the home were warm and friendly.

People's care and support plans were detailed, up to date and easily accessible. Care plans centred around people's wishes and preferences which were used to inform good practice. Information is laid out in a structured way and any risk issues and valuable information for staff regarding health concerns are central to the care and support plan and are kept updated by staff.

Family members that we spoke to made positive comments about the standard of care planning and felt involved in the process along with their loved ones. The home conducted regular reviews of care plans which reflected people's current needs and wishes.

We were told that there were a good variety of activities available for people to participate in with the activity coordinator and with staff. However, we did not see much evidence of this. People's care plans clearly outlined how they liked to spend their time and it is important that people are able to participate in their chosen hobbies and pastimes. People and relatives that we spoke made negative comments about the lack of activities. Comments included:

'nothing to do'
'the lack of staff in living room is a concern'
'no activities'
'nothing going on in the mornings'.

We found many of the communal lounges to be empty. When people were present in the communal areas they were mainly either sleeping or watching TV. We only saw one person engaged in an activity with staff. People were alone in their rooms and we observed people to be sitting unoccupied or

watching TV. We were told that the activity coordinator spends time with people in their rooms undertaking reminiscence work and supporting people with physical exercise. There is only one activity coordinator across the four units. We were told that prior to the Covid-19 pandemic that the lounges were busy and thriving. There is work to be done to encourage people to start socialising and to be active again as this will benefit both their physical and mental health.

People who lived in the home and their relatives commented on the lack of activities. We also observed a lack of recording of activities in the care plan. We were told by the management team that this is an area that they were working on improving. We saw preparations for the Queens Platinum Jubilee Weekend taking place. Whilst this was positive, we would like to see regular activities taking place daily which reflect the wishes and preference of the people living in the home. We have made this an area for improvement.

Health support plans were detailed, clear and easily accessible by staff. There were specific plans to support people with their individual health issues such as epilepsy and diabetes. There was access to equipment and to technology which allowed people to be as independent as possible. Staff received appropriate training

and training was up to date. People's medication was regularly reviewed to promote best outcomes for people and there was access to community healthcare for people as required. Relatives and carers that we spoke were positive about the health care that was available within the home.

Recording and monitoring of key indicators of health were generally good. We evidenced good practice in relation to monitoring of people's skin care, nutrition, weight loss and fluid intake. However repositioning charts and oral hygiene charts had gaps in them. Without accurate recording in all charts there is no assurance that people's health needs are being met. We have made this an area for improvement.

We found that medication records were kept up to date. However, as required medication was administered but not evaluated. As a result we could not be assured that people were always getting the right medication at the right time. We have made this an area for improvement.

People's relatives and friends were visiting freely and people that we talked to told us that they had been kept informed of any changes to visiting policy during the Covid -19 pandemic. Visitors were made welcome by staff when they arrived and had an opportunity to talk to staff about anything they needed to. This arrangement had been put in place during the pandemic and remains in place as it has been beneficial for visitors to have this opportunity to speak with staff.

Staff are aware of the importance of Personal Protective Equipment (PPE) which was for infection prevention and control. There were plentiful supplies of PPE available at various points throughout the home. The equipment was arranged in the correct order for donning to assist staff.

We noticed that the hand sanitisers were sometimes not positioned at the stations and the manager took immediate action to move these closer. At the morning delegation meetings staff were asked to demonstrate hand hygiene, donning, and doffing which encouraged staff to undertake best practice.

The home was clean, and the furnishings were well maintained. We were told that further refurbishments would be undertaken this year. Equipment was cleaned regularly, and this was recorded on the equipment with stickers which indicated when equipment was last cleaned. Cleaning records were up to date.

Areas for improvement

1. The provider should address the lack of regular activities for people to participate in. Through addressingthis it should facilitate a positive impact on people's physical health and emotional wellbeing.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) that state "I can choose to have an active life and participate in a range of recreational, social. creative, physical and learning activities every day, both indoors and outdoors.' (1.25)

2. The provider should ensure that all health charts and medication recordings are kept up to date and thatthey provide information which demonstrates and informs best practice.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) that state 'My care and support meets my needs and is right for me' (1.19)

How good is our leadership? 3 - Adequate

We evaluated this area as adequate as we found significant gaps in undertaking quality assurance work detracted from the positive aspects of leadership.

Managers evaluated peoples experiences of living in the home through conducting six monthly reviews of people's care plans. During these reviews the people who resided the home were involved in giving their views on their support. Relatives were also able to participate in reviews and give their views. This meant that people were recognised as being the expert in what their needs and wishes were.

Individual staff supervision sessions were not taking place which meant that we could not be assured that staff were adequately supported in order to give the best care and support to people. Plans for regular staff supervision were in place and a couple of group staff supervisions sessions had taken place. The manager had also made herself available once a week for staff to approach her with any issues. These meetings were positive and provided an opportunity for two way communication between management and staff. We received feedback from staff that they felt well supported by the management team. However, given the lack of individual supervision sessions we have made an area for improvement around this issue.

There was no evidence of any surveys aimed to find out the views of people and their relatives on the care and support provided within the home. It is important that people and their carers are involved and included in any decision making about the home in which they live. Participation by people and their relatives ensures that people feel valued and are enabled to give views which can help the service to improve. We have made this an area for improvement.

There were no regular audits taking place and therefore there was no overview of staff practice. Without this overview people cannot benefit from a culture of continuous improvement which is only possible when an organisation has robust quality assurance processes. We were shown new paperwork which managers will use to undertake a range of audits however this was not yet implemented as the time of our visit. We have made this an area for improvement.

