Agenda

West Dunbartonshire
Health & Social Care Partnership

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

Date:	Tuesday, 20 June 2023
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 – Tom Reid

Date of Issue: 13 June 2023

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, 20 JUNE 2023

1 STATEMENT BY CHAIR – AUDIO STREAMING

2 APOLOGIES

3 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.

4 RECORDING OF VOTES

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

5 (a) MINUTES OF PREVIOUS MEETING **7 - 10**

Submit for approval, as a correct record, the Minutes of Meeting of the Health and Social Care Partnership Board Audit and Performance Committee held on 14 February 2023.

(b) ROLLING ACTION LIST **11 - 13**

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

6 MSK PHYSIOTHERAPY SERVICE ANNUAL REPORT 2022/23 **15 - 35**

Submit report by Helen Little, MSK Physiotherapy Manager presenting the Annual Report for MSK Physiotherapy service (Greater Glasgow and Clyde) 2022/23.

7 ANNUAL PERFORMANCE REPORT **To Follow**

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

8 AUDIT PLAN PROGRESS REPORT 37 - 53

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

9 REVIEW OF CIPFA FINANCIAL MANAGEMENT CODE 55 - 76

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

10 AUDIT ANNUAL REPORT AND ASSURANCE STATEMENT FOR 2022-23 77 - 84

Submit report by Andi Priestman, Chief Internal Auditor regarding the above.

11 REVIEW OF THE LOCAL CODE AND DRAFT ANNUAL GOVERNANCE STATEMENT 85 - 111

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

12 DRAFT UNAUDITED ANNUAL ACCOUNTS AND REPORT To Follow

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

13 INTERNAL AUDIT ANNUAL STRATEGY AND PLAN 2023-2024 113 - 121

Submit report by Andi Priestman, Chief Internal Auditor providing the indicative Internal Audit Strategy and Plan for 2023-2024 to Audit Committee for approval.

14 ACCOUNTS COMMISSION REPORT – INTEGRATION JOINT BOARDS FINANCIAL ANALYSIS 2021/22 123 - 146

Submit report by Julie Slavin, Chief Financial Officer presenting, for information, the recently published Accounts Commission report – Integration Joint Boards Financial Analysis 2021/22.

15/

15 COMMUNITY PLANNING PARTNERSHIP'S JOINT INSPECTION OF CHILDREN AND YOUNG PEOPLE AT RISK OF HARM IN WEST DUNBARTONSHIRE **147 - 207**

Submit report by Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Worker providing information on the progress of the Community Planning Partnership's Joint Inspection of children and young people at risk of harm in West Dunbartonshire.

16 INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE **Verbal**

Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Worker will provide a verbal update on the improvement work undertaken in response to the inspection of Adoption Service in West Dunbartonshire.

17 INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE **Verbal**

Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Worker will provide a verbal update on the improvement work undertaken in response to the inspection of Fostering Service in West Dunbartonshire.

18 CARE INSPECTORATE INSPECTION REPORT FOR AN OLDER PEOPLE'S CARE HOMES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE **209 - 264**

Submit report by Val Tierney, Chief Nurse providing an update on Care Inspectorate inspection reports for three independent sector residential older peoples' Care Homes located within West Dunbartonshire.

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, 14 February 2023 at 1.05 p.m.

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

Attending: Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Margaret-Jane Cardno, Head of Strategy and Transformation; 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, Head of Health and Community Care; Val Tierney, Chief Nurse; Andi Priestman, Chief Internal Auditor; Nigel Ettles, Principal Solicitor; Carol-Ann Burns, Senior Democratic Services Officer and Ashley MacIntyre and Nicola Moorcroft, Committee Officers.

Also Attending: Tom Reid, Audit Director, Mazars.

Apologies: Apologies for absence were intimated on behalf of Lesley Rousselet, NHS Greater Glasgow and Clyde Health Authority and Michelle McGinty, West Dunbartonshire Council.

Rona Sweeney in the Chair

STATEMENT BY CHAIR

Rona Sweeney, Chair advised that the meeting was being audio streamed and broadcast live to the internet and would be available for playback.

DECLARATIONS OF INTEREST

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

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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 15 November 2022 were submitted and approved as a correct record.

ROLLING ACTION LIST

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

AUDIT PLAN PROGRESS REPORT

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

After discussion regarding overtime, opt-out agreements and income data and having heard the Chief Internal Auditor, Chief Financial Officer, Head of Health and Community Care and Head of Strategy and Transformation in further explanation of the report and in answer to Members' questions, the Committee agreed to note the progress made in relation to the Internal Audit Annual Plan for 2022/23.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) QUARTERLY PERFORMANCE REPORT 2022/23 QUARTER THREE

A report was submitted 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.

After discussion regarding the primary care team, delayed discharges, MSK, unpaid carers and looked after children and having heard the Head of Strategy and Transformation, Head of Service for Mental Health, Addictions and Learning Disabilities, Head of Health and Community Care and Head of Children's Health, Care and Justice Services and Chief Social Work Officer 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 Three and performance against the Strategic Plan 2019 - 2023 by exception;

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

(3) to note that Quarter Two information previously unavailable to the Committee was contained within the report.

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

2022/23 ANNUAL ACCOUNTS AUDIT PROCESS

A report was submitted by Julie Slavin, Chief Financial Officer providing an overview of the process for the preparation of the 2022/23 Annual Accounts of the HSCP Board identifying legislative requirements and key stages.

Having heard the Chief Financial Officer in further explanation of the report, the Committee agreed:-

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

(2) to approve that due to the Audit and Performance meeting schedule, External Audit's draft 2022/23 Annual Audit Plan would be presented to the 15 March HSCP Board for consideration.

INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE

A report was submitted by Lesley James, Head of Children's Health, Care and Justice Services and Chief Social Worker providing an update on the improvement work undertaken in response to the inspection of Fostering Service in West Dunbartonshire.

After discussion regarding the grading scale, expectations and next steps and having heard the Head of Children's Health, Care and Justice Services and Chief Social Work Officer in further explanation of the report and in answer to Members' questions, the Committee agreed:-

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

(2) to note the requirements and improvements that have been asked of the service following the short notice announced inspection that was completed in November 2022.

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CARE INSPECTORATE INSPECTION REPORTS FOR CROSSLET HOUSE WITHIN OLDER PEOPLE'S CARE HOME AND DAY CARE SERVICES OPERATED BY WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

A report was submitted by Fiona Taylor, Head of Health and Community Care providing information regarding the most recent inspection report for Crosslet House.

Having heard Val Tierney, Chief Nurse in further explanation of the report, the Committee agreed to note the contents of the report.

Martin Rooney commented on the positive report and wished to note thanks to everyone involved.

REVIEW OF TERMS OF REFERENCE OF THE AUDIT AND PERFORMANCE COMMITTEE

A report was submitted by Julie Slavin, Chief Financial Officer providing a revised Terms of Reference (ToR) of the Audit and Performance Committee following a recent scheduled review.

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

(1) to note the updated CIPFA guidance for audit committees;

(2) to agree the changes to the current Terms of Reference of the Audit and Performance Committee; and

(3) to remit the updated Terms of Reference of the Audit and Performance Committee to the HSCP Board for final approval, recognising that the Audit and Performance Committee is a formal committee of the Board.

The meeting closed at 3.00 p.m.

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WEST DUNBARTONSHIRE HSCP AUDIT AND PERFORMANCE COMMITTEE
ROLLING ACTION LIST

Agenda Item	Decision/ Minuted Action	Responsible Officer	Timescale	Progress/ Update/ Outcome	Status
2021/22 LOCAL CODE OF GOOD GOVERNANCE AND GOVERNANCE STATEMENT	Initial due dates and revised due dates to be made visible.	Julie Slavin	June 2023	The 2022/23 Local Code Review will incorporate any initial and revised dates. June 2023 APC meeting - Refer to Item x on this agenda that addresses this action.	Recommend Close
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	Ongoing	The action plan is being progressed, supported by Joint Inspection Development Sessions	Open
AUDIT PLAN PROGRESS REPORT	Martin Rooney questioned the expected date of 31/03/26 against “Sustainability of Services” after some discussion it was requested by Rona that the 3 projects to be		Ongoing	The progress of the 3 Service Redesign Reviews are progressing. The Financial Performance Report will track the progress made on	Open

	separated and a detailed timeline for each to be brought to a future meeting of the Committee (standard format required): (1) Care at Home (2) Learning Disability (3) Children and Families	 Fiona Taylor Sylvia Chatfield Lesley James		savings attached to these reviews. The Chief Officer will agree a timescale with the Chair and Vice Chair.	
WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) QUARTERLY PERFORMANCE REPORT 2022/23 QUARTER THREE	Discussion required regarding the reporting of quarterly data – continue with current reporting format or revert to previous reporting format? Complaints data – further information to be provided on the context/ any themes around complaints partially upheld. For stage 1 complaints closed within timescale it notes that accurate recording is in development, what is the timescale for this to be provided?	Margaret-Jane Cardno Margaret-Jane Cardno Margaret-Jane Cardno	Timescales tbc?		Open

	Confirmation required regarding exception reports tolerance level. Positive destination data to be compared to the national measure and shared with Committee Members via email. MSK Physio – Rona asked about the impact of filling vacancies/additional staff regarding the WT trajectory.	Lesley James Helen Little		Beth thinks this is covered in the MSK cover report to the 21 Feb Board. If not then this needs to be taken forward as an action.	
INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE	Relate any additional findings and actions arising from the inspection to the plan that we have been monitoring (last seen on 15.11.2022) or to outline for members how the existing actions will address the points noted in the most recent report if no additional actions are deemed necessary.	Lesley James	Timescale tbc?	See report on this June agenda	Open

Item 6

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
Audit and Performance Committee

Report by Musculoskeletal Physiotherapy Service and
Helen Little MSK Physiotherapy Manager GGC

20 June 2023

Subject: **Annual Report for Musculoskeletal Physiotherapy Service (MSK) 2022/23**

1. Purpose

1.1 To present the Annual Report for Musculoskeletal (MSK) Physiotherapy service (Greater Glasgow and Clyde) 2022/23.

2. Recommendations

2.1 It is recommended that the Audit and Performance Committee:

(i) Note the content of the report; and
(ii) Note the achievements of the MSK service in regards to performance, priority project work, patient feedback and involvement, use of data and work on digital enhancement within the MSK service.

3. Background

3.1 This paper presents the Annual Report for MSK Physiotherapy Service for 2022/23 which can be found at Appendix 1 of this report. The paper is not meant to be representative of all the work that was carried out within the service but represents the key performance areas and priority project work during the period when still remobilising following the Covid 19 pandemic.

4. Main Issues

4.1 The paper presents an overview of service performance data from 2022/23. This includes waiting times data; impact data (including patient reported outcome measures and patient experience and impact data from Advanced Practice Physiotherapists within GP practice). The priority projects presented reflect the service priorities for that period. The Scottish Government waiting times target for AHP MSK services is that 90% of patients should be seen within 4 weeks of referral. For clarity some current MSK performance information is bulleted below:

- Since March 22 the total number of patients waiting for an appointment has decreased from 17,151 patients to 13,540 patients (and for a routine appointment from 15,743 patients to 11,552 patients).

- Since March 22 the maximum routine wait has decreased from 24 weeks to 12 weeks.
- Since Mar 22 the average waiting time (in days) has reduced from 76 days to 44 days.
- At present the MSK service ensures that all urgent patients are seen within the 4 week target. Work continues to address the routine waiting list as until the routine waiting times are closer to the 4 week target the proportion seen within 4 weeks will not significantly change.

4.2 The paper provides an overview of the 6 priority objectives and associated priority project work within the service. The 6 priority objectives were waiting times; Recruitment and Retention; Staff wellbeing; Introduction of Electronic Patient Records/Active Clinical Notes; Streamlining MSK Pathways of Care and Training, Education and Staff Development. A brief overview is provided for each project. Hyperlinks are included to provide more detail on any particular project, including stakeholder feedback.

5. Options Appraisal

5.1 None required.

6. People Implications

6.1 No implications.

7. Financial and Procurement Implications

7.1 No implications.

8. Risk Analysis

8.1 Performance Management has been identified by the HSCP Board as a strategic risk. The presentation of this annual report mitigates against this risk by providing an opportunity for the Committee to review and scrutinise performance management information in relation to the MSK service. 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 its organisational responsibilities.

9. Equalities Impact Assessment (EIA)

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

10. Environmental Sustainability

10.1 N/A

11. Consultation

11.1 This report has been completed in consultation with MSK Physiotherapy Extended Management Team and with support of MSK Practice Development staff.

12. Strategic Assessment

12.1 On 15 March 2023 the HSCP Board approved its Strategic Plan 2023-26 “Improving Lives Together”. The Plan outlines sustained challenge and change within health and social care. These changes bring with them a host of governance implications: cultural, operational, structural, ethical and clinical. Good governance, which includes performance management, is essential to ensure the actions within the Strategic Plan are implemented effectively and efficiently in a way which promotes safe and effective care whilst achieving best value.

13. Directions

13.1 No Directions are required for this report.

Name	Dr Helen Little
Designation	MSK Physiotherapy Manager Greater Glasgow and Clyde
Date	20 June 2023

Person to Contact	Dr Helen Little
Appendices:	Appendix 1: Annual Report for Musculoskeletal Physiotherapy Service 2022/23.
Background Papers	None

Introduction

Welcome to our Musculoskeletal (MSK) Physiotherapy annual report which covers the period from April 2022 to March 2023.

MSK conditions continue to have a major impact on people's lives. It is one of the leading causes of time off work and more years are lived with an MSK disability than any other condition. The MSK Physiotherapy Service continues to provide a person-centred approach where each person is individually assessed and their bespoke care is focused on symptom management, movement, exercise and supported self-management. As we help patients to recover and return to normal activities, we also encourage them to take up more active and healthy lifestyles. In addition we focus on health improvement and support patients who have wider health needs (e.g. who require support on issues such as alcohol, smoking, weight management, stress management) by signposting to appropriate services.

Our report provides a brief overview of the main areas of focus over the last year, namely:

- Service performance: data on demand/activity and waiting times.
- Impact data: Patient reported outcomes measures and patient reported experience.
- Impact data: Success of Advanced Practice Physiotherapists within Primary Care.
- Brief summary of 6 key priority projects.
- MSK Digital strategy.

We believe that our report provides an overview of some of the key areas of work and successes within the MSK service over the last year and that the data presented within our report reflects the amount of work that goes into ensuring that our MSK service is “Fit for the Future, fit for life”.

Section 1: A year in data.

MSK Service Performance: priority project work
There has been a huge focus on service performance over the period, in particular with a priority project to reduce both routine waiting times and the number of patients waiting for a routine appointment (both of which increased over 2021/22 due to redeployment of staff to support the pandemic effort). The data for 22/23 shows a downward trend in both maximum routine waiting times and number of patients waiting for a routine appointment in 2022/23 (see Table 1 and Graph 2 below). Between April 22 and March 23 the wait for a routine appointment halved, reducing by 12 weeks (from 24 weeks to 12 weeks). There were 3,611 less patients waiting for a routine appointment over the period (reducing from 17,151 in April 22 to 13,540 end of March 23).

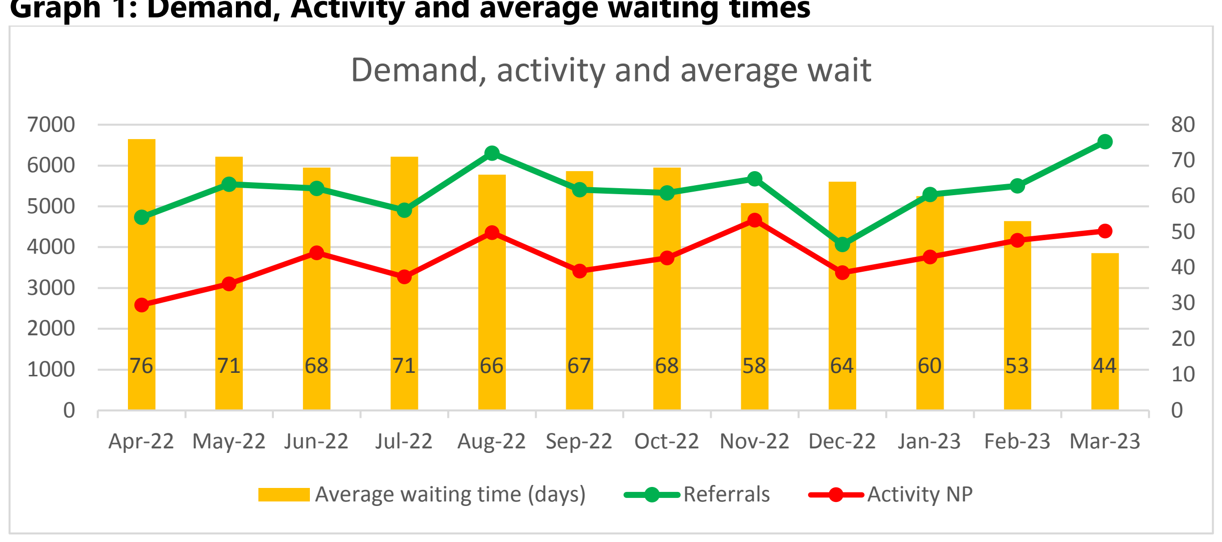
MSK performance data demonstrated within Section 1.1 of the report. Data collected from patients in regard to their treatment outcome and experience of the MSK service is presented within Section 1.2 and Section 1.3 provides data on the success of Advanced Practice Physiotherapists within GP practice.

1.1 Referral rate; activity and average waiting times.

1.1.1 Referrals and Demand

Demand for the MSK service has generally risen in 2022/23 compared to the two previous years when referral rates were extraordinarily low due to the pandemic. The service received 65,017 referrals in 2022/23 (c/f 61,877 referrals in 2021/22). The referral rate was consistently between 5 - 5.5 thousand referrals per month (other than the usual seasonal dip in December). In March 23 the referrals peaked at 6,584 for the month (see green line on Graph 1. below).

Graph 1: Demand, Activity and average waiting times



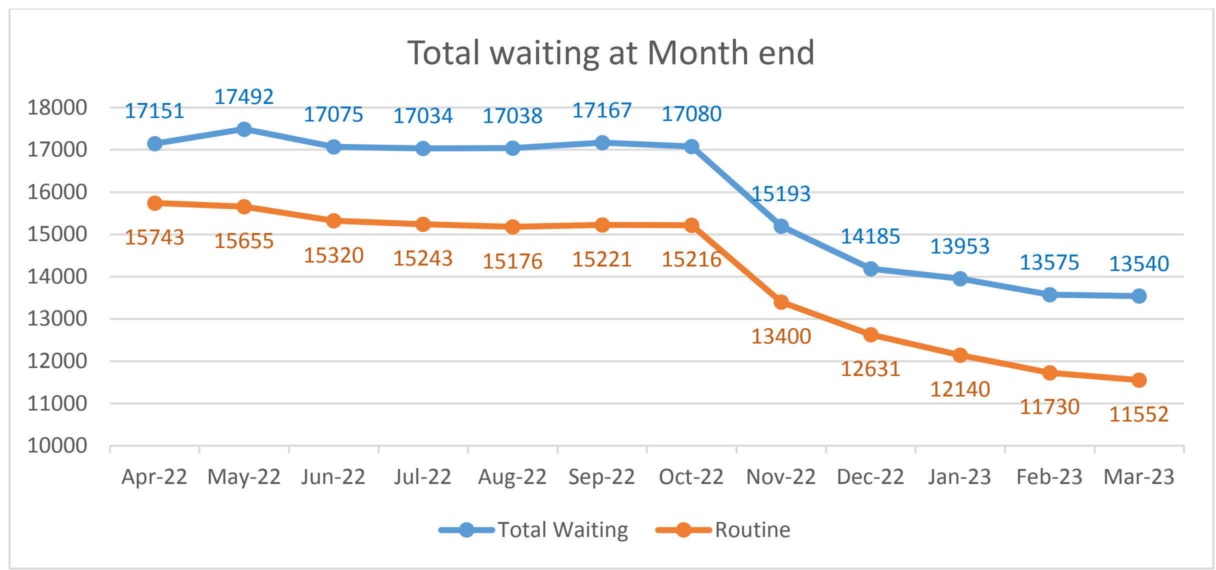
The above graph and Table 1 below show the downward trend in waiting times in 2022/23. The maximum wait for a routine appointment reduced from 24 weeks to 12 weeks.

Table 1: Demand, Activity and data showing reduction in max waiting times

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Referrals	4731	5544	5439	4906	6300	5404	5326	5671	4062	5288	5501	6584
Activity NP	2584	3104	3863	3272	4354	3417	3734	4662	3375	3763	4170	4395
Waiting time in w	24	22	20	20	20	20	20	16	17	17	16	12

There was also a downward trend in the number of patients waiting on an appointment over 2022/23. Graph 2 below illustrates the reduction in total number of patients waiting as well as the reduction over 2022/23 of those waiting for a routine appointment. The impact of the priority project work which commenced in Sep 22 can be clearly seen on the graph.

Graph 2: Monthly total number of patients waiting for an appointment



1.1.2 Service Capacity and Activity

New patient (NP) activity levels within 2022/23 demonstrate a general upward trend (see red line within Graph 1). There were 15,067 more new patient appointments in 2023/23 compared to the previous year (57,316 NPs in 2022/23 compared to 42,249 NPs in 2020/21). This is reflective of the ongoing focus on recruitment of MSK staff and ongoing remobilisation of service provision. Recruitment is a national problem for the profession and for MSK services within other national health boards. A priority project (see section 2.2 below) has improved vacancy levels within the service but

recruitment of experienced MSK staff at Band 6 level still remains a challenge. This is primarily due to movement of staff into promoted posts as Advanced Practice Physiotherapists (APPs) within GP practice (see section 1.3 below for APP impact data). At end March 2023 there were 6 vacant MSK Band 6 posts across the Board area.

Sickness absence has also impacted on capacity throughout 2022/23. Prior to the pandemic sickness absence rates within MSK service were rarely over the 4% target. However during 2023 sickness absence rates between August 22- Mar 23 were constantly over the 4% target (ranging from 4.04% in September to a high of 7.84% in Jan 23). The service employed agency staff to address waiting times but maximum benefit from agency staff was impacted due to the need to absorb caseloads of staff on long term sickness absence.

Accommodation challenges across several MSK sites have also detrimentally impacted on service capacity and the ability to provide the best rehabilitation environment for our patients. This has primarily been due to other services taking over MSK space during the pandemic and a delay in getting bespoke MSK rehabilitation space returned to the service. To date there is one site where MSK space remains compromised. The service continues to work with Acute colleagues to resolve this issue.

1.1.3 Demand vs Capacity and impact on reduction of waiting times

The gap between the red and green lines on Graph 1 demonstrates that the referral rate (demand) continues to be higher than New Patient (NP) capacity. This, as well as the backlog of patients waiting for a routine appointment (following periods of staff redeployment during the pandemic) has meant that addressing waiting times has been an ongoing challenge. This resulted in the start of a priority project to reduce routine waiting times (see section 2.1).

The gap between demand and capacity is not as great as the data suggests as a variable proportion of patients referred routinely to the service do not ‘opt in’ at the time of appointment offer. However, there is still a challenge around demand continuing to exceed capacity, which limits ability to address the backlog of patients waiting for a routine appointment.

1.2 Impact data: Patient Reported Outcomes and Experience of the MSK service.

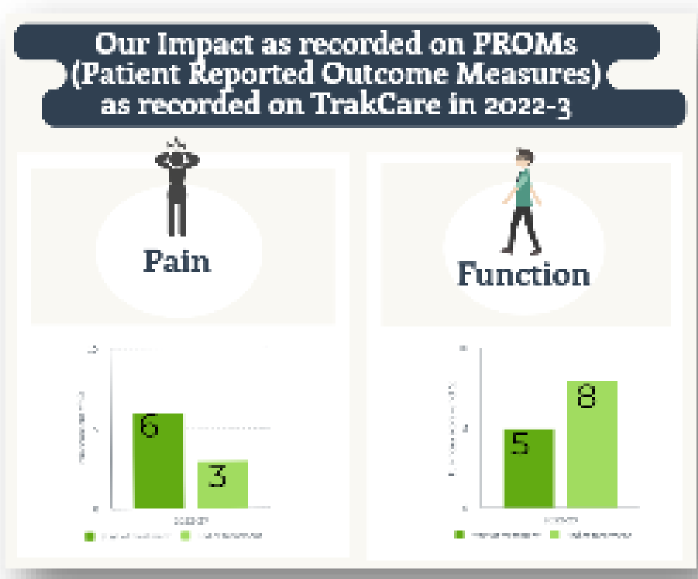
Patient Reported Outcome Measures (PROMS) using validated tools are gathered routinely after a course of treatment. The MSK service collects PROMS across the 4 quadrant areas. This is to demonstrate impact of care, quality of care and provide assurance around equity of clinical care across all areas. The results over the years have indicated real consistency within the MSK Physiotherapy service with very similar quantitative outcome data across the wide geographical area (see hyperlink below).

There have been historical challenges in completion rate of PROMs over the years. The main issues impacting completion has been staff turnover, staff remembering to ask the relevant questions and the covid pandemic (when the service was primarily delivered virtually). Despite these challenges, the service has continued to produce the same consistent paired scores in relation to reducing pain, increasing function and successful return to work status over several years.

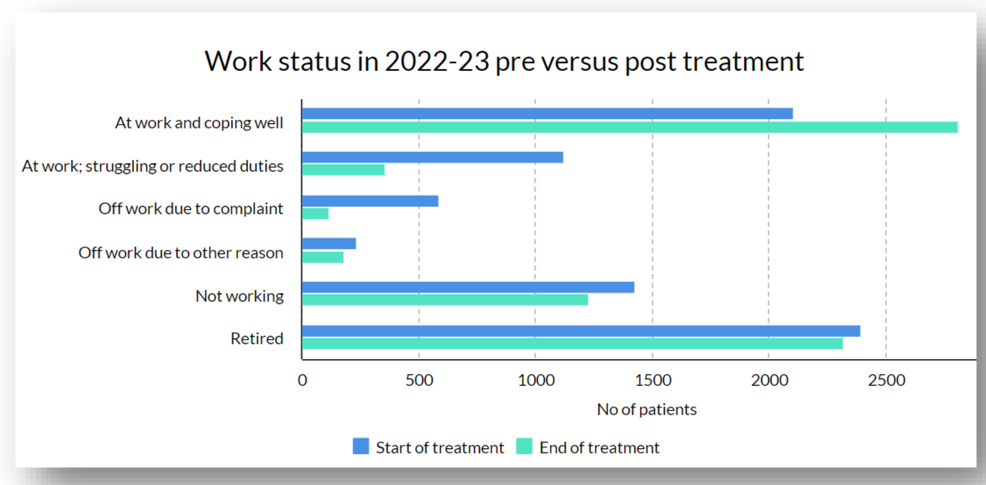
There has been a significant increase in the completion of PROMs in 2022/23. This is related to the MSK Physiotherapy service transitioning to Digital Clinical Records/Active Clinical Notes (ACN) and the embedding of the PROMs within the ACN (see graph within hyperlink). There was a sharp increase in completion rate between July and November 23 which correlated with the incremental roll out of ACN across the Board area. For full details please click on this hyperlink MSK physiotherapy PROMs.

A snapshot of 2022/23 data are presented in the infographics 1 and 2 below and demonstrate the reduction of pain (from a score of 6 to 3); improvement in function(from a score of 5 to 8) and successful return to work as a result of MSK service intervention (infographic 2).

Infographic 1: PROMs of pre and post physiotherapy, Pain and Function 2022/23



Infographic 2: Work status pre and post physiotherapy



Before the pandemic each staff member collected 25 Patient Reported Experience Measures (PREMS) using the CARE measure. This gave us over 3000 PREMS each year. We were unable to use this paper based method due to pandemic restrictions and a virtual method of gathering feedback was developed.

In the past year, all patients were invited to feed back on their 'experience' of the service through a webropol survey link (included in any email communication) and

through a QR code in departmental posters. On some sites admin staff supported patients with this.

Patients were asked about a range of aspects of care and their overall recommendation. In 2022/23, 119 patients responded. The feedback was very posiitve and a summary of their feedback is presented here.

Due to low numbers of patients providing feedback this is an area of improvement for 2023/24. The service has plans to increase the opportunities for patient feedback now that the pandemic is over and service provision is back to primarily face to face consultation.

Infographic 3: Patient Reported Experience of MSK Physiotherapy

Did they feel confident in the physio's ability to assess and treat them effectively?

97%

said YES

Did they receive as much information as they wanted about their condition?

94%

said YES

1.3 Impact data: Patient Reported outcome and experience for Advanced Practice Physiotherapists within GP practice

Advanced Practice Physiotherapists (APPs) were recruited to support GP practices as part of the Multidisciplinary team within the Primary Care Improvement Plan. This was with a view to releasing GP time and providing expert and timely MSK advice for patients.