The service did not have an up to date improvement plan which is needed to ensure that care and support benefits from continuous improvement and that it is well led and managed. We have made this an area for improvement.

Areas for improvement

1. The provider should ensure that robust audits are put in place to ensure that people are receivingappropriate care and support of a high standard and that people receive high quality care that is delivered in a planned and safe way. The provider should also ensure that the improvement plan is regularly updated in order that the management team can track progress made on any outstanding actions which are required to improve the quality of care and support.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) that state 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (4.19)

2. The provider should ensure that there is a mechanism in place to obtain regular feedback from peoplewho reside in the home and their relatives.

This is to ensure that people feel valued and included in decision making about their care.

This is to ensure that care and support is consistent with the Health and Social Care Standards(HSCS) that state ' I can be meaningfully involved in how the organisations that support and care for me work and develop'(4.6) and 'I am supported to give regular feedback on how I experience my care and support and the organisation uses learning from this to improve'. (4.8)

3. The provider should ensure that staff are given regular supervision and support. Through addressing this,staff will be supported to develop and improve the quality of their practice and be able to discuss relevant issues regarding the people they are supporting.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) that state 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes.' (3.14) and 'I am confident that people are encouraged to be innovative in the way they support and care for me'. (4.25)

How good is our staff team? 5 - Very Good

We evaluated this area as very good as we saw major strengths in the staff team along with very positive feedback from people and their loved ones about the staff.

Staff were supported by the management team to undertake a good range of mandatory training courses to equip them to provide care and support to the people who resided in the home. Staff training was mainly up to date. We were told that when staff made errors that they were encouraged to write a reflective account and this was a source of learning for staff.

Staff described that they had good emotional support from the management team and said that managers were approachable and were willing to support them with their wellbeing needs.

Staff had an induction period and a probationary period after which they received a review of their performance. Staff were given the opportunity to shadow more experienced staff during their induction. Staff commented positively on the good staff team around them. They found the electronic system for recording care outcomes to be very good, efficient and easy to use and described it as helping them to do their job better.

Feedback from people who lived in the home and their relatives about the staff was positive. People commented that the staff were nice, friendly and you could have a laugh with them. Relatives saying that staff were warm and were caring towards relatives.

Some positive comments included:

'staff great, can have a joke with them'
staff are nice'
'(loved one) always well kempt and clean and fresh'
'bedrooms well cleaned'
'dad is spotlessly clean'

The recruitment process was good and this meant that people could be confident that the people who supported and cared for them had been appropriately and safely recruited.

Complaints

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

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.1 People experience compassion, dignity and respect	5 - Very Good
1.2 People get the most out of life	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	4 - Good
1.4 People experience meaningful contact that meets their outcomes, needs and wishes	5 - Very Good
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	5 - Very Good

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

How good is our staff team?	5 - Very Good
3.2 Staff have the right knowledge, competence and development to care for and support people	5 - Very Good

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Care Home Service

30 Strathleven Place
Dumbarton
G82 1BA

Telephone: 01389 742 286

Type of inspection:
Unannounced

Completed on: 16
September 2022

Service provided by:
Pelan Ltd

Service provider number:
SP2003000288

Service no:
CS2003001442

About the service

Strathleven Care Home has been registered with the Care Inspectorate since April 2011. The home is registered to care for 21 older people. The provider is Pelan Ltd.

The care home is a detached villa that has been converted and extended into accommodation over two floors. Strathleven offers 13 single bedrooms and 4 shared bedrooms. Some of the single bedrooms offer ensuite facilities. There are adapted bathrooms and toilets on both floors for residents' use.

The large communal lounge and dining room at the rear of the home has views and access to a secure decking area with a range of garden furniture. There is a small quiet sitting room for residents and their families to use, which offers a more private space.

The service is located in a residential area of Dumbarton near local amenities including shops, bus routes and train links. Allied health professionals and district nursing services attend the home to deliver care and support as required.

About the inspection

- This was an unannounced inspection which took place on 7th, 9th, 12th and 15th September.
- The inspection was carried out by four inspectors from the Care Inspectorate.
- To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.
- In making our evaluations of the service we spoke with seven people using the service and six of their family members. We spoke with twelve staff and management; we observed practice and daily life; reviewed documents and spoke with visiting professionals.

Key messages

- There needs to be more meaningful activity for people living in the home.
- Medication management must be improved.
- Records of people's health needs need to be better.
- People should be encouraged to maintain their independence.
- Relatives and visiting professionals described positive experiences for people living in the home.
- Rooms are kept clean and tidy and odour free.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	2 - Weak

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 2 - Weak

We evaluated this area as weak as we found significant weaknesses in the service that adversely affected people's experiences and outweighed the strengths in this area.

People that we spoke with were mainly positive about the care and support they received from staff. However, we observed at times that staff interactions with people were abrupt and left little time for any meaningful interactions with people. Staff practice revolved about routine tasks and did not reflect people's preferences. We observed that people were left for long periods unsupported and without any attention from staff. People's views were not reflected in staff practice. For example, we observed that people who preferred to have a lie in in the morning were seen up and dressed early in the morning when we visited. People who enjoyed music were left for long periods without any stimulation and people with sensory impairments were not given adequate stimulation. This meant that people were not always experiencing compassion, dignity and respect in their interactions with staff.

We found that people's personal plans were not being used by staff to enhance the care provided to them. Activities were not linked to people's interests or hobbies. Opportunities to participate in meaningful interactions were sparse and mainly included small group activities at set times of the day or week. We observed a small room that we were told was being used by the activity coordinator to provide individual pamper sessions. When we visited this room it smelled strongly of urine and was unpleasant to be in. Within the dining area/sitting room, people were sitting for long periods without any stimulation as the TV volume was low and there was no music to listen to. People generally appeared to sit passively or were observed to be withdrawn or asleep.