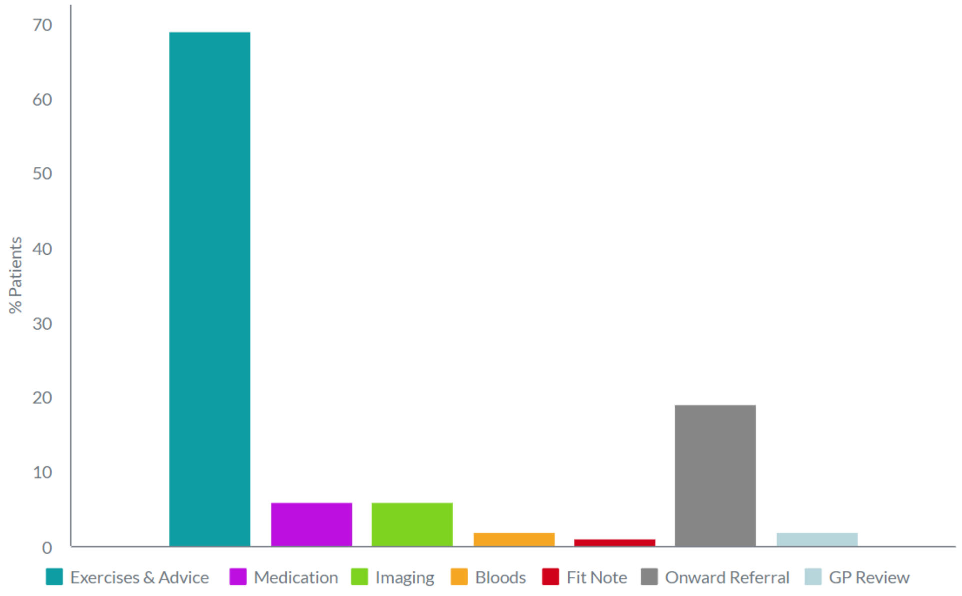
There are now almost 30wte APPs in GP practices across GGC (covering 44% of the GGC population). The resource was based on the recommended national model of one whole time equivalent APP per 16 -18,000 head of population. In 2022/23, APPs provided 58,582 new patient appointments across GGC (an increase of 8177 appointments on 2021/22). Impact data from the Board area can be accessed via this hyperlink https://create.piktochart.com/output/61132847-nhsggc-app-in-primary-care-activity-report-mar22-apr23

Impact data shows that:

63% of patients had not seen a GP prior to their APP appointment, demonstrating the release of GP time spent on MSK consultations. The remaining 37% of patients were directed to the APP via the GP.

Over 79% of patients attending an APP were supported to 'self manage' their MSK condition with exercises and advice. Please refer to the infographics below.

Infographic 4: What happened when patient attended GP APP?



2.0 Key Priority Objectives

Despite the challenges of remobilisation post pandemic, the service had a year of success with regards to delivering 6 priority objectives. The service priority objectives were:

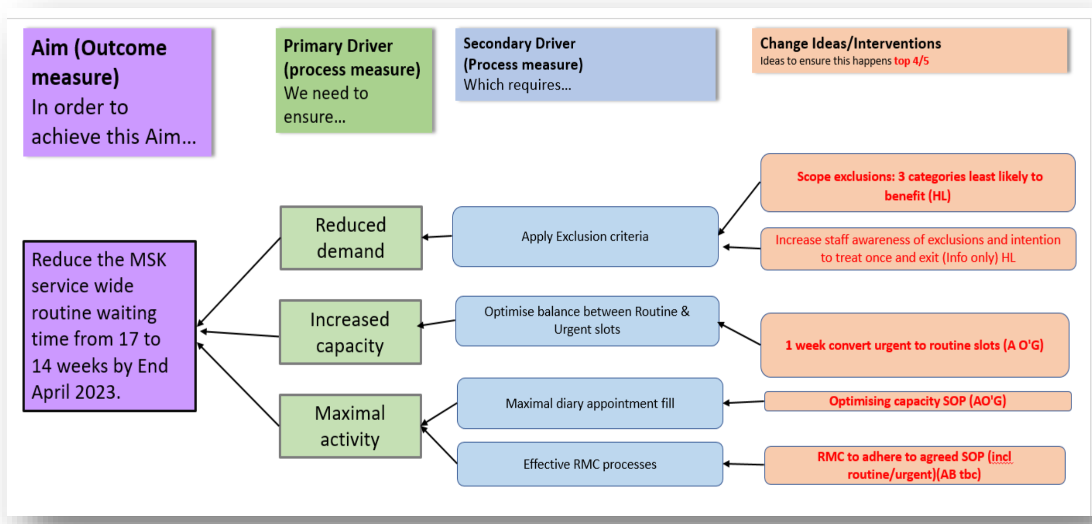
- Waiting times
- Recruitment and Retention
- Staff wellbeing
- Introduction of Electronic Patient Records/Active Clinical Notes.
- Streamlining MSK Pathways of Care and shared decision making for patients with OA of Hip/Knee.
- Training, education and staff development towards best patient care.

A short summary of each project is presented below.

2.1 Waiting times

The waiting times data has been presented within Section 1.1. This section presents the Priority Project work which went towards reduction in routine waiting times from a maximum wait of 24 weeks in April 2022 to 12 weeks by end of March 23. Quality Improvement methodology was used within the project work. The driver diagram for the project work is within Infographic 4 below.

Infographic 5: Driver diagram demonstrating Quality Improvement Approach to waiting times project.



The service over- achieved on the aim of reducing the waiting times by 2 weeks (achieved 12 week max wait rather than 14 weeks at end March 23). There were 2 key tests of change over the period (with another 2 planned for 2023/24). Firstly, over 2 separate weeks (end November and end Feb) the service converted all new urgent appointments to routine appointments to support those patients waiting longest. This successfully reduced the waiting times by 2 weeks (Nov) and 3 weeks (Feb) although it should be acknowledged that variation in waiting times are multifactorial. Secondly, the service introduced a Standard Operating Procedure to maximise efficiency. This involves local admin staff merging any two unutilised return slots in clinician's diaries and converting to new patient slots. The increase in new patient availability is being measured and this created an additional 179 New Patient (NP) appointments in Feb 23 and 273 NPs appointments in March. The service is scoping out 2 further service change ideas for 23/24. These will include further work to ensure that Referral Management Centre do not book urgent referrals into routine NP appointment slots (as this reduces routine availability and impacts on patients waiting longer for assessment). The service is also currently scoping out the number of patients on active caseloads where MSK service is unlikely to be of benefit according to the evidence base. This is with a view to focussing service provision on those patients with true MSK need and thereby likely to be helped by MSK input.

2.2 Staff recruitment and retention.

The aim of this priority project was to fill vacancies within our core MSK Service and thereby increase capacity. Recruitment is an issue for the profession nationally. Vacancies have arisen for a variety of reasons including the impact of Primary Care Improvement Programme (PCIP) and associated movement of staff into Advanced Practice Physiotherapy posts in GP practice. There is also a national shortage of graduates and historical natural movement and staff turnover within GGC MSK service.

Within the Musculoskeletal service we have seen over 30 wte GP Advanced Practice physiotherapists employed as part of PCIP (and similar promotional opportunities have been provided by other health boards). The large majority of these staff have moved internally within the MSK service. This left both a promotional opportunity staff at Band 6 level (for Band 5 staff), but also a lack of experienced Band 6 staff (see also section 2.6 below) and vacancies at Band 5 level. In order to attract staff into vacant posts a recruitment video https://youtu.be/Z2N8vQWlF_8 and website Careers in MSK Physiotherapy - NHSGGC were developed. The recruitment video was sent to all universities within UK and Ireland, targeting students/graduates, in particular to attract MSC graduates (on 2 year course). The service has subsequently been successful in recruiting to all band 5 vacant posts. Most applicants have been MSC graduates, with some recruits relocating from England to take up posts. The service will need to continue with targeted recruitment within HEIs yearly to support workforce planning.

2.3 Staff wellbeing

The service recognises that staff wellbeing is essential in delivering the high quality care we aspire to. The wellbeing of all staff in our MSK service has been an important consideration for several years now and we focus our efforts through the well-established Wellbeing steering group. The service aim is to maintain a focus on staff wellbeing and a working culture that supports it.

The annual half day wellbeing event was held in the Beardmore conference centre in December 2022 and attended by over 80 staff. The keynote presentations delivered by Helen Little (MSK Physiotherapy Service Manager) and James Docherty (Violence Reduction Unit) concerned the topic of Adverse Childhood Experiences (ACEs) and their impact. These was followed by physically active breakout sessions.

The Wellbeing session evaluated well**:**

- 98% rated the event “excellent” or “very good”.

- 100% would recommend it to colleagues.
- All breakout sessions rated above 85%.
- New Taekwondo and Broadway Boogie breakout sessions rated over 95%.

In response to the topic of ACEs, the service is liaising with Consultant psychologist Dr Ross Turner on how to ensure that we are a 'Trauma informed workplace' and have included NES introductory material 'opening doors' in our regular service newsletter.

Each staff group has representation on the Wellbeing Steering group who meet 6 times a year. Wellbeing is a standing item on local agendas and all are encouraged to bring suggestions and act locally to enhance wellbeing. The regular service newsletter always contains up to date wellbeing resources and shares good practice related to the 5 steps to wellbeing that we use as a guide.

We seek regular weekly feedback from the extended management team (EMT) about the functioning of the meeting and more in-depth feedback about the overall functioning of the team. As a result we have commissioned the Kinharvie Institute to work with us on maximising the functioning of the EMT.

Staff wellbeing at all levels in our service is important and continues to be one of the service priorities.

2.4 Introduction of Electronic Patient Records/Active Clinical Notes (EPR/ACN)

The MSK service is the first nationally to have successfully introduced Electronic Patient Records known as Active Clinical Notes (ACN) across the Board area. The rollout of ACN was completed by December 2022. This innovation has allowed a reduction in transfer of clinical records between sites and provides accessibility of MSK Physiotherapy record to all Trak users (including Emergency Department and MSK Physiotherapy staff providing second opinions or support from different sites). It has also helped with record standardisation, patient reported outcome measure reporting (see section 1.2 above), financial savings (printing and notes storage costs) and provision of copy of records for Health Records Legal Department (reduction in time delay and cost due to previously needing to recall records from storage).

The use of Digital Records is in keeping with our digital strategy (see section 3 below) and also meets previous Ombudsman requirements which recommended that MSK notes be accessible to other health care professionals within the organisation.

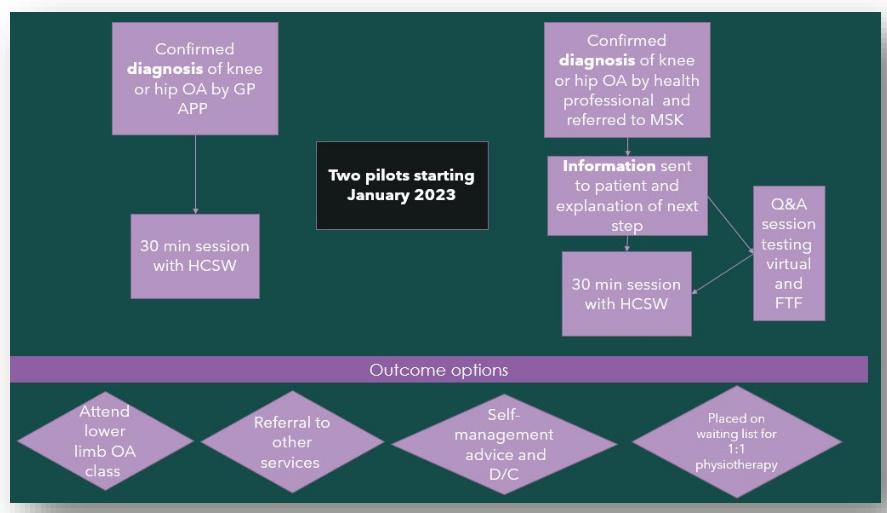
Work is ongoing to ensure best practice and reporting of data (in liaison with Business Intelligence colleagues).

2.5 Streamlining Pathways (<u>and shared decision making for patients with Hip or knee OA)</u>.

The MSK service is seeking to improve the care options for patients referred into the service with either hip or knee osteoarthritis. These new pathway options are underpinned with the principles of realistic medicine, shared decision making, right person right time and aligns with national and international clinical guidelines.

The project has two stages. The first stage was to ascertain how many patients would have their care options improved by the new pathways. Early audit suggests in the region of 13% of MSK patients would be impacted by this change.

The next stage is to design pathways to ensure sustainable effective and safe care whilst maximising the resources available. This led to the introduction of two pilots, detailed below.



These pilots are ongoing with evaluation including feedback from both patients and Health Care Support Workers. Initial results will be ready at end of June and any further adaptations made to the pathways prior to rolling out across GG&C.

A wider piece of work across primary care, MSK and orthopaedics is underway to design a 'decision support tool' for patients with Osteoarthritis. We have involved the help of a PhD student to design this tool following input from both patients and healthcare professionals.

A further initiative is underway to modernise our pathways and improve efficiency for our patients by maximising the use of our Advanced practitioners. The service is currently conducting a 6-month pilot to evaluate direct referral from GP APP staff in Primary care to our low back pain Advanced Practice Physiotherapists within MSK.

2.6 Training, Education and staff development towards best patient care

The aims of this project were to establish an educational plan to meet the needs of clinicians and service now and in the future and to be able to define a core package of training resources for all staff with a focus on NES pillar of clinical practice.

A focused training plan was required to allow a greater understanding of the return on investment from staff training. Patients are presenting with more complex and multiple co-morbidities and the service needs to ensure that staff have the skills and knowledge to effectively assess and manage this patient group. This is especially required given the movement of experienced Band 6 staff into roles within Primary Care (see section 1.3)

A scoping exercise was carried out amongst staff to establish current skills and knowledge and identify gaps and training requirements. This was stratified against the banding and to the current profile of patient most commonly accessing the service. This has resulted in development of a framework that represents a sliding scale of recommended training for MSK physiotherapy staff which will be tested with a view to implementing in May 2023. The framework will be monitored to see how many times it is accessed by staff and the survey repeated in 2024 to establish any change in skills and knowledge amongst staff.

This will be a continuous process to ensure staff continue to have the right skills and knowledge to support our patients. Almost £40k was invested in staff training within 2022/23 from reserves budget.

3.0 MSK Digital Strategy

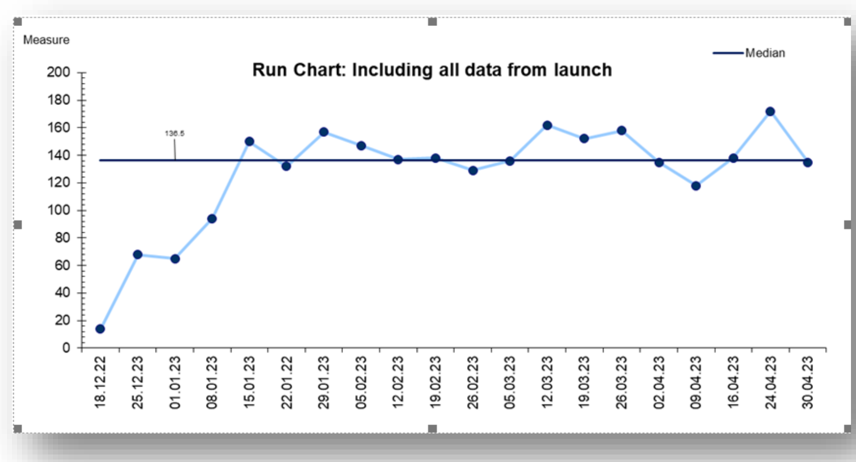
The use of Digital technology has become much more of a normal part of our service delivery in recent years and is a common thread running through the majority of work plans we have progressed through this period.

Our Digital Steering Group for our service oversee our digital projects and this is recorded within the MSK Digital Strategy. This gives an overview of our current digital projects, but is also a place to articulate our future digital ambitions.