There were limited opportunities for engagement in the community. Some residents had been taken shopping and another lady had been supported to attend church but overall there was not enough emphasis on supporting people to be more socially active. We found no evidence of an activity planner or any review of activities. We saw no evidence of people's views on activities being undertaken. This meant that people were not getting the most out of life. (see requirement one and area for improvement one).

Staff attention to people's personal care needs revolved around routines rather than people's choices. For example, we were told that after lunch people were not supported to go to the toilet under after people had received their medication. This meant that we could not be confident that people were being supported to the toilet when they needed to. There were significant gaps in continence management charts and records of when people were supported with bathing or showering were not kept up to date. We saw no evidence of people being encouraged or supported to get up and walk around during the day. We saw people sitting for extended periods in slumped positions without any support from staff. We found evidence of 'as required' medications being used multiple times a day without any evaluation of their effectiveness or a request for a GP review of the medication. This meant that people's health and wellbeing was not always benefitting from their care and support. (see requirement two and three)

We observed people having visits from family members during our inspection and we spoke to some relatives in person and over the phone. People that we spoke to were in general positive about the support that their loved ones received and were happy with the safe visiting arrangements that had been made during the pandemic.

Positive comments made by family members included;

'mum's happy there'
'the staff are lovely with dad'
'the food's good, its all homemade'

One family member commented that there could have been greater use made of technology to support contact with loved ones during the pandemic and a comment was made about there not being enough for people to do within the home. We did not see any evidence of relative meetings or forums but there was a regular newsletter provided to relatives and the home had their own Facebook page which provided families with updates. This meant that people were seen to be have meaningful contacts although there was scope for better communication with family members.

We found that staff used PPE (personal protective equipment) properly when going about their work. However we observed that staff were not always ensuring that PPE stations were replenished with supplies. This meant that staff did not always have access to equipment where and when they needed it. Communal areas and bedrooms within the home were clean and tidy. However we observed equipment that was was unsanitary. Cleaning schedules were in place but there was a need for more attention to detail. We also found areas of the kitchen to be in an unsanitary condition and this was brought to the attention of the management team. Although there was evidence of good practice in relation to safe infection and control practice and procedures there was room for improvement in this area and we could not be confident that people were always were benefiting from safe practice. (see requirement four).

Requirements

1. By the 23rd December 2022 the provider must provide a varied programme of meaningful activities.

To do this the provider must at a minimum provide:

a) an activity plan developed from people's interests and hobbies

b) a range of meaningful activities for people living in the service.

c) opportunities for people to be physically actived opportunities for people to be out in the community.

This is to comply with Regulation 4 - welfare of users of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that 'my care and support meets my needs and is right for me' (HSCS 1.19 and 'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors' (HSCS 1.25)

2. By the 23rd December 2022 the provider must improve the management of medication.

To do this the provider must as a minimum provide:

a) an effective system of recording the purpose and effectiveness of 'as required' medications.

b) a robust system for auditing and reviewing the use of 'as required' medications and evidence ofconsideration of GP referrals for further management of these medications.

This is in order to comply with Regulation 4 - Welfare of users of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that 'any treatment or intervention that I experience is safe and effective'. (HSCS 1.24).

3. By the 23rd December 2022 the provider must ensure that daily health charts are fully completed and the information is readily available to staff.

To do this the provider must as a minimum provide:

a) a mechanism for the daily recording of bowel movements, food and fluid intake and weight where this isindicated.

b) ensure that this information is audited and evaluated regularly with consideration of GP referrals forfurther management of people's conditions, as appropriate.

This is in order to comply with Regulation 4- Welfare of users of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standards(HSCS) which state that 'my care and support meets my needs and is right for me' (HSCS 1.19).

4. By the 23rd December 2022 the provider must ensure that the home is clean and free from avoidable intrusive smells.

To do this the provider must as a minimum ensure:

a) that the source of the unpleasant smell in the activity room is identified and eradicated.

b) that all equipment, including bath chairs, are kept clean and hygienic.

This is in order to comply with Regulation 4 - Welfare of users of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that 'My environment is relaxed, peaceful and free from avoidable and intrusive noise and smells'. (HSCS 5.18).

Areas for improvement

1. People should be encouraged to participate in activities of daily living if they are able to and they choose to do so.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that 'I get the most out of life because the people and organisation who support and care for me have an enabling attitude and believe in my potential' (HSCS 1.6)

How good is our leadership? 2 - Weak

We evaluated this key area as weak as we found significant weaknesses in quality assurance processes which outweighed any strengths that we seen.

We saw that there were some systems in place to monitor aspects of service delivery however we found that they did not indicate clearly what actions had been taken by the service when issues had been found during the auditing process. Many areas of service delivery were not audited and were needed to ensure that health monitoring for people was up to date and accurate. For example, audits would capture if weight monitoring was kept up to date. The poor quality and lack of audits meant that we could not evidence that standards of good practice were being adhered to by staff. (see requirement one)

We saw no evidence of staff practice being observed and monitored by the management team. We suggested to the management team that it might be helpful to conduct spot checks to ensure that staff are providing the best quality of care to people. This would be a useful tool to help staff reflect on their

practice and to develop their skills. Without these checks we could not be sure that staff had the appropriate skills and knowledge to deliver good quality care to people.