The main digital based projects during 22-23 are as follows:

- Electronic Patient Records – see section 2.4 above.
- Virtual Patient Management (VPM) – The service has continued to look at ways to ensure we offer patients a choice of VPM where appropriate, to allow optimal patient choice and also improve diary management between face to face and VPM consultations. The service has moved towards template rebuilds that allow all return appointments to be offered as either a face to face or telephone appointment, with the option of video available also.
- Electronic Self-Referral – The lack of electronic self-referral has been a consistent theme within patient feedback for some time. In December we launched our electronic self-referral form which is accessed through our updated website with uptake / use over the last 6 months gradually increasing. A run chart showing number of electronic self referrals is shown in Graph 3 below.

Graph 3: run chart showing number of electronic self referrals received weekly since launch



- Electronic Referral – the service continues to work on the best process for other specialities within GG&C to refer to us electronically as a preferred

route to current paper referrals. The main barrier is lack of electronic referral route back should we receive a referral that is inappropriate for our service, despite many conversations with eHealth. We hope to finalise and launch our process in 23-24.

- Website – Our public facing website continues to be updated to make sure all the information provided is current and evidence based making it a valuable self-management resource. A webinar was held in March to launch this to GP's to enable signposting to appropriate support self-management resource and with the option of electronic self-referral. Feedback received is that this is proving to be a valuable resource that other specialities are now using the MSK website to support their patients with MSK conditions.
- Netcall – An SBAR has been submitted to request that the service has use of Netcall to interact better with patients waiting on the routine waiting list. This would support patients to be fully informed and directed to appropriate self-management advice while they wait. Netcall also has potential to provide the service with more information from patients in the forms of PREMS and feedback. The service hopes this will progress in 23-24 but there has been some delay to date in this moving forward.
- Artificial Intelligence (AI) – The service is scoping out the possible use of AI to aid vetting of referrals and thereby free up clinical time currently spent in vetting. AI also has potential to direct patients through the best possible MSK Physiotherapy pathway. The service is currently working with the West of Scotland Centre for Innovation to progress the use of AI. The service continues to highlight to Scottish Government that a 'One for Scotland' approach would be preferred across all national MSK Physiotherapy services to provide a consistent point of access for patients with an MSK condition.

Conclusion

We believe that this summary report demonstrates the huge volume of quality work that has been carried out within the MSK service within the last year. We take pride in the amount of data that we collate and use towards best staff and patient care. The service continues to drive forward to ensure the best care for MSK patients.

Musculoskeletal Physiotherapy
Fit for the future, fit for life

Item 8

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Chief Internal Auditor

Audit and Performance Committee: 20 June 2023

Subject: Audit Plan Progress Report

1. Purpose

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

1.2 The report also presents an update on the Internal Audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow and Clyde (NHSGGC) since the Audit Committee meeting in February 2023 that may have an impact upon the WD HSCP Board's control environment.

2. Recommendations

2.1 It is recommended that the Audit and Performance Committee note the progress made in relation to the Internal Audit Annual Plan for 2022/23.

3. Background

3.1 In April 2022, the Audit and Performance Committee approved the Internal Audit Annual Plan which detailed the activity to be undertaken during 2022/23.

3.2 This report provides a summary to the Audit and Performance Committee of recent Internal Audit activity against the annual audit plan for 2022/23. A summary is also provided in relation to internal audit work undertaken at West Dunbartonshire Council and NHSGGC which may have an impact upon the WD HSCP Board's control environment.

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

4. Main Issues

4.1 The audit plan for 2022/23 is almost complete. One audit has been finalised in relation to IJB Response and Recovery Arrangements and the remaining audit is at fieldwork stage.

IJB Recovery and Response Arrangements

4.2 West Dunbartonshire Council is part of the Joint Civil Contingencies Service (CCS) hosted by Renfrewshire Council. The West Dunbartonshire Health & Social Care Partnership (WD HSCP) was included in the services provided by the CCS throughout the Pandemic.

4.3 From March 2021 changes to the Civil Contingencies Act 2004 made Integrated Joint Boards (IJB) Category One Responders with specific roles and responsibilities for those involved in emergency preparation and response at the local level.

4.4 The WD HSCP has in place a Business Continuity Plan to ensure that the essential health and social care needs of the population continue to be met in the event of failure or disruption to WD HSCP facilities or services.

4.5 The review focussed on the high level processes and procedures in place in relation to the HSCP Board's ability to fulfil its Category 1 responsibilities and to continue to deliver core business functions in the event of a major incident.

4.6 The objective of this audit was to provide the WD HSCP Board 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 IJB's recovery and response arrangements.

4.7 The overall control environment opinion was **Satisfactory**. Two Green issues were identified as follows:

Formalisation of business continuity management support from Civil Contingencies Service (Green)
From March 2021, IJBs became Category 1 Responders under the Civil Contingencies Act 2004. Discussions between the IJB and the Civil Contingencies Service provided by Renfrewshire Council have been taking place to revise the Business Continuity arrangements which are necessary to reflect this changes in responsibility. However, at the time of the audit this arrangement had not yet been formalised.

Provision of assurance to the Board on Business Continuity Arrangements (Green)
The audit identified that there is no specific reporting to the WD HSCP Board which provides assurance on the business continuity arrangements that are in place in relation to Category 1 responder status.

The provision of regular reporting on an annual basis would provide the WD HSCP Board with an appropriate level of assurance in relation to the Board's business continuity management arrangements.

4.8 The audit identified 2 issues and an action plan is in place to address both issues by 30 September 2023.

4.9 In relation to internal audit action plans, there were no actions due for completion by 30 April 2023. There are 3 current action points being progressed by officers. The current status report is set out at Appendix 1.

4.10 In relation to external audit action plans, there were no actions due for completion by 30 April 2023. There are 2 current actions which are being progressed by officers. The current status report is set out at Appendix 2.

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

West Dunbartonshire Council

4.12 Since the last IA Progress Report considered at the February meeting of the Audit and Performance Committee, there were 5 Internal Audit report issued to the Council which are relevant to the WD HSCP Board:

Report	**Control Environment Opinion**	**Grading of Issues**		
		Red	**Amber**	**Green**
Vehicle Tracking System (1)	Satisfactory	0	3	2
Financial Assessment Process (2)	Satisfactory	0	3	3
Corporate Purchase Cards (3)	Satisfactory	0	1	3
Corporate Procurement – Supplier Management (4)	Satisfactory	0	1	2
Occupational Therapy – Waiting Times (5)	Requires Improvement	1	2	0
	Total	**1**	**10**	**10**

(1) This risk-based audit review identified 3 Amber issues as follows:

- Lack of formal process for authorising user access to vehicle tracking system.
- Lack of tracking units in hired vehicles which impairs the ability of management to effectively monitor usage for the benefit of both management and the driver should an adverse driving event occur.
- Under-utilisation of vehicle tracking system reports and functionality.

(2) This risk-based review identified 3 Amber issues as follows:

- Due to a change in process for invoice processing on Carefirst, invoices were not issued to service users for the non-residential chargeable services between 6th June and 2nd September 2022. This was rectified immediately during the audit.
- There is no independent check of the financial assessment calculation by another officer for accuracy and completeness. In addition a copy of the supporting documentation is not retained for verification by another officer.

- The Audit highlighted that within the Adult Care Team and Community Older Peoples Team the annual review of Financial Assessments is not being carried out.

(3) This risk-based review identified one Amber issue as follows:

- A weekly report of all leavers generated from the Council's Workforce Management System is issued to the Finance Service Centre for action, however there is no checking process to ensure corporate purchase cards assigned to leavers have been cancelled.

(4) This risk-based review identified one Amber issue as follows:

- Through discussions with the HSCP Heads of Service it was identified that other than general monitoring of the financial costs of contracts, there is currently no formal contract and supplier management practiced in line with Council Guidance.

(5) This risk-based review identified one Red and two Amber issues as follows:

- Red - Due to a lack of capacity to manage the workload, the occupational therapy team is prioritising the high priority cases for assessment which has resulted in large backlogs for medium and low priority cases that require assessment. In addition, the medium and low priority cases are not being reassessed to ensure the priority has not changed.
- Amber – Due to a lack of capacity there is a significant backlog in blue badge applications which has significantly increased since October 2022 resulting in a significantly long waiting time for an assessment.
- Amber – management information relating to waiting times for occupational therapy is not being adequately monitored, actioned and reported.

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

NHS Greater Glasgow and Clyde

4.14 Since the last Audit Committee meeting in February 2023, there were 4 audits finalised which are relevant to the WD HSCP Board:

Audit Title	**Rating**	**Number and Priority of Issues**			
		4	**3**	**2**	**1**
Financial Systems Healthcheck (Payroll) (1)	Minor Improvement Required	-	1	4	-
Sustainability and Value Programme	Minor Improvement Required	-	-	2	-
Capital/Estates Planning – Neurological Science Project	Minor Improvement Required	-	-	2	1

Waiting List Management	Minor Improvement Required	-	-	2	-
Q4 Management Action Follow Up	N/A	N/A	N/A	N/A	N/A
Total		**-**	**1**	**10**	**1**

(1) The audit identified one key area for improvement relating to maintaining pace with current efforts to ensure line managers' adherence to eESS procedures for starters, leavers and payroll amendments. The audit also made a number of less significant recommendations concerning the strengthening of procedures and the elimination of paper forms, to make full use of the eESS system.

4.15 Internal Audit undertakes follow up work to confirm the implementation of recommendations. The results of this follow up work are reported to the NHSGGC Audit Committee with any matters of concern being drawn to the attention of this Committee.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Risk Analysis

7.1 The annual audit plan for 2022/23 was constructed taking cognisance of the risks included in the WD HSCP Board risk register. Consultation with the Chief Officer and the Chief Financial Officer was carried out to ensure that risks associated with delivering the strategic plan were considered.

8. Equalities Impact Assessment (EIA)

8.1 There are no issues.

9. Environmental Impact Assessment

9.1 There are no issues.

10. Consultation

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

11. Strategic Assessment

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

12. Directions

12.1 This report does not require a Direction.

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

Date: **25 May 2023**

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Appendices: Appendix 1 – Status of Internal Audit Action Plans at 30 April 2023
Appendix 2 – Status of External Audit Action Plans at 30 April 2023

Background Papers: Internal Audit Annual Audit Plan 2022-2023

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Appendix 1

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF INTERNAL AUDIT ACTION PLAN POINTS AT 30 APRIL 2023

Summary:

Section 1 **Summary of Management Actions due for completion by 30/04/2023**

There were no actions for completion by 30 April 2023.

Section 2 **Summary of Current Management Actions Plans at 30/04/2023**

At 30 April 2023 there were no audit reports delayed due to management not finalising the action plan within agreed timescales.

Section 3 **Current Management Actions at 30/04/2023**

At 30 April 2023 there were 3 current audit action points.

Section 4 **Analysis of Missed Deadlines**

At 30 April 2023 there was one audit action point where the agreed deadline had been missed.

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

SUMMARY OF MANAGEMENT ACTION PLANS DUE FOR COMPLETION BY 30.04.2023

SECTION 1

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

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

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

SUMMARY OF CURRENT MANAGEMENT ACTIONS AS AT 30.04.2023

SECTION 2

CURRENT ACTIONS

Month	No of actions
Due for completion September 2023	3
Total Actions	**3**

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

CURRENT MANAGEMENT ACTIONS AS AT 30.04.2023

SECTION 3

Action	Owner	Expected Date
Performance Management Arrangements (July 2022)		
Adequacy of Procedures/Guidance for Statutory Reporting Process (Green) 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 and Transformation**	**30 September 2023***
IJB Recovery and Response Arrangements (April 2023)		
Formalisation of Business Continuity Management Arrangements with CCS (Green) Management to finalise the arrangements for the provision of Civil Contingencies Services to the IJB and for the financial provision for the WD HSCP proportion of the costs involved.	**Head of Strategy and Transformation**	**30 September 2023**
Provision of Assurance to the Board on Business Continuity Arrangements (Green) As control improvement and example of good practice, management to consider presenting members with an annual Business Continuity Assurance Statement.	**Head of Strategy and Transformation**	**30 September 2023**

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

SECTION 4

Report	Action	Original Date	Revised Date	Management Comments
Performance Management Arrangements (July 2022)	**Adequacy of Procedures/Guidance for Statutory Reporting Process (Green)** 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.	**31.03.23**	**30.09.23**	Due to the high number of statutory reports produced this action is partially complete. It is anticipated that the action will be fully completed by 30 September 2023.

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Appendix 2

WEST DUNBARTONSHIRE HSCP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF EXTERNAL AUDIT ACTION PLAN POINTS AT 30 APRIL 2023

Summary:

Section 1 Summary of Management Actions due for completion by 30/04/2023

There were no actions due for completion by 30 April 2023.

One action with a completion date of 30 September 2023 has been reported as completed by management.

Section 2 Summary of Current Management Actions Plans at 30/04/2023

At 30 April 2023 there were no audit reports delayed due to management not finalising the action plan within agreed timescales.

Section 3 Current Management Actions at 30/04/2023

At 30 April 2023 there were 2 current audit action points.

Section 4 Analysis of Missed Deadlines

At 30 April 2023 there were no audit action points where the agreed deadline had been missed.

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

SUMMARY OF MANAGEMENT ACTION PLANS DUE FOR COMPLETION BY 30.04.2023

SECTION 1

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

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

There was one action with a completion date of 30 September 2023 which has been reported as completed by management:

Agreed Action	Status
2021/2022 Annual Audit Report (November 2022)	
PY 20/21 Review of Standing Orders 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.	The revised Standing Orders were approved at the WD HSCP Board meeting on 16 May 2023.

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

SUMMARY OF CURRENT MANAGEMENT ACTIONS AS AT 30.04.2023

SECTION 2

CURRENT ACTIONS

Month	No of actions
Due for completion September 2023	1
Due for completion March 2026	1
Total Actions	**2**

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

CURRENT MANAGEMENT ACTIONS AS AT 30.04.2023

SECTION 3

Action	Owner	Expected Date
2021/2022 Annual Audit Report (November 2022)		
PY 18/19 Best Value The HSCP has drafted a Quality Improvement Framework based on the public sector improvement framework. Once implemented this will support a formal review of Best Value arrangements. Update A meeting was held with Heads of Service on 11 January to consider the Audit Scotland BV self-evaluation template which was incorporated into the 2019/20 Annual Performance Report. This will be refreshed and used to demonstrate the how best value is supported within current structures and frameworks and identify where improvements can be made.	**Head of Strategy and Transformation**	**30.09.2023**
Sustainability of Services 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.	**Operational Heads of Service**	**31.03.2026**

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

SECTION 4

Report	Action	Original Date	Revised Date	Management Comments
There are no current actions which have missed the original due date.				

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by the Chief Financial Officer

20 June 2023

Subject: CIPFA FINANCIAL MANAGEMENT CODE

1. Purpose

1.1 To present and update the HSCP Board's Audit and Performance Committee on:

- The CIPFA Financial Management Code as it applies to all local government bodies, including Integration Joint Boards (IJB); and
- A self-assessment of compliance with recommended actions for improvement.

2. Recommendations

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

- Note the key principles and requirements of the CIPFA Financial Management Code; and
- Note the self-assessment of compliance and the actions to be progressed to support improvement.