We looked at the services developmental plan however we did not find that it was detailed enough to evidence that there had been any impact from any changes to service delivery. We could therefore not be sure that the management team was to identify risks or weaknesses in the service and drive improvement.

We found that there was no evaluation of people's experience of living within the home. This would be useful in terms of directing the improvement plan and ensuring that people's views were heard by management. We also thought that it would helpful if both staff and people living within the home were encouraged to participate in auditing aspects of service delivery. For example, ensuring that PPE stations were replenished or conducting surveys of residents views and wishes. This meant that the service could do more to improve feedback and learning to improve practice. (see area for improvement one).

Requirements

1. By the 23rd December the provider must have maintained a robust quality assurance system.

In order to do this they must provide:

a) systems that audit healthcare issues, including but not exclusive to bowel movements, weights, wounds,and falls risk

b) records of spot checks of the environment

c) records of spot checks of staff practice

d) a SMART action plan to address any deficits or issues identified.

This is necessary in order to comply with Regulation 3 of the Social Work and Social Care Improvement Scotland Regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that ' I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

Areas for improvement

1. The provider should ensure that people are given opportunities to share their views and to be involved in decision making about their care and support. This should include evaluation of people's dining experience, activities and support from carers.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS)which state that ' my views will always be sought and my choices respected, including when I have reduced capacity to fully make my own decisions.' (HSCS 2.11)

How good is our staff team? 2 - Weak

We evaluated this area as weak as we found that there were significant weakness in practice which outweighed strengths and indicated that staffing arrangements were not working as well as they could.

We found that staff were recruited in a way that was informed by all aspects of the safer recruitment guidance. Staff did not commence employment until all the pre-employment checks were completed. Staff complied with the Social Services Council (SSSC) registration process within the first six months of employment. The issuing of contracts and roles and responsibility had been made a previous area for improvement was seen to have been improved.

The service had three care staff on overnight and three care staff on during the day along with ancillary staff, management and on some days the activity coordinator. We observed that staff did not spend a lot of time interacting with people during the day. Some of the time that we were in the service there were one or two staff present in the dining room/sitting room and this was usually at mealtimes. Other times there were periods when no staff were present in the communal areas. At the time of inspection the service was not operating at full capacity as it had vacancies for carers. This means that staff were having to cover extra shifts and this could lead to staff becoming less effective in their role due to tiredness. We observed that some staff were better at interacting with residents than others and this meant that there was a lack of consistency in good quality care being delivered to people.

We found that the service had a dependency assessment which is a tool used to ensure that the right number of staff are deployed in the service and we were given assurances by the management team that this tool accurately reflected the number of staff needed in the service. However, we found that there did not appear to be the right number of staff with the right skills working at times to meet people's needs. This meant that staff were not deployed effectively and efficiently to meet people's needs. We have required the service to address this. (see requirement one)

We found evidence that management held meetings with staff and these meetings were used to share information. However, there was little evidence of staff contributing positively to this process by sharing good practice or making suggestions which would improve processes and help staff work more effectively.

This meant that opportunities to learn and improve practice were missed and that there was a need to support staff development to improve outcomes for people living within the home.

Requirements

1. By the 23rd December the provider must ensure that the skills mix, number and deployment of staff meets the needs of people.

In order to do this they must provide:

a) evidence of staff arrangements which allow for more than basic care needs to be met and which supportpeople to get the most out of life.

b) evidence that staff help each other by being flexible in response to changing situations to ensure careand support is consistent and stable.

This is necessary to comply with regulation 4 of the social care and social work Improvement Scotland (Requirements for Care Services) regulations 2011.

This is to ensure that care and support is consistent with the Health and Social Care Standard which states that 'people have time to support and care for me and to speak with me' (HSCS 3.16) and 'I am confident that people respond promptly, including when I ask for help' (HSCS 3.17)

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The provider should demonstrate that people who share bedrooms have their rights to choice promoted and protected. The provider was asked to consider plans for the longer term use of shared bedrooms and possible improvements to laundry facilities.

This ensures care and support is consistent with the Health and Social Care Standards, which state, as an adult living in a care home, I have my own bedroom that meets my needs but can choose to live with and share a bedroom with my partner, relative or close friend. (HSCS 5.26) My environment is relaxed and free from avoidable and intrusive noise and smells. (HSCS 5.18).

This area for improvement was made on 18 July 2019.

Action taken since then

The shared bedrooms are now single occupancy rooms except one bedroom which is shared by two residents who are happy with the current arrangement. The manager has stated that in the future the shared rooms will be used for single occupancy unless a couple are admitted to the home and wish to share a room. The area for improvement has been met.

Previous area for improvement 2

The service provider should ensure that they implement robust and thorough recruitment procedures in accordance with current best practice for example, the Scottish Government's national guidance Safer Recruitment Through Better Recruitment.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) 4.24 which states, 'I am confident that people who support and care for me have been appropriately and safely recruited'.

Improvements should include evidence of:

- letters of offer to staff
- issuing staff contracts
- terms and conditions of employment- staff roles and responsibilities.

This area for improvement was made on 18 July 2019.

Action taken since then

The recruitment process has been improved and there is evidence of staff being given letters of offers, contracts, terms and conditions and an outline of their role in the service. This area for improvement has been met.

Complaints

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

Detailed evaluations

How well do we support people's wellbeing?	2 - Weak
1.1 People experience compassion, dignity and respect	2 - Weak
1.2 People get the most out of life	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	2 - Weak
1.4 People experience meaningful contact that meets their outcomes, needs and wishes	3 - Adequate
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	3 - Adequate

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	2 - Weak
3.1 Staff have been recruited well	4 - Good
3.3 Staffing arrangements are right and staff work well together	2 - Weak

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WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP AUDIT AND PERFORMANCE COMMITTEE

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

15 November 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 report and the updated action plan (Appendix1)

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, 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 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 scrutinised (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. **Complete.**

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. **Complete.**

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

Revised processes have been developed 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 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 are now 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. Overall, there has been continuous improvement in the services ability to track children's plans and to consider internal solutions to ensuring Plans are not further delayed. There remains ongoing challenges in respect of staffing resources, however overtime, mentoring, support and training have been used to mitigate the impact of ongoing staffing challenges to make progress in outstanding permanency plans.

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

The introduction of an independent chair has demonstrated an ability to provide external scrutiny and decision making independent from the service, across our permanence and adoption panels. This follows the agreement and financial support for a two year period for an independent chair within this domain. We have put measures in place to evaluate the impact that this is making.

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

There have been two panel development sessions that have taken place. These have largely been welcomed and has provided an opportunity for panel members to contribute to the overall development of this formal process. Additionally, there has been a further recruitment drive where we have managed to secure four extra panel members. These new members are currently going through a process of induction with the support of the new chairperson and senior managers. A robust process of induction has been agreed and

staff/volunteers are helped to navigate their way through the parameters of the panel, enabling them to be gradually built up towards them becoming established panel members, who can focus on reaching positive recommendations for the children in which they are supporting in this process.

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 chairing arrangement are being progressed to ensure oversight and scrutiny on children's planning processes. Two year funding agreement has been reached for four independent reviewing officers to be established across our LAAC processes.

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

The reporting of LAC data from Care First is under development, in the interim a single spreadsheet has been developed to ensure all LAAC children and their Looked after reviews are being tracked.

Further quality assurance and oversight is being developed with the appointment of 4 independent review officers to ensure children receive rights based services, their views are heard and their plans delivered within agreed timescales.

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.

8. Financial and Procurement Implications

8.1 Additional budget from reserves approved at June 2022 IJB and posts approved by WDC in September 2022.

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. A further inspection of the service has been advised by the Care inspectorate and commences on 26th October.

10 Equalities Impact Assessment (EIA)

10.1 There is no requirement to undertake and equalities impact assessment

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 Note Content of this report.

Name	Lesley James
Designation	Head of Children's Health, Care and Justice Services Chief Social Work Officer
Date	11th October 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 19/10/22

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 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 are scheduled on a monthly basis to monitor and track permanence which are 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 take place monthly that address monitoring of drift and delay. Colleagues from Legal Department contribute to these meetings. Permanence Tracking Review Meeting are solution focussed and discuss problems moving forward. Identified concerns are provided with a timescale of review to reduce further drift will be provided, reducing drift. Additional resourcing to be identified Business object report has been set up from Care first which reflects progression around drift and 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. Aims and objectives have been 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**	**30/4/22**	**amber** Imporvement Planning sessions.d	In February 2022 a meeting took place with Care First regarding the gathering of data and how best to make use of Care First systems. We are continuing to identifying gaps in data and progressing forwards to using the system more effectively. Staff have continued to work alongside care first team to realise this plan.

	This will provide a significant emphasis on the oversight arrangements for managers.	**Kathy Currie** **Senior Social Worker** **Adoption** **Monica Bristow** **Senior Social Worker** **Fostering** **Care First**		TRAINING LOG.docx	CAREFIRST appraisal has taken place in respect of gathering the right data set. Staff were in attendance at the Care Inspectorate planning sessions, between the 24th May to 24th June 2022. Training records and opportunities have been provided to carers. The Family Placement Team have continued to make themselves available to support development of fieldwork services social workers. Staff within the Adoption Service have completed and CAPR reports and supported fieldwork services social workers to complete parenting assessments. The Senior Social workers across the Family Placement team and fieldwork services are responsible for ensuring the reports submitted to the Adoption Panel are good quality to ensure Panel members are able to make informed decisions for children's' plans.
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	**Lesley James, Chief Social Work Officer**	**30/4/22**	**Green**	Funding was agreed to identify Independent Chair's for Fostering & Permanence Panels. An independent Chair has been in place since June 2022 on a 2 year contract. This is proving to be positive in supporting the demands of the Service that were not being met and providing additional quality assurance. Funding for two years has been approved for employment of four Independent Chair's for LAAC Review and Foster Carer Reviews. These

	reaching this outcome. Findings of these will be reported back to the Head of Service for financial consideration.				posts have been through job evaluation and progressing to advert in September/October 2022.
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.	**Paul Kyle, Senior Manager (LAAC)** **Clinical & Care Governance**	**30/04/2022**	**Amber**	Procedures 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

	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.				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.
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	**Paul Kyle** **Mark Mulvenna Team Leader Under 12's** **Scott Barclay, Team Leader Under 12's** **Elaine Kelly, Youth Services**	**30/04/2022**	**Amber** Imporvement Planning sessions.d	Cases have been identified for external audit using the Care Inspection Audit Tool. The identified Auditor has been unable to complete this, therefore, these case have been redistributed among the senior management team. A Manager has been identified to review and develop our LAAC processes and procedures. These should be concluded in October. Meeting with Admin Support to ensure that moving forward every LAAC Review has a minute taken to ensure an accurate record of the meeting. This has been in place from May 2022. Every looked after child and their adopters will have a copy of their care plan. Staff have been provided with training opportunities which have included Child's Adoption & Permanence Report training and additional training dates have been identified for Brothers and sisters training along with