3. Background

3.1 The challenging fiscal landscape has placed the finances of all public sector bodies under significant strain. While the HSCP SMT and Board work to streamline costs and transform services and their delivery, for these approaches to be successful it is crucial to have good financial management embedded as part of the organisation. Good financial management is an essential element of good governance and longer-term service planning, which are critical in ensuring that local service provision is sustainable.

3.2 CIPFA has published a Financial Management Code which is designed to support good practice in financial management and to assist local authority bodies in demonstrating their financial sustainability. It was anticipated that 2021/22 would be the first full year of compliance, however most local authorities deferred the self-assessment and identification of any improvement actions until this year and the preparation of the 2022/23 annual accounts and report.

4. Main Issues

4.1 The Financial Management Code is a series of financial management standards which set out the professional standards needed if an IJB (HSCP Board) is to meet the minimal standards of financial management acceptable to meet fiduciary duties to taxpayers and customers. Since these are minimum standards CIPFA's judgement is that compliance with them is obligatory if an IJB is to meet its statutory responsibility for sound financial administration. Beyond that, CIPFA members must comply with it as one of their professional obligations.

4.2 While CIPFA has provided leadership, the development of the Code recognises that self-regulation is the preferred response to potential financial management failures. To ensure that self-regulation is successful, compliance with the Code cannot rest with the CFO acting alone and therefore demonstrating compliance is a collective responsibility of IJB members, the CFO and professional colleagues in the leadership team.

4.3 The Code applies a principle-based approach (consistent with CIPFA's Delivering Good Governance in Local Government – "Local Code") that recognises the size, diversity and responsibilities of organisations across the public sector. It is for each organisation to determine what is right for them in order to comply.

4.4. There are six principles which are the benchmarks against which IJB's financial management practices should be assessed. The principles have been designed to focus on an approach that will assist in determining whether, in applying standards of financial management, the IJB is financially sustainable.

1. Organisational **leadership** – demonstrating a clear strategic direction based on a vision in which financial management is embedded into organisational culture.

2. **Accountability** – based on medium-term financial planning that drives the annual budget process supported by effective risk management, quality supporting data and whole life costs.

3. Financial management is undertaken with **transparency** at its core using consistent, meaningful and understandable data, reported frequently with evidence of periodic officer action and elected member decision making.

4. Adherence to professional **standards** is promoted by the leadership team and is evidenced.

5. Sources of **assurance** are recognised as an effective tool mainstreamed into financial management, including political scrutiny and the results of external audit, internal audit and inspection.

6. The long-term **sustainability** of local services is at the heart of all financial management processes and is evidenced by prudent use of public resources.

4.5 The six principles are translated into seventeen Financial Management (FM) Standards (denoted A-Q), which are set-out in more detail within Appendix 1. The Code expands and explains the requirements of the seventeen standards under seven sections and these form the structure of the self-assessment:

i. The responsibilities of the chief finance officer and leadership team.
ii. Governance and financial management style.
iii. Medium to long-term financial management.
iv. The annual budget.
v. Stakeholder engagement and business cases.
vi. Performance monitoring.
vii. External financial reporting.

4.6 The outcome of the self-assessment exercise is the IJB is compliant with the CIPFA Financial Management Code, with the detail attached at Appendix 2. The exercise also highlights some areas for development which reflect other assurance work undertaken by the Chief Financial Officer, Senior Management Team and Chief Internal Auditor as part of the preparation of the 2022/23 annual accounts and financial statements.

5. Options Appraisal

5.1 The CIFPA Financial Management Code is a series of financial management standards which set out the professional standards needed if an IJB is to meet the minimal standards of financial management acceptable to meet fiduciary duties to taxpayers and customers. Since these are minimum standards, CIPFA's judgement is that compliance with them is obligatory if an IJB is to meet its statutory responsibility for sound financial administration. Beyond that, CIPFA members must comply with it as one of their professional obligations.

6. People Implications

6.1 There are no people implications specific to this report at this time.

7. Financial and Procurement Implications

7.1 There are no financial implications specific to this report at this time.

8. Risk Analysis

8.1 Failure to comply with the CIPFA Financial Management Code would be considered as a breach of the IJBs statutory responsibilities for sound financial administration.

9. Equalities Impact Assessment (EIA)

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

10. Environmental Sustainability

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

11. Consultation

11.1 The Chief Financial Officer has consulted with the Chief Officer and Senior Management Team, Chief Internal Auditor, members of the HSCP and WDC Finance Team and other CFOs from the pan-Glasgow group of HSCPs.

12. Strategic Assessment

12.1 The CIPFA Financial Management Code has been developed to support organisations to maintain financial management standards which will assist with an organisation remaining financial sustainable.

13. Directions

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

Julie Slavin
Chief Financial Officer
11 June 2023

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Appendices: Appendix 1: Code Principles and FM Standards
Appendix 2: Self-assessment and Action Plan

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

Item 9
Appendix 1

Leadership

- A. The leadership team is able to demonstrate that the services provided by the authority provide value for money
- B. The authority complies with the CIPFA statement on The Role of the Chief Financial Officer in Local Government | CIPFA
- O. The leadership team monitors the elements of its balance sheet that post a significant risk to its financial sustainabilities

Accountability

- D. The authority applies the CIPFA/SOLACE Delivering Good Governance in Local Government Framework (2016)
- P. The chief finance officer has personal and statutory responsibility for ensuring that the statement of accounts produced by the local authority complies with the reporting requirements of the Code
- Q. The presentation of the final outturn figures and variations from budget allows the leadership team to make strategic financial decisions

Transparency

- L. The authority has engaged where appropriate with key stakeholders in developing its long term financial strategy, medium term financial plan and annual budget
- M. The authority uses an appropriate documented option appraisal methodology to demonstrate the value for money of its decisions

Standards

- H. The authority complies with the CIPFA Prudential Code for Capital Finance in Local Authorities
- J. The authority complies with its statutory obligations in respect of the budget setting process
- K. The budget report includes a statement by the chief financial officer on the robustness of the estimates and a statement on the adequacy of the proposed financial reserves

Assurance

- C. The leadership team demonstrates in its actions and behaviours responsibiity for governance and internal control
- F. The authority has carried out a credible and transparent financial resilience assessment
- N. The leadership team takes action using reports enabling it to identify and correct emerging risks to its budget strategy and financial sustainability

Sustainability

- E. the financial management style of the authority supports financial sustainability
- G. The authority understands its prospects for financial sustainability in the longer term and has reported this clearly to members
- I. The authority has a rolling multi year medium term financial plan consistent with sustainable service plans

Item 9
Appendix 2

CIPFA Financial Management Code – Self Assessment and Action Plan

<table>
<tr><th>FM Ref</th><th>Requirement</th><th>What we are currently doing</th><th>Areas for Development</th></tr>
<tr><td colspan="4">1. The responsibilities of the chief finance officer and leadership team</td></tr>
<tr><td>A</td><td>The leadership is able to demonstrate that the services provided by the IJB provide value for money</td><td>The HSCP Board has the following in place to ensure best value:-
Regular reports to every HSCP Board in relation to financial performance supported by quarterly performance reports to the Audit and Performance Committee.
The Board have an agreed Reserves Policy and application and creation of reserves is clearly set out in financial performance reports.
All reports to the HSCP Board requiring decisions are clear and can include:-
Options available as required
Implications for people, service users
Results of consultations as required
Equality impacts assessments
Financial consequences and how these will be funded
Identification of risk and mitigations
The SMT are all members of the Project Management Office (PMO) which oversees the progress and delivery of all service transformation and redesign projects. This supports the Board's priority for continuous improvement and directing limited resources to delivering strategic outcomes.</td><td>As part of the 2023/24 Internal Audit Strategy and Plan there will be a Best Value Assurance Review to consider current BV arrangements and identify any areas for improvement.</td></tr>
</table>

		- External inspection reports for services such as care services are reported to the Audit and Performance Committee - The statutory Annual Performance Report produced, maps performance activity against the 9 national health and wellbeing outcomes as well as local targets. This supports that performance management activity across the Partnership is effectively focussed on outcomes. - As part of the annual accounts audit, external Audit assess these arrangements to ensure best value is delivered for the HSCP Board. The most recent audit concluded that the "the IJB demonstrates aspects of best value, but arrangements could be enhanced through the introduction of a formal review of Best Value".	
B	The IJB complies with the CIPFA Statement on the Role of the Chief Finance Officer (CFO) in Local Government (2016)	- The CFO is a key member of the HSCP's Senior Management Team (SMT) and is the HSCP Board's s95 Officer. - The CFO is actively involved in all material business decisions and offers challenge and influence on decisions made. This is evidenced through the CFO's attendance and participation at key business meetings such as the HSCP Board pre-agendas and meetings, SMT, PMO, Chief Officer and Heads of Service monthly performance meetings. - The CFO champions the promotion and delivery of good financial management. This is reflected in the management structure within the organisation and the reporting of financial performance to all key management	Succession Planning conversations has identified the risk that there is little opportunity for career development as structures are relatively flat. The HSCP and partner organisations (WDC and NHSGGC) have not invested in trainee accountant programmes for a number of years. The CFO will discuss with partner CFOs the possibility of identifying funding to develop a trainee programme.

		groups, including the Extended Management Team and the Joint Staff Forum. • The HSCP Board's Financial Regulations clearly outlines the role and responsibilities of the CO, CFO and all budget holders in relation to financial management. • The CFO is a professionally qualified accountant with significant experience as a CFO. The HSCP's finance team is suitably resourced and experienced in support of the CFO undertaking their role. The HSCP Board have provided additional resources to the team through the application of reserves to support team resilience.	
2. Governance and financial management style			
C	The leadership team demonstrates in its actions and behaviours responsibility for governance and internal control.	• The HSCP Board and SMT has a shared vision and commitment to deliver outcomes in line with the strategic plan 2023 – 2026. • Behaviours are underpinned by various codes of conduct developed for both HSCP Board Members and HSCP employees. • The importance of governance and internal controls is reflected in the all HSCP Policies and the partner bodies Schemes of Delegation which defines the responsibilities for all staff members and establishes the levels at which financial management responsibilities lie in terms of decisions and approvals of spend. • An annual assessment of compliance with governance and internal controls is undertaken by the SMT for both partner bodies and is part of the annual assurance for	Continue to review outcome of internal audit reviews of internal controls taking remediation actions where required. Consider the production and implementation of a HSCP Scheme of Delegation, which complements the individual partner schemes but reflects the span of responsibility for the Chief Officer and other statutory and senior posts delivering delegated services.

		both internal and external auditors. This in turn supports the production of the Annual Governance Statement (AGS) for the HSCP Board and the partner bodies. • Internal audit reviews provide assurance on a range of internal controls. The outcome of these is reported to The HSCP Board's Audit and Performance Committee with actions identified where required and progress in delivering actions monitored. • The Terms of Reference for the Audit and Performance Committee, the HSCP Board's Standing Orders and other key policies are reviewed in line with the Policy Register. • Annually External Audit assess these arrangements to ensure arrangements are appropriate and operate effectively. The most recent audit concluded that there were no issues with arrangements in place.	
D	The IJB applies CIPFA/SOLACE "Delivering Good Governance in Local Government: Framework (2016)".	• The HSCP Board has adopted governance arrangements consistent where appropriate with the six principles of the CIPFA/SOLACE framework "Delivering Good Governance in Local Government Framework" or "Local Code". The system of internal control is designed to manage risks to a reasonable level based on a risked based approach. • The Annual Governance Statement (AGS) outlines how the HSCP Board has complied with its Local Code. The statement for 2021/22 confirmed there were no new significant governance concerns, but identified some improvement actions. The 2022/23 review will update on	

		the progress/completion of these actions and identify some new actions to strengthen the governance framework.	
E	The Financial Management style of the IJB supports financial sustainability	• The HSCP Board's financial management style can be describes as 'enabling transformation' using the CIPFA FM Financial Management hierarchy Model. • Financial Sustainability is recognised as a key strategic risk within the HSCP Board's Strategic Risk Register. The risk and mitigating actions are reviewed regularly. • The HSCP Board has set a balanced budget each year since 2015/16 and has supported the creation of both unearmarked and earmarked reserves to support current and future year funding pressures. • The HSCP Board has a framework in place to manage its financial affairs including:- • Financial regulations • Standing Orders • Partner Schemes of Delegation • Financial regulations and Standing Orders of both Partner Bodies • Medium Term Financial Plan • Reserve Strategy • The SMT has a collaborative approach to developing financial strategies for financial sustainability and this can be evidenced in the way the budget and medium term financial plan are updated. The key themes being: • Better Ways of Working • Community Empowerment	Given the scale of the financial challenge, the Medium Term Financial Plan 2022/23 – 2026/27 will be reviewed and updated as part of the 2024/25 budget setting process. This will include a refresh of the sensitivity analysis parameters to reflect the economic climate.

		• Prioritise our Services • Equity and Consistency of Approach • Service Redesign and Transformation • The Finance Team support all services and the PMO in developing financial strategies and reporting and advising on all finance matters. Operational teams are also supported by the Team to assist them with managing budgets and financial performance. • The CFO presents regularly to the Extended Management Team, the Joint Staff Forum and the HSCP Board Members through scheduled development sessions. • The HSCP Board fosters a culture of continuous improvement supported by the Audit and Performance Committee and Strategic Planning Group. These formal sub-committees both develop and monitor the HSCP Board's transformation agenda and delivery of its Strategic Priorities through the accompanying Delivery Plan. • The application of Eligibility Criteria through the completion of the My Life Assessment, promotion of Self-Directed Support and equity of financial resource allocation is supported by the redesigned Adults Area Resource Group (AARG). • The Medium Term Financial Plan considers the sustainability of the HSCP Board over the medium term, including an assessment of funding, cost and demand pressures and the risks over the medium term. This	

		includes a review of reserves. The annual budget process for 2023-24 identified a number of risks in relation to the level of inflation, demand and application of reserves both in 2023-24 and over the medium term.	
3. Medium to long term financial management			
F	The IJB has carried out a credible and transparent financial resilience assessment	• All financial performance reports to the HSCP Board are prepared on a projected outturn basis, including early identification of key risks and application of reserves in line the both the reserves policy and HSCP Board decisions. • The Medium Term Financial Plan considers the sustainability of the HSCP Board over the medium term, including an assessment of funding, cost and demand pressures and the risks over the medium term. This includes a review of reserves. • The Medium Term Financial Plan includes sensitivity analysis which identifies the implications if planning assumptions change and what the impact of this would be for the financial position of the partnership. • The Medium Term Financial Plan describes the key themes available to the Board to deliver financial sustainability over the medium term (see section E above). It also recognises the scale of the financial gap is so significant that there needs to be continuous discussions with partner bodies in relation to funding. • The annual budget process for 2023-24 identified a number of risks in relation to the level of inflation,	The draft annual accounts report which will be presented to the IJB in June will include a review of all reserves including proposals, where available, to increase the level of reserves to a level which will offer the HSCP Board a greater level of financial sustainability. Given the scale of the financial challenge, the Medium Term Financial Plan 2022/23 – 2026/27 will be reviewed and updated as part of the 2024/25 budget setting process. This will include a refresh of the sensitivity analysis parameters to reflect the economic climate.