	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.				report writing. 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. Four training sessions have been concluded across the council with two additional manager sessions being built in. Additional training sessions to be rolled out, including Education, health and third sector stake holders. All children with a LAAC & CP background have been linked to the Viewpoint APP. Allowing each child the opportunity to have their say through this platform. A view point sub group has been established to explore recording children's time in foster care by means of photographs and documentation such as nursey report, certificates etc. Business support arrangements reviewed an agreed systems of tracking and minuting 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**	**Green**	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**	**Green**	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**	**Green**  LAAC & Perm Process May 21 A3.v  PERMANENCE PLANNING FLOW CH	The adoption team will be part of the monthly meetings working alongside legal services as part of solution focused discussions. The adoption team manager attends and contributes at the PRTM and is able to identify children whose permanence plans are drifting. In terms of individual children their families a worker, within the family placement team, is identified to assist in monitoring the progression children's plans. The Family Placement Team continue to support the requirement in completing child's reports in a timeous fashion, including the identification of suitable staff to complete identified pieces of work. Support to staff to enable them to undertake identified assessments in a timely manner. Staff supervision to support and identify gaps in learning. The legal advice meetings are being chaired by Fieldwork Services Team Leaders. Additional training around this has been sought and in November 2022 there will be input by Association of Fostering, Kinship and Adoption Scotland around the chairing of such meetings. This will help reduce drift and delay ensure they are sighted which will link to the LAAC and permanence process. Monthly management meetings across the Team Lead Group will assist to strengthen the communication across the service areas.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
AUDIT AND PERFORMANCE COMMITTEE

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

15 November 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 progress and the content of this report including the action plan (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 two further sweep up sessions in November. Daytime and evening online sessions have been developed to support the many demands on carers. All carers will be trained in this area by November 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 on keeping the focus of young people at the centre. Work is underway to consider the current structure and resource alignment and this feedback will be further considered in any service redesign. The current structure of over 12s and under 12s teams remains, however it is anticipated that this will feature in the work of our 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. This is an area that we will need to keep in scope and can be a part of any LAAC data, set out against our renewed/updated procedures.

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 are now be responsible for the Chairing of the Legal Advice Meeting. Additional training and mentoring around this area should provide extra confidence and will ensure management oversight at a much earlier stage than was previously carried out for those children who may require permanency away from home.

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.

Funding for two years has been approved for employment of four Independent Reviewing Officers to Chair LAAC Reviews to ensure all plans are reviewed timeously. These posts have been through job evaluation, SRRG and will be subject to formal job advertisement in Sept/Oct 2022.

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.

6.5 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 implemented and independent scrutiny has commenced 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 IJB approved Independent Reviewing Co-ordinators for all our looked after children will significantly enhance the scrutiny around children's plans to ensure these plans are progressed timeously and delay minimised. Improvement in ensuring parents and children's views are visible and considered to ensure services are rights based and families participate in decision making is required.

Quarterly reports will be produced by the independent chairs on a range of measure to strengthen oversight and quality assurance

6.6 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 – 4.6

The service has reinstated minute taking for all review meetings which had been reduced during the pandemic. Evidence and recording of decision making around any child in care is a statutory requirement. The approved funding for our independent reviewing officers will enhance this position significantly, providing a level of independent scrutiny that has not been afforded to these procedures in the past. Additionally, the support and training provided around Viewpoint will enhance our ability to record our engagement with children and young people more proficiently.

6.7 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 staff on the fostering website. Each carer now has access to an electronic version of the carers handbook and with the support in gaining laptops for all carers this has enabled us to communicate and update processes more efficiently.

6.8 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 – 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, this will be presented to HSCP Senior Management Team in October 2022.

Continuing Care Training has been identified for Foster Carers, which is taking place in October 2022.

7. People Implications

7.1 In order to strengthen scrutiny, management oversight and collaborative leadership, additional fixed term posts have been agreed and job evaluated and approved by IJB and the council. 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 integrated children's services planning and the work across the Community Planning Partnership.
- An independent Chair of Fostering and Adoption Panel
- Senior Manager for children's services to add capacity to management oversight and improvement.

8. Financial and Procurement Implications

8.1 Addition: budget was approved by the IJB on a 2 year basis in June 2022 and agreed by council in September 2022

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. A further inspection by the care inspectorate of fostering and Adoption services has been announced and will take place on 26th October 2022

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.

14. Directions

14.1 Note content of this Report

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

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

Fostering Improvement Plan – updated 26/09/22

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** **Monica Bristow Senior SW (Fostering) Family Placement Team** **Clair Strain McCafferty Supervising SW, Family Placement Team**	**30/04/2022**	**Green**	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	**Monica Bristow Senior SW (Fostering) Family Placement Team** **Clair Strain McCafferty Supervising SW** **Audrey McPhail, Supervising SW**	**Completed 27/01/2022** **Completed 29/04/2022** **Completed 29/04/2022** **Schedule Complete**	**Green** Child Protection Training.pptx Foster Carer Training Record.do	Discussion at Quarterly Meeting 26th & 27th January 2022 re requirement of training and CP in particularly following inspection. Chromebooks provided to all foster carers to enable them to access virtual training. CP training programme developed by Family Placement Team and attached. 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. Minutes attached.

	accommodate carer's needs. Training to move to mandatory for all carers and will be evaluated at each foster care review beyond April 2022 and a record of training to be established for each carer. To be co-ordinated around the yearly FC review.		**30/04/2022**	Training Letter Carers.doc Foster Carer have your say minutes.do CP Training Evaluation AH.docx Child%20Protection%20Training%20Eva Child Protection Training Evaluation	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. Both Attached Online CP training identified via Kate Cairns, offered as an alternative to virtual/face to face group training to take account of different learning styles. All carers have either completed the CP training or are attending our sweep up sessions in November. A sample of evaluation forms attached.
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.	**Monica Bristow Senior SW (Fostering) Family Placement Team** **Audrey McPhail Supervising SW, Family Placement Team** **Jean Cameron, Team Leader**	**Completed & Email out to all Foster Carers 29/04/22**	**Green** FOSTER CARERS HANDBOOK MARCH	Fostering Handbook reviewed, reduced and updated. Final draft quality assured by Team Leader. 29/04/22 Fostering Handbook emailed out to all carers with CP procedures within in.