		demand and application of reserves both in 2023-24 and over the medium term. • The HSCP Board has an established Reserves Policy which is reviewed annually.	
G	The IJB understands its prospects for financial sustainability in the longer term and has reported this clearly to members.	• The HSCP Board's Annual Budget, Annual Accounts, Medium Term Financial Plan and Risk Register reflect the main risks to sustainability. These are subject to regular review to ensure these remain robust and relevant for the Board. • The Medium Term Financial Plan assesses both cost and demand pressures and forecasts for funding and uses this to develop a financial strategy over the medium term to address these risk. This is used by the SMT to support the development of plans which aim to deliver financial balance over the longer term. This is monitored through the Programme Management Office (PMO). • The Medium Term Financial Plan includes sensitivity analysis which identifies the implications if planning assumptions change and what the impact of this would be for the financial position of the HSCP Board. • The medium term position and sensitivity analysis are extrapolated over the longer term and reported within the Financial Outlook section of the Annual Accounts and other key reports and plans. • Development Sessions with HSP Board members, the Joint Staff Forum and Extended Management Team and the SMT are undertaken as part of the annual budget	Given the scale of the financial challenge, the Medium Term Financial Plan 2022/23 – 2026/27 will be reviewed and updated as part of the 2024/25 budget setting process. This will include a refresh of the sensitivity analysis parameters to reflect the economic climate.

		process and these include an overview of the longer term financial sustainability and risks based on the Medium Term Financial Plan.	
H	The IJB complies with the CIPFA Prudential Code for Capital Finance in Local Authorities	This is not relevant as the HSCP Board does not have capital programmes or borrowing powers.	
I	The IJB has a rolling multi-year medium-term financial plan consistent with sustainable service plans.	• The IJB has a Medium Term Financial Plan 2022/23 – 2026/27 which should be reviewed and updated annually and presented to the HSCP Board for approval in support of delivery of the strategic plan. The complexities around the setting of the 2023/24 budget and the presentation of the new Strategic Plan 2023 – 2026 only allowed for a high level refresh of the future financial gaps. • The Medium Term Financial Plan is underpinned by a range of other strategies including commissioning strategies, workforce planning and property and ICT strategies which also support delivery of the HSCP Board's Strategic Plan. • The Medium Term Financial Plan is prepared in conjunction with all service areas and reflects all significant demand and cost pressures being experienced both at a local and national level. The plan describes the key themes available to the Board to deliver financial sustainability over the medium term (see section E above). It also recognises the scale of the financial gap is so significant that there needs to be continuous discussions with partner bodies in relation to funding.	Given the scale of the financial challenge and the approval of the new Strategic Plan 2023 -2026, the Medium Term Financial Plan 2022/23 – 2026/27 will be reviewed and updated as part of the 2024/25 budget setting process. This will include a refresh of the sensitivity analysis parameters to reflect the economic climate.

		• The Medium Term Financial Plan includes sensitivity analysis which identifies the implications if planning assumptions change and what the impact of this would be for the financial position of the HSCP Board.	
4. The annual budget			
J	The IJB complies with its statutory obligations in respect of the budget setting process.	• The HSCP Board is fully aware of the need to set a balanced budget as established in s108 (2) of the Local Government (Scotland) Act 1973 and s93 (3) of the Local Government Finance Act 1992. The need to meet this requirement is set out within the annual budget report. • The Reserves Policy is reviewed annually in conjunction with the March Budget Setting Report. • A balanced budget was agreed by the HSCP Board on 15 March 2023 for 2023/24.	
K	The budget report includes a statement by the CFO on the robustness of the estimates and the statement on the adequacy of the proposed financial reserves.	The requirement for a CFO statement in relation to this is a specific legislative requirement in England and Wales, but not in Scotland. • The 2023/24 Budget report includes information and the outlook from the CFO on the implications of the projected budget gap on general reserves and the adequacy of these reserves in relation to the financial risks which face the HSCP Board. • This Budget report also highlights where there are risks linked to financial estimates. This includes in 2023/24 the uncertainty around public sector pay uplifts and funding, the impacts of rising inflation on prescribing and risk to the cost of commissioning services from the independent sector.	

		• The Medium Term Financial Plan includes sensitivity analysis which demonstrates the implications if estimates differ from assumptions and the potential impact this could have on HSCP Board finances. • The HSCP Board has a Reserve Policy which is based on CIPFA guidance and recommended practice. The regular Financial Performance Reports, the Medium Term Financial Plan, the Annual Budget Report, the Outturn report and Annual Accounts provide information on levels of general reserves and whether they are sufficient to ensure ongoing sustainability. These reports include actions where these are required to improve the position.	
5. Stakeholder engagement and business cases			
L	The IJB has engaged where appropriate with key stakeholders in developing its long-term financial strategy, medium-term financial plan and annual budget.	• The HSCP Board undertakes comprehensive engagement with all stakeholders when it develops its strategic plan which determines the strategic priorities which the HSCP Board sets out to deliver over the medium term. This engagement provides stakeholders to have their say on what their priorities are and this is used to shape the strategic plan, which is then used in shaping the budget both annually and over the medium term. • The HSCP Board engages with stakeholders in developing its annual budget, this includes the partner bodies. This can be in relation to specific budget proposals, for example where stakeholders are part of the development of transformation plans and also where the impact of savings require detailed EQIAs and therefore consultation with stakeholders.	

		• Stakeholders are well represented on the HSCP Board and participate in all Board Development Sessions including those considering the budget setting position before presentation to the HSCP Board both in terms of the annual budget and the medium term financial outlook. • In preparing the annual budget each year, the SMT engage fully with both partner bodies to ensure that pressures are fully understood as well as the implications of changes to funding for services. The Chief Officer, CFO and other senior officers are members of both partner bodies' corporate management teams.	
M	The IJB uses an appropriate documented option appraisal methodology to demonstrate the value for money of its decisions.	• As part of the annual budget process consideration is given to options for savings. This process includes a detailed assessment of impacts and appraisal on care quality for service users and patients to ensure services remains safe, effective and person-centred as well as other operational delivery and financial risks. Where relevant this will also include a consideration of options and a recommendation in relation to the preferred option. • The HSCP's Programme Management Office (PMO) Office involves co-ordinating work across multiple programmes, projects to facilitate transformation and change. The PMO framework aims to provide a portfolio view of programmes and projects and enhance the accountability and probability of success across HSCP strategic programmes and projects. • Options appraisals are also used, where relevant, as part of transformation programmes overseen by the PMO.	

		These are well documented and where relevant are reported to the HSCP Board with a clear assessment and recommendation for the HSCP Board to consider. • While the HSCP Board cannot own capital assets or undertake capital borrowing, the partner bodies provide capital investment to support the delivery of delegated services. Option appraisal is also used as part of capital planning when making investment decisions. This is well documented and business case and options appraisal follow project management methodology in line with the processes established by both partner bodies, which includes project management documentation, governance and review meetings and a lesson learned process on follow up post completion which reviews value received and benefit realisation.	
6. Performance monitoring			
N	The leadership team takes action using reports, enabling it to identify and correct emerging risks to its budget strategy and financial sustainability.	• All services review their operational risk registers on a regular basis and this feeds into the strategic risk register update. The strategic risk register is reviewed and reported regularly to the SMT, the Audit and Performance Committee and the HSCP Board to ensure oversight and governance. This is used to highlight emerging risks including those which would impact on the budget. • "Deep dives" into individual strategic risks are considered by the Audit and Performance Committee around areas of significant pressure. If relevant any decisions on mitigation actions would be remitted to the HSCP Board. • The SMT and HSCP Board receive regular financial performance reports both from the partner bodies'	

		financial management information systems or consolidated reports across all delegated health and social care services. Any projected variances identified from the approved budgets are considered and mitigating actions identified. Where possible variation should be contained within the distinct service areas before implementing an action across HSCP budgets including application of reserves. • The financial performance reports include progress updates against agreed savings programmes and other management actions required to maintain budget balance e.g. turnover. This includes completion of a savings tracker by all Heads of Service and all vacancies presented to the Vacancy Control Panel for approval by the HSCP Chief Officer, CFO and the Head of HR. • The Medium Term Financial Plan is prepared in conjunction with all service areas and leadership teams are asked to identify any emerging risks for consideration as part of the annual budget strategy and the medium term financial outlook.	
O	The leadership team monitors the elements of its balance sheet that pose a significant risk to its financial sustainability.	• Monthly financial reports are produced in relation to the balance sheet showing the movement in balances. This is used to ensure that historical balances are reviewed and debtor and creditor balances remain under constant review. • While reserves adjustments are only made at the end of the financial year and shown within the financial statements, the regular financial performance reports	

		detail all planned additions and drawdowns from reserves and highlight the projected final balance sheet position. • As part of the 2021/22 annual accounts and 2022/23 budget setting exercise, the HSCP Board accepted responsibility for any bad debt arising from the provision of delegated services from the date of establishment. The financial performance reports to the HSCP Board provide information on any bad debt to be written off or recommended for write-off. The impact of this on the bad debt provision is monitored regularly.	
7. External Financial Reporting			
P	The CFO has personal responsibility for ensuring that the statutory accounts provided to the local IJB comply with the Code of Practice on Local IJB Accounting in the United Kingdom.	• The HSCP Board's CFO is responsible for the preparation of the Board's annual accounts in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom and by the deadlines set in legislation. These responsibilities are set within the Statement of Responsibilities included in the annual accounts, which is signed by the CFO. • The CFO oversees the production of the accounts and ensures those completing them have access to the Code of Practice and are suitably trained and professionally qualified. • These responsibilities of the CFO are set out in statute (s95 of the Local Government (Scotland) Act 1973) are also included in the CFO's job description. • The HSCP Board has met all of its statutory reporting deadlines for the submission of draft accounts to the external auditor by 30 June (even during the pandemic when deadlines were relaxed).	

		• The HSCP Board has consistently received an unqualified opinion from the external auditor from the audit of its Annual Accounts.	
Q	The presentation of the final outturn figures and variations from budget allow the leadership team to make strategic financial decisions.	• Every financial performance report to the HSCP Board provides a projected outturn position. • The HSCP Board's financial outturn for the year (usually May) is presented to the Board along with a comprehensive analysis of variations to budget and the drivers of any such variation. • The cover report for the draft annual accounts in June would explain any material variation from the draft outturn position. • Information from the final outturn is used to target budget monitoring work for each new financial year.	

Item 10

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE: 20 JUNE 2023

Subject: Internal Audit Annual Report for the year ended 31 March 2023

1. Purpose

1.1 To submit the Chief Internal Auditor's Annual Report for 2022/23 based on the internal audit work carried out for the year ended 31 March 2023, which contains an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health & Social Care Partnership Board's internal control environment that can be used to inform its Annual Governance Statement.

2. Recommendations

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

3. Background

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

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

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

The annual report must incorporate:

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

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

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

4. Main Issues

4.1 The Internal Audit Annual Report for 2022/23 included at Appendix 1 concludes with the Chief Internal Auditor's independent and objective opinion that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2023 that the Health & Social Care Partnership Board requires to rely upon within both the Council and the Health Board.

Covid-19

The longevity of the Covid-19 pandemic and its extension from 2020/21 into 2021/22 meant that the effect on the residents, partners and workforce remained an area of concern in 2022/23.

The COVID-19 pandemic has created additional demands for services whilst dealing with backlogs which have accumulated alongside which there are rising costs and reduced funding available. Continued transformation activity is crucial to ensure the Health & Social Care Partnership Board can continue to deliver services and positive outcomes for the people of West Dunbartonshire.

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

- The Assurance Statement for the year ended 31 March 2023 from the Shared Service Manager – Audit & Fraud (Chief Internal Auditor) of West Dunbartonshire Council; and
- Information provided by the Internal Auditors of NHS Greater Glasgow and Clyde on audits that they have carried out during 2022/23.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

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

10. Impact Assessments

10.1 None.

11. Consultation

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

12. Strategic Assessment

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

13. Directions

13.1 This report does not require a Direction.

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

Date: **8 June 2023**

Person to Contact: Andi Priestman, Shared Service Manager – Audit & Fraud
West Dunbartonshire Council
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Appendix: 1 - Internal Annual Audit Report for the year ended 31 March 2023 from the Chief Internal Auditor

Background Papers: Internal Audit Progress Reports to Audit Committee in September 2022 and March 2023

Wards Affected: All Wards

Item 10
Appendix 1

West Dunbartonshire
Health & Social Care Partnership

Internal Audit Annual Report for the year ended 31 March 2023 from the Chief Internal Auditor

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

As the appointed Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board, I am pleased to present my annual statement on the adequacy and effectiveness of the internal financial control system of the Health & Social Care Partnership Board for the year ended 31 March 2023.

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

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

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

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

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

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

The work of internal audit

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

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

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

Work Performed in 2022/23

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

A budget of 40 days was allocated to undertake the following: service the audit committee; carry out specific risk based work including including a review of the adequacy and effectiveness of the Health & Social Care Partnership Board's pandemic response and recovery arrangements and a review of workforce planning; and monitor the progress of the implementation of the agreed internal audit actions plans by management.

Progress reports highlighting internal audit activity were provided to the Health & Social Care Partnership Board Audit and Performance Committee meetings in September 2022 and March 2023. There were no significant matters arising from internal audit activity carried out in relation to the Health & Social Care Partnership Board for the financial year ended 31 March 2023. However, it should be noted that the Annual Report and Assurance Statement for 31 March 2023 in relation to West Dunbartonshire Council identified one audit where a "requires improvement" opinion was given in relation to Occupational Therapy – Waiting Times. An action plan is in place to address all issues identified which will be monitored by the Council's internal audit team.

Planned work for 2023/24

Following a risk-based assessment of the activities of Health & Social Care Partnership Board and consultation with the Chief Officer and the Chief Financial Officer the Internal Audit Plan for 2023/24 provides for 20 days of Internal Audit resource drawn from the Internal Audit Service of West Dunbartonshire Council.

This will be used to undertake the following: service this audit committee; carry out specific assurance work including a review of the recently updated CIPFA Guidance for Audit Committees and a review of best value arrangements; and monitor the progress of the implementation of the agreed internal audit actions plans by management.

The Internal Audit Plan for 2023/24 was approved by the Health & Social Care Partnership Board Audit and Performance Committee on 20 June 2023.

COVID-19

The longevity of the Covid-19 pandemic and its extension from 2020/21 into 2021/22 meant that the effect on the residents, partners and workforce remained an area of concern in 2022/23.

The COVID-19 pandemic has created additional demands for services whilst dealing with backlogs which have accumulated alongside which there are rising costs and reduced funding available. Continued transformation activity is crucial to ensure the Health & Social Care Partnership Board can continue to deliver services and positive outcomes for the people of West Dunbartonshire.

Basis of Opinion

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

- The audit work undertaken by Internal Audit within the Council and the Health Board and also for the Partnership Board during the year to 31 March 2023;
- The Assurance Statement for the year ended 31 March 2023 from the Chief Internal Auditor of West Dunbartonshire Council;
- The Assurance Statement for the year ended 31 March 2023 from the Internal Auditors for NHSGG&C;
- The review of the Local Code of Good Governance and the identified improvement actions;
- The assurance statement from the Chief Officer on the operation of the internal financial controls for the services for which she was responsible during the year to 31 March 2023;
- Reports issued by the External Auditors of the Council and the Health Board and other review agencies; and
- My knowledge of the Partnership Board’s governance, risk management and performance monitoring arrangements.

Opinion

It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2023 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself.

Signature: Andi Priestman

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

Date: 8 June 2023

Item 11

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by the Chief Financial Officer

20 June 2023

Subject: 2022/23 Code of Good Governance and Annual Governance Statement

1. Purpose

1.1 To present to the HSCP Board's Audit and Performance Committee:

- The outcome of the self-evaluation of compliance of the HSCP Board's Code of Good Governance and associated improvement actions;
- The Annual Governance Statement for inclusion in the HSCP Board's 2022/23 Unaudited Annual Accounts; and
- To inform members of the requirement to complete a response to our external auditor on compliance with International Auditing Standards (ISAs) in relation to fraud, litigation, laws and regulations.

2. Recommendations

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

- **Note** the outcome of the annual self-evaluation and the update of the improvement actions;
- **Consider** the detail of the 2022/23 Annual Governance Statement and **approve** its inclusion in the 2022/23 Unaudited Annual Accounts; and
- **Agree** that the CFO will work with the Chief Internal Auditor, the Chair and Vice Chair of the Audit and Performance Committee to prepare a response to our external auditor by the 31 July 2023 deadline.

3. Background

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

3.2 The concept underpinning the Framework is that it assists local government bodies in taking responsibility for developing and shaping an informed

approach to governance, aimed at achieving the highest standards in a measured and proportionate way. The Framework is intended to assist organisations individually in reviewing and accounting for their own unique approach. The overall aim is to ensure that:

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

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

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

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

3.6 As part of the annual approach taken by the HSCP Board's external auditors, Mazars, they have written to both the HSCP Senior Management Team and the Audit and Performance Committee to seek responses on our approach and reporting arrangements for a number of key areas covered by International Accounting Standards in relation to fraud, litigation, laws and regulations (see Appendix 3). The responses will inform Mazars audit of the 2022/23 annual accounts.

4. Main Issues

4.1 The annual self-evaluation review for 2022/23 has been carried out by the Chief Financial Officer and the Head of Strategy and Transformation and considered by the Senior Management Team.

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

4.3 The self-evaluation review (as referred to above in sect 3.1) has identified that current practice is mainly fully compliant (73 sub-principles) and generally compliant (17 sub-principles) against our Code of Good Governance, with no areas identified as non-compliant.

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

4.5 The HSCP SMT, supported by members of the Board, Audit and Performance Committee and Strategic Planning Group, continue to strengthen our governance framework through the Direction's policy reflecting statutory guidance, the refresh of the Strategic Risk Register and the approval of the 2023-2026 Strategic Plan.

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

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

"It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2023 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself."

4.8 This Annual Governance Statement will be published within the unaudited Annual Accounts for the year ended 31 March 2023 and will be examined by external audit.

4.9 The terms of reference for the HSCP Board's Audit and Performance Committee sets out the scope and responsibilities of the committee including their core function on overseeing the strategic processes for risk, control and governance and the governance statement. The letter from our external auditor, included within Appendix 3, sets out the request for those charged with governance to provide assurance on how they discharge their responsibilities.

4.10 The request is set out as a series of 14 questions with sub-sections explaining the relevant IAS, with a response due by 31 July 2023. The CFO will work with the Chief Internal Auditor, Chair and Vice Chair of the committee to prepare a comprehensive response that reflects the assurance work

undertaken this year as set-out within the review of the Local Code, the Annual Governance Statement and CIPFA's Financial Management Code. The response will also be clear on the lead role our partner organisations have in relation to ensuring that sound systems of internal control are in place.

5. Options Appraisal

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

6. People Implications

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

7. Financial and Procurement Implications

7.1 There are no financial implications specific to this report.

8. Risk Analysis

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

9. Equalities Impact Assessment (EIA)

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

10. Environmental Sustainability

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

11. Consultation

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

12. Strategic Assessment

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

13. Directions

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

Julie Slavin
Chief Financial Officer
11 June 2023

Person to Contact: Julie Slavin – Chief Financial Officer,
Church Street, Dumbarton G82 1QL
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Appendices: Appendix 1: Update on Local Code Improvement Plan
Appendix 2: 2022/23 Draft Governance Statement
Appendix 3: Letter from Mazars to the members of the Audit and Performance Committee.

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

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Appendix 1

Annual Review of Code of Good Governance Improvement Action Plan 2023

West Dunbartonshire
Health & Social Care Partnership

OUTSTANDING ACTIONS FROM PREVIOUS YEARS

Improvement Action	Lead Officer	Due Date	Review June 2023
Refresh and update local Self Directed Support arrangements.	Head of Strategy and Transformation	Initial Due Date: September 2020 Revised Date: March 2023	**COMPLETE** The HSCP's Self-Directed Support (SDS) Policy was approved by the Board on 21 March 2022. The SDS Lead has been in post since June 2022 and has rolled out staff engagement sessions and training sessions. This is further supported by SDS Surgeries for social workers and other staff to seek general advice and enhance their knowledge and skills. A full review of the Adult Area Resources Group (AARG) is complete and a new process implemented on 1 April 2023, to ensure consistency of practice across all HSCP adult services, streamline processes and creates a practice of peer support and challenge. This forum along with the My Life Assessment also promotes signposting to community based services.
Review the effectiveness of the new Strategic Planning Group (SPG)	Chief Officer & Head of Strategy and Transformation	Initial Due Date: October 2020 Revised Date: March 2023	**COMPLETE** The Strategic Planning Group has undergone a series of well attended development sessions supported by Healthcare Improvement Scotland. The SPG is now meeting regularly and has developed the HSCP Strategic Plan 2023 - 2026

			"Improving Lives Together". The Strategic Plan and the supporting delivery plan was approved by the HSCP Board in March 2023. The Strategic Planning Group will continue to meet to develop policy and monitor the implementation of the Strategic Plan. The SPG can be considered to be effective in that it meets its duties under the Public Bodies (Joint Working) (Scotland) Act 2014. However, the SPG will continue to undertake self-evaluation activity as it matures and develops.
Develop a robust Commissioning Plan driven by new Strategic Plan 2019 - 2022	Head of Strategy and Transformation	Initial Due Date: October 2020 Revised Date: March 2023	**COMPLETE** The HSCP Board approved their Strategic Plan 2023 – 2026 "Improving Lives Together" in March 2023. The implementation of the strategic plan is supported by a clear delivery plan, the implementation of which will be monitored by the HSCP Board on a six monthly basis.
Ministerial Strategic Group Review on the Progress of Integration Action Plan – from May 2019 Self Evaluation	Chief Officer	Multiple actions on going since 2019. Revised Date: March 2024	**PART COMPLETE** The HSCP Board considered progress on the delivery of the MSG Action Plan on 19 August 2021. This report identified a number of areas where the actions/improvements had been implemented and those with work on-going. It was anticipated that a further report would be brought to the February 2022 Board; however with the resurgence of Covid (Omicron) in late 2021 into 2022 this has been delayed. The HSCP Audit and Performance Committee will receive an assurance report on the 14 November 2023.

Review to current Scheme of Officer Delegation in line with the required review of the HSCP Board's Standing Orders. External audit recommended the current Standing Orders are refreshed to reflect the outcome of the statutory review of the Integration Scheme. The review of the 2015 Integration Scheme was approved by WDC in Feb 20 but the outbreak of the pandemic delayed its progression through NHSGGC Health Board. This work has recommenced in partnership with all 6 IJBs within the GGC area.	Chief Financial Officer and Head of Strategy and Transformation	Initial Due Date: March 2023 Revised Date: August 2023	**PART COMPLETE** Significant progress has been made in respect of the review of Standing Orders. The HSCP Board considered a paper on the 16 May 2023 at which not all recommended changes were agreed. A further revised version of the Standing Orders will be reconsidered by the Board in August 2023
Review the Terms of Reference of the Audit & Performance Committee	Chief Financial Officer	Initial Due Date: December 2022	**COMPLETE** The 14 February 2023 Audit and Performance Committee considered the proposed amendments to the ToR. After discussion some changes were recommended to be put to the HSCP Board on 15 March 2023. The March meeting of the Board accepted the revised ToR. The ToR will be reviewed again as part of the programme of review of all HSCP Board Policy documents.

NEW ACTIONS (June 2023)

Improvement Action	Lead Officer(s)	Due Date
Publish Register of Interests – to support Principle A – "Behaving with integrity, demonstrating strong commitment to ethical values and respecting the rule of law"	HSCP Board Standard's Officer	November 2023
Scheme of Delegation – the HSCP Board should consider drafting its own Scheme of Delegation which draws on our partners (WDC and NHSGGC) own schemes, to support statutory officers and other key post holders and members to fulfil their responsibilities in accordance with legislative and regulatory requirements.	Chief Financial Officer and Head of Strategy and Transformation	March 2024

Align more clearly the Strategic Plan to the Integrated Workforce Plan (IWP) to support the delivery of the approved strategic outcomes. The current IWP covers a 3 year period and this work will be undertaken in Year 2.	Head of Strategy and Transformation and Head of Human Resources	August 2024
Refresh the Medium Term Financial Plan – the current plan covers the 5 year period 2022/23 – 2026/27 and was refreshed at a high level as part of the 2023/24 budget setting exercise, but the challenging fiscal outlook requires the sensitivity analysis to be reviewed and the projection of funding gaps.	Chief Financial Officer	March 2024

ANNUAL GOVERNANCE STATEMENT

Introduction

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

Scope of Responsibility

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

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

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

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

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

Impact of COVID-19 Response on Governance Arrangements

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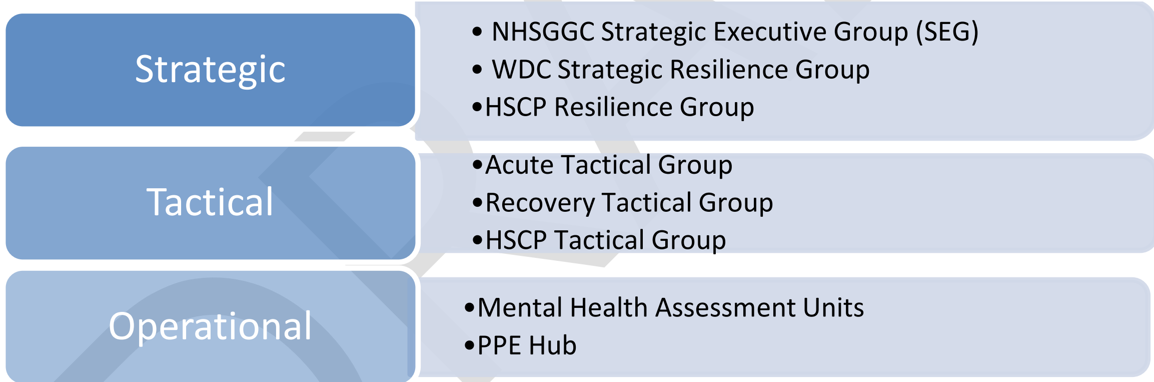
On the 3 May 2023, the head of the United Nations World Health Organisation (UN WHO) declared “with great hope” an end to COVID-19 as a public health emergency. Throughout 2022/23, the partnership continued to respond and recover to the impacts of COVID-19 with staff continuing to work proactively and with agility in light of the various public health restrictions in place. A number of changes made to protect the integrity of governance framework in which the HSCP Board operates, remained in place in 2022/23 and will likely continue in the coming year.

One significant change which is now cemented within the HSCP Board’s standing orders is the ability for members to attend meetings either in person or remotely, i.e. hybrid meeting.

Throughout 2022/23 the HSCP Board and Audit and Performance Committee met as planned. As public health restrictions on social distancing eased from June 2022, meetings moved to a hybrid model with some members and officers attending meetings in person while others contribute remotely.

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



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

The Scottish Government required that NHSGGC and each of the six HSCPs within Glasgow’s boundary prepared a Local Mobilisation Plan (LMP). The LMP and associated Financial Cost Tracker set out the impact of the pandemic on services and their response.

The financial costs aligned to the LMP were submitted monthly to the Scottish Government and formed the basis of all funding received. The final position is set-out in detail within these accounts and confirms that all 2022/23 COVID-19 related costs were covered from the funds held in an earmarked reserve created in 2020/21 and added to in 2021/22.

Purpose of the Governance Framework

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

The system of internal control is a significant element of the governance framework. Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. The system is maintained on an ongoing basis to identify, prioritise and manage the risks facing the organisation. It enables the HSCP Board to monitor and evaluate the achievements of the strategic objectives laid out within its Strategic Plan and consider whether these have been delivered in an appropriate and cost effective manner.

Governance Framework and Internal Control System

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

Following the Local Government elections held in May 2022, the three elected members (one SNP, one Labour and one Independent Councillors) were replaced in June 2022 by three new elected members (three Labour Councillors). Their membership was confirmed at the 27 June 2022 HSCP Board meeting.

The HSCP Board is scheduled to meet six times per year and all agendas, meeting papers and minutes are available on the HSCP Board website. From the meeting of the Board on 16 August 2022 to date, the audio recordings of each meeting are available to download by the public.