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**	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.	**Mark Mulvenna Team Leader Under 12's** **Scott Barclay, Team Leader Under 12's** **Elaine Kelly, Youth Services** **Kathy Currie, Senior SW (Permanence) Family Placement Team**	**30/04/2022**	 Clydebank (Scott's Team) Permanence A  Vale (Mark's Team) Permanence April 2  Over 12's and CWD (Elaine's Team) per	Permanence Tracking Business object report has been set up from Care first to provide information on children's permanence plans to identify drift and delay. This has been shared with Team Leaders across the service to enable the plans to be reviewed. Permanence Tracking Review Meeting are scheduled on a monthly basis reviewing and monitoring those children in need of permanent fostering. These are chaired by the Senior managers. Funding has been secured for an Independent Fostering and Adoption Panel Chair who is now in post from June 2022. Funding for two year has been approved for employment of four Independent Reviewing Officers to Chair LAAC Reviews to ensure all plans are reviewed timeously. These post have been through job evaluation and at advanced stages of being moved forward. Following SSRG input these are now progressing towards Advert – Sept/oct. 2022.

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.	**Mark Mulvenna Team Leader Under 12's** **Scott Barclay, Team Leader Under 12's** **Elaine Kelly, Youth Services** **Kathy Currie, Senior SW (Permanence) Family Placement Team**	**30/04/2022**	**Amber**  LAAC & Perm Process May 21.vsdx	Business object report has been set up from Care first which will identify any drift in delay. Permanence Tracking and Review Meetings are taking place monthly and address drift and delay. Colleagues from Legal Department will contribute to meetings. Those children with lengthy delays have been identified and plans put in place to move these on. However the current situation with reduced staffing levels across the services is having a negative impact on this. Permanence Tracking Review Meeting will be solution focussed and discuss problems moving forward, a timescale of review will be provided reducing drift. There has been an acknowledgement that resource and staffing implications continue to be problematic in addressing this. Training workshops have been set up from Oct. 2022 to support staff with report writing skills (CAPR).
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.	**Mark Mulvenna Team Leader Under 12's** **Scott Barclay, Team Leader Under 12's** **Elaine Kelly, Youth Services** **Kathy Currie, Senior SW (Permanence) Family Placement Team**	**30/04/2022**	**Amber**	Permanence Tracking Review Meetings will monitor and review assessments in line with timescales. As above these meetings are taking place monthly.

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**	Young people will be able to remain in their existing placements beyond 18 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) Decide how best to assess, train and approve foster carers as adult placement carers.	Training around provision for young adults within Foster care and residential care will be considered by this work stream starting June 2022	**Monica Bristow , Senior SW (Fostering) Family Placement Team** **Family Placement Team** **Jean Cameron, Team Leader** **Paul Kyle,** **Senior Manager LAAC Services**	**30/04/2022**	**Amber**	Seeking Social Work Scotland assistance in comparing other local authorities practice. Continuing Care Training has been identified via the Fostering Training hub and will take place on the 3rd October 2022. Following the training we plan to offer a Continuing Care Support Group for carers.
b) How best to assess young people to ensure that continuing care is in their best interests.	Working group to be re-established to generate policy/guidance documents and create training requirements across the staff and carers groups. Working Group to be implemented.	**Elaine Kelly, Team Leader Youth Services** **Jean Cameron, Team Leader**	**30/04/2022**	**Amber**  continuing-care-an d-the-welfare-asses	Advice and guidance has been sought from Care Inspectorate (Moira Blain). The attached guidance will be used to adapt assessments to ensure that young people have an assessment taking account of continuing care. Training to be rolled out to support staff and carers in this area. A Manager has been identified to review and develop our Continuing Care Policy to be rolled out.

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.	**Lesley James, Chief Social Work Officer** **Jean Cameron, Team Leader** **Monica Bristow, Senior SW (Fostering) Family Placement Team**	**30/04/2022**	 Guidance CC 2019.pdf	Advice and guidance has been sought from Care Inspectorate (Moira Blain). The attached guidance highlights the need for care inspectorate registration for Continuing Care/Adult Placement Service. Jean Cameron Team Leader has been liaising with Care Inspectorate regarding this. As above a Manager has been identified to review and further develop out Continuing Care Policy to be rolled out. Jean Cameron liaising in with Care Inspectorate to register the service as an Adult Placement Provider.

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** **Monica Bristow , Senior SW (Fostering) Family Placement Team** **Family Placement Team**	**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.	**Monica Bristow , Senior SW (Fostering) Family Placement Team** **Family Placement Team**	**Completed 31/03/22 Updated 29/04/22**	 Child Friendly Version FOSTERING  Aims of the Service.docx	These were completed 31/3/22 and updated in line with Continuing Care Service 29/04/22 These have been distributed to all social work staff, foster carers and adopters. These will be added to the West Dunbartonshire HSCP website.
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 fostering team has commenced, with local systems being re-aligned and updated where required. This will provide a significant emphasis on the oversight arrangements for managers. 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,	**Lesley James, Chief Social Work Officer** **Paul Kyle, Senior Manager (LAAC)** **Monica Bristow , Senior SW (Fostering) Family Placement Team** **Kathy Currie, Senior SW (Permanence) Family Placement Team** **Care First Team** **Eric Brown Independent Auditor**	**31/04/22**	Amber  Improvement Planning Session W	We are liaising 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. We are also liaising with our residential services regarding the systems they use. Funding has been secured for an Independent Fostering and Adoption Panel Chair who is now in post providing independent scrutiny for our panels. Funding for two years has been approved for employment of four Independent Reviewing Officers to Chair LAAC Reviews to ensure all plans are reviewed timeously. These post have been through job evaluation and at advanced stages of being moved forward. Progressed to recruitment/advertising Sept/Oct 2022 following successful agreement at SRRG. Eric Brown Independent Auditor had been completing audits across children's services using the Care Inspection Audit Tool. This was not completed and the identified files have

	with formal links have been made with other council's to consider models and approaches to reaching this outcome.				been allocated to mangers across the service for review. Care Inspectorate have delivered Improvement Planning Session from 24th May to 24th June 2022. Staff across the service have attended these.
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.	**Lesley James, Chief Social Work Officer**	**31/04/22**		Funding has been secured for an Independent Fostering and Adoption Panel Chair who is now in post providing independent scrutiny for our panels. Funding for two years has been approved for employment of four Independent Reviewing Officers to Chair LAAC Reviews to ensure all plans are reviewed timeously. These post have been through job evaluation and at advanced stages of being moved forward. Progressing to advert - as noted above.

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. Every child in foster carer will be sent an up to date 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.
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.	**Lesley James, Chief Social Work Officer.** **Mark Mulvenna Team Leader Under 12's** **Scott Barclay, Team Leader Under 12's** **Elaine Kelly, Youth Services** **Monica Bristow, Senior SW (Fostering) Family Placement Team** **Admin Support**	**31/04/22**		Every child in foster carer will be sent 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. Meeting with Admin Support to ensure that moving forward every LAAC Review has a minute taken to ensure an accurate record of the meeting. This has been in place from May 2022. Cases have been identified for external audit using the Care Inspection Audit Tool. The identified Auditor has been unable to complete this, therefore, these case have been

	This will allow us to consider areas surrounding care plans, the LAAC processes, the child's voice and oversight of the processes that surround this. An evaluation of the business support model is required to meet the expectations surrounding the recording of associated meetings and reviews.	**Jean Cameron, Team Leader** **Eric Brown Independent Auditor**			redistributed among the senior management team. A Manager has been identified to review and develop our LAAC processes and procedures. These should be concluded in October 2022.
b) The role of the fostering service is well articulated in the plan.	To be addressed via the reviewed and improved LAAC Processes and Procedures.	**LAAC Review Chairperson** **Social Worker's Children & Families**	**31/04/22**	LAAC Part 2 Carer-GLASGOW.doc New Foster Care Report for LA Revie Aberdeenshire Council LAAC Repo	To assist with foster carer contribution at LAAC reviews and within the child's plan, there is a proposal for Foster Carer to complete Reports for LAAC Review. Scoping with other local authorities has taken place are examples attached. This proposed paperwork will be part of a larger scoping exercise around LAAC paperwork generally in preparation for Independent Chair's commencing. A Manager has been identified to review and develop our LAAC processes and procedures and these should be concluded in October.
c) A copy of the Child's Plan and any updates are received by foster carers.	To be addressed via the reviewed and improved LAAC Processes and Procedures.	**Mark Mulvenna Team Leader Under 12's** **Scott Barclay, Team Leader Under 12's** **Elaine Kelly, Youth Services**	**31/04/22**	**Amber**	Every foster carer will be sent 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.

		Monica Bristow, Senior SW (Fostering) Family Placement Team **Admin Support**			A Scoping exercise is underway to ensure that this is now happening. This will also be explored through the auditing of cases.
d) The format of the Child's Plan is accessible to children in foster care who wish a copy.	To be addressed via the reviewed and improved LAAC Processes and Procedures.	**Allocated Social Workers** **(Working group re format of plans?)**	**31/04/22**		The format of plans has not been adapted as yet, however, all children will have a copy of their plan. IT issues have arose and we have overcome these. The format of plans will be further updated in line with our new LAAC processes and procedures in October.
e) The views of children and carers is contained within the minutes of planning meetings.	To be addressed via the reviewed and improved LAAC Processes and Procedures.	**LAAC Review Chairperson** **Social Worker's Children & Families** **Admin taking the Minute**	**31/04/22**	.	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. There have been 5 sessions in total delivered, 3 directly to social work staff and 2 for managers. There will also be a sweep up session to ensure all staff are aware of Viewpoint and how to use this effectively. This has also be linked to the Champion's Board. Every child with LAAC status has a live Viewpoint account and staff can enable children to access this when gathering views.
f) Appropriate independent scrutiny is in place to ensure professional challenge to the	The findings of the working group will be presented to SMT via a management report, highlighting current provision and any challenges noted to allow	**Lesley James, Chief Social Work Officer.**	**31/04/22**		Funding has been secured for an Independent Fostering and Adoption Panel Chair who is now in post. Funding for two year has been approved for employment of four Independent Reviewing

service aimed at improving practice.	appropriate scrutiny across the service to take place.				Officers to Chair LAAC Reviews to ensure all plans are reviewed timeously. These post have been through job evaluation and at advanced stages of being moved forward. Progressing to advert as noted.