The main features of the HSCP Board's governance framework and system of internal control is reflected in its Local Code, with the key features for 2022/23 summarised below:

- The HSCP Board is formally constituted through the Integration Scheme agreed by WDC and NHSGGC and approved by Scottish Ministers as required by the Public Bodies (Joint Working) (Scotland) Act 2014. The scheme (currently at the final stages of review as required by statute every five years) sets out the local governance arrangements, including definition of roles, workforce, finance, risk management, information sharing and complaints;
- The overarching strategic vision, priorities and outcomes of the HSCP Board are set-out within its Strategic Plan 2023 – 2026: Improving Lives Together. The production of this plan was led by the Strategic Planning Group, established as required by the 2014 Act, with a cross-cutting membership of local internal and external partners and stakeholders;

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- The Health & Social Care Partnership Board positively promotes the principles of sound corporate governance within all areas of its affairs. It has established the Audit and Performance Committee has an essential component of the governance framework. The committee is scheduled to meet in public four times per year;
- The scope, authority, governance and strategic decision making of the HSCP Board and Audit and Performance Committee is set out in key constitutional documents including the HSCP Strategic Plan 2023 – 2026, terms of reference, code of conduct, standing orders and financial regulations, directions policy, records management and complaints handling;
- The Chief Officer has established an HSCP Resilience Group as IJB's are now category one responders. This group will review the business continuity plan and pandemic flu plan.
- The Performance Management Framework commits to regular performance and financial reporting to the HSCP Board and Audit and Performance Committee. These reports review the effectiveness of the integrated arrangements including delivery of the strategic priorities and the financial management of the integrated budget;
- The Medium Term Financial Plan 2022/23 – 2026/27 and the high level review of future funding gaps presented to the HSCP Board in March 2023, outlines the financial challenges and opportunities the HSCP Board faces over the next five years and provides a framework which will support financial sustainability;
- Programme Management Office (PMO) supports the co-ordination of work across multiple programmes and projects designed to facilitate transformational change;
- The robust application of key policies including Eligibility Criteria, My-Life Assessment, Self-Directed Support, Assisted Transport and Non-Residential Charging policies are managed and monitored through the recently revamped Adults Area Resource Group (AARG). This group supports equity of support across different care groups while delivering best value;
- Weekly Chief Officer reports considered by the SMT and used as the basis for reporting at an executive level to our partners at corporate management teams and formal Organisational Performance Reviews (OPRs);
- Clinical and Care Governance Group – provides oversight and scrutiny of all aspects of clinical and care risk, quality and effectiveness to ensure that it remains safe and person centred. The group produces an annual report on the output of its work which includes an appraisal on the impact of care quality.
- The Risk Management Strategy, including the risk management policy and strategic risk register, are scrutinised bi-annually by the Audit and Performance Committee with level of risk, its anticipated effect and mitigating action endorsed before being referred to the HSCP Board;
- The Reserves Policy is reviewed as part of the annual budget setting process and has identified a reasonable level of both general and earmarked reserves;
- Self-assessment of compliance with the CIPFA Financial Management Code;
- A performance appraisal process is in place for all employees and staff who are also required to undertake statutory and mandatory training to reinforce their obligations to protect our service users, including information security;
- A Policy Register is maintained to support regular reviews e.g. Supervision Policy for Social Work and Care Services approved at the May 2023 HSCP Board; and
- Effective scrutiny and service improvement activities are supported by the formal submission of reports, findings, recommendations and associated action plans by Audit Scotland, Ministerial Strategic Group, our external and internal auditors and the Care Inspectorate.

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

Compliance with Best Practice

The HSCP Board's financial management arrangements conform to the CIPFA Financial Management Code, a series of financial management standards designed to support local authority bodies meet their fiduciary duties

The HSCP Board's financial management arrangements conform to the governance requirements of the CIPFA statement *"The Role of the Chief Financial Officer in Local Government (2010)"*. To deliver these responsibilities the Chief Financial Officer (Section 95 Officer) must be professionally qualified and suitably experienced and lead and direct a finance function that is resourced and fit for purpose.

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

The HSCP Board's Audit and Performance Committee operates in accordance with CIPFA's *"Audit Committee Principles in Local Authorities in Scotland"* and *"Audit Committees: Practical Guidance for Local Authorities and Police (2022)"*.

Review of Adequacy and Effectiveness

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

HSCP Board Development

A one year programme of board development work with an external consultant, with significant experience in the operation of IJBs, commenced in November 2022 with a one day "Structural Dynamics Workshop". The other elements of the programme include an assessment of governance arrangements, board skills, one to one mentoring with Chair, Vice Chair and Chief Officer and wider work with the Senior Management Team, culminating in a development plan.

HSCP Board's compliance to CIPFA's Financial Management Code

A self-assessment review of the HSCP Board's compliance was undertaken in June 2023 by the HSCP Senior Management Team led by the Chief Financial Officer. This was presented to the HSCP Board's Audit and Performance Committee on the 20 June for their consideration

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and to provide assurance that they were broadly compliant. A small number of improvement actions were recommended to strengthen overall compliance and performance. A copy of the report can be found here (See Appendix 1, x). The improvement actions replicate the new actions identified in the annual review of the Local Code detailed below.

HSCP Board's Local Code Review

As stated above the HSCP Board adopted its own local code in 2017. This is reviewed each year by the Chief Financial Officer and the Senior Management Team as part of the year end assurance processes for both partner organisations and the HSCP Board. For the 2023 review the Audit and Performance Committee which met on 20 June 2023 noted the outcome that there were no areas assessed to be non-compliant and around 80% were considered fully compliant. A copy of the 2023 report is available here (See Appendix 1, x)

There have been a number of improvement actions identified and an update on these is provided below, including the recommended closure of some actions and the addition of some new actions to strengthen the internal control environment. The priority for 2023/24 will be to progress the remaining ongoing actions to further strengthen the governance framework.

New June 2023 Actions

Improvement Action	Lead Officer(s)	Target Date
Publish Register of Interests – to support Principle A – "Behaving with integrity, demonstrating strong commitment to ethical values and respecting the rule of law"	HSCP Board Standard's Officer	November 2023
Scheme of Delegation – the HSCP Board should consider drafting its own Scheme of Delegation which draws on our partners (WDC and NHSGGC) own schemes, to support statutory officers and other key post holders and members to fulfil their responsibilities in accordance with legislative and regulatory requirements.	Chief Financial Officer and Head of Strategy and Transformation	March 2024
Align more clearly the Strategic Plan to the Integrated Workforce Plan (IWP) to support the delivery of the approved strategic outcomes. The current IWP covers a 3 year period and this work will be undertaken in the Year 2 review.	Head of Strategy & Transformation and Head of Human Resources	August 2024
Refresh the Medium Term Financial Plan – the current plan covers the 5 year period 2022/23 – 2026/27 and was refreshed at a high level as part of the 2023/24 budget setting exercise, but the challenging fiscal outlook requires the sensitivity analysis to be reviewed and the projection of funding gaps.	Chief Financial Officer	March 2024

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Update on Previously Agreed Actions

Improvement Action	Lead Officer(s)	Target Date	June 2023 Review
Refresh and update local Self Directed Support arrangements.	Head of Strategy and Transformation	September 2020 Revised March 2023	**Complete**
Review the effectiveness of the new Strategic Planning Group (SPG)	Head of Strategy and Transformation	October 2020 Revised March 2023	**Complete**
Develop a robust Commissioning Plan driven by new Strategic Plan 2019 - 2022	Head of Strategy and Transformation	October 2020 Revised March 2023	**Complete**
Ministerial Strategic Group Review on the Progress of Integration Action Plan – from May 2019 Self Evaluation	Chief Officer	Multiple actions Revised September 2023 request to revise to March 2024	**Part Complete:** The HSCP Board considered progress on the delivery of the MSG Action Plan on 19 August 2021. This report identified a number of areas where the actions/improvements had been implemented and those with work on-going. It was anticipated that a further report would be brought to the February 2022 Board; however with the resurgence of Covid (Omicron) in late 2021 into 2022 this has been delayed. The HSCP Audit and Performance Committee will receive an assurance report on the 14 November 2023.
Review of the HSCP Board's Standing Orders.	Chief Financial Officer and Head of Strategy and Transformation	Initial Due Date: March 2023 Revised Date: August 2023	**Part Complete:** Significant progress has been made in respect of the review of Standing Orders. The HSCP Board considered a paper on the 16 May 2023 at which not all recommended changes were agreed. A further revised version of the Standing Orders will be reconsidered by the Board in August 2023.
Review the Terms of Reference of the Audit & Performance Committee	Chief Financial Officer	Initial Due Date: December 2022	Complete Approved by the HSCP Board 15 March 2023

<u>HSCP Board's 2022/23 Audit Plan Progress</u>

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The HSCP Board's Annual Audit Plans are developed to support assurance of the Board's Governance Framework. A total of 40 days are allocated to undertake the plan. This work is additional to the internal audit activity undertaken by internal auditors for NHSGGC and WDC.

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

Internal Audit Undertaken	Overall Opinion of Control Environment	Update of Actions
Complete: Adequacy of Reporting on the Implementation of the Directions Policy	**Satisfactory** Two Green ratings One Amber rating	**Target Date September 2022:** **Complete** Direction Reference now included within Minutes. Follow-up with officers the requirement to complete a direction where appropriate. Directions Log progress reported to HSCP Board.
Complete: Performance Management Arrangements	**Satisfactory** Two Green ratings	**Target Date March 2023:** **Part Complete** Improvements made to the documentation of a number of key processes including collection, collation and reporting. **Revised target date is September 2023**.
Complete: Adequacy of Pandemic Response and Recovery Arrangements	**Satisfactory** Two Green ratings	**Target Date September 2023:** **Ongoing** IJB to finalise arrangements for civil contingencies support. Prepare for members an annual business continuity assurance statement.

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

Within WDC Chief Officers complete a Local Code of Governance Checklist which is a self-assessment against each aspect of council's local code. These are considered by the Chief Internal Auditor and inform each Chief Officer's Certificate of Assurance as well as the Council's Governance Statement.
Within NHSGGC a similar process is in operation which required the Chief Officer to complete a "Self-Assessment Checklist" covering all the key areas of the internal control framework.

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Other reviews to support continuous improvements and the control environment include the work undertaken by WDC & NHSGGC internal audit teams. Any specific control issues emerging from these audits are considered through each organisation's own Audit Committee and recommendations on improvements agreed. The HSCP Board are updated on any control issues that would impact on HSCP service performance through regular performance and financial updates reports.

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

Update on Previous Governance Issues

The 2021/22 Annual Governance Statement did not identify any significant control issues for the HSCP Board. Updates of previous HSCP Board governance issues are mainly covered under the "Review of Adequacy and Effectiveness" section above. The remaining previously reported governance issues are updated below:

- Improve sickness absence rates – this continues to be an area of significant focus as the consequences of sickness absence coupled with recruitment and retention challenges impacts on service delivery. There are targeted interventions for areas with higher absence levels to support line managers and ensure individual absences are being managed in an appropriate manner to support return to work; and
- Progress with service reviews within Learning Disability Services, Children and Families and Care at Home to ensure services are fit for the future - the Care at Home review has continued to make significant progress despite some key management changes, with the final redesign report receiving sign off from the Chief Officer and Senior Management Team. The Children and Families and Learning Disability Services reviews have undergone some initial scoping but securing additional staffing resources to support continues to be challenging. The HSCP Board will receive progress updates on the reviews as there are significant saving targets aligned to their success.

Governance Issues 2022/23

The 2022/23 Internal Audit Annual Report for the HSCP Board identifies no significant control issues. As stated above the HSCP Board must also place reliance on the Council and Health Board's internal control framework. Both partner bodies Internal Audit Annual Reports have concluded their reviews of control procedures in key areas with the overall opinions being generally satisfactory with some improvement needed.

As stated above under "Review of Adequacy and Effectiveness" the Chief Officer of the HSCP completes a self-assessment of the HSCP's operational performance against the WDC local code. The Council's Chief Internal Auditor has considered this and has identified some areas for improvement which form part of the WDC Annual Governance Statement and progress will be monitored through the Performance Management Review Group (PMRG) and the WDC Audit Committee. These include:

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- Strengthening the evaluation processes of some key projects;
- Self-evaluation work on review of complaints and how they are used to inform service improvements across the HSCP;
- Strengthen Community Engagement and Participation;
- Strengthen arrangements for procurement and commissioning; and
- Monitor compliance with “Off-Payroll Working Guidance”.

The Health Board’s Internal Auditor’s Annual Report has now been received, and the opinion is one that reasonable assurance can be placed on the adequacy and effectiveness of the current governance and control systems and processes.

Conclusion and Opinion on Assurance

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

“It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2023 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself.”

<u>COVID-19</u>

The longevity of the Covid-19 pandemic and its extension from 2020/21 into 2021/22 meant that the effect on the residents, partners and workforce remained an area of concern in 2022/23.

The COVID-19 pandemic has created additional demands for services whilst dealing with backlogs which have accumulated alongside which there are rising costs and reduced funding available. Continued transformation activity is crucial to ensure the Health & Social Care Partnership Board can continue to deliver services and positive outcomes for the people of West Dunbartonshire.

Assurance and Certification

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

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

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

Michelle McGinty **Date: 20 June 2023**
HSCP Board Chair

Beth Culshaw **Date: 20 June 2023**
Chief Officer

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Date: 19 May 2023

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Dear Audit and Performance Committee Members,

West Dunbartonshire Integration Joint Board (the IJB) – 2022/23: Audit and Performance Committee briefing note – ISA 240 (Fraud), ISA 250 (laws and regulations), ISA 501 (litigation and claims) & ISA 570 (going concern)

Introduction

This letter aims to summarise for the Audit and Performance Committee (the Committee) the requirements under International Auditing Standards, in respect of preventing fraud in the annual accounts, compliance with laws and regulations, litigation and claims, and going concern. This letter requests an update from the Committee in order to inform our continuous audit planning as we move into the final stage of our audit of the IJB's 2022/23 accounts.

International Standard for Auditing 240 - The auditor's responsibility to consider fraud in an audit of financial statements

Background

Under the ISA, the primary responsibility for preventing and detecting fraud rests with both management and 'those charged with governance', which for the IJB is the Audit and Performance Committee.

This includes fraud that could impact on the accuracy of the annual accounts.

The ISA requires us, as external auditors, to obtain an understanding of how the Committee exercises oversight of management's processes for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

What is 'fraud' in the context of the ISA?

The ISA views fraud as either:

- the intentional misappropriation of the IJB's assets (cash, property, etc); or
- the intentional manipulation or misstatement of the financial statements.

What are auditors required to do?

We have to obtain evidence of how management and those charged with governance are discharging their responsibilities, if we are to properly discharge our responsibilities under ISA 240. We are therefore making requests from the Committee and management on the following, or similar, issues:

1) How does the Committee, in its role as those charged with governance, exercise oversight of management's processes in relation to:

- undertaking an assessment of the risk that the financial statements may be materially misstated due to fraud or error (including the nature, extent and frequency of these assessments);
- identifying and responding to risks of fraud in the organisation, including any specific risks of fraud which management have identified or that have been brought to its attention, or classes of transactions, account balances, or disclosure for which a risk of fraud is likely to exist;
- communicating to employees of views on business practice and ethical behaviour (for example by updating, communicating and monitoring against the organisation's code of conduct); and
- communicating to those charged with governance the processes for identifying and responding to fraud or error?

2) How does the Committee oversee management processes to identify and respond to the risk of fraud and possible breaches of internal control? Is the Committee aware of any breaches of internal control during 2022/23? Please provide details.

3) Has the Committee knowledge of any actual, suspected or alleged fraud during the period 1 April 2022 – 31 March 2023? Where appropriate please provide details.

4) Has the Committee any suspicion that fraud may be occurring within the organisation? Please provide details.

- Has the Committee identified any specific fraud risks within the organisation? Please provide details.
- Does the Committee have any concerns that there are areas within the organisation that are at risk of fraud? Please provide details.
- Are there particular locations within the organisation where fraud is more likely to occur? Please provide details.

5) Is the Committee satisfied that internal controls, including segregation of duties, exist and work effectively? Please provide details.

- If not, where are the risk areas?
- What other controls are in place to help prevent, deter or detect fraud?

6) Is the Committee satisfied that staff are encouraged to report their concerns about fraud, and the types of concerns they are expected to report? Please provide details.

7) From a fraud and corruption perspective, what are considered by the Committee to be high risk posts within the organisation? Please provide details.

- How are the risks relating to these posts identified, assessed and managed?

8) Is the Committee aware of any related party relationships or transactions that could give rise to instances of fraud? Please provide details.

- How are the risks associated with fraud related to such relationships and transactions mitigated?

9) Is the Committee aware of any entries made in the accounting records of the organisation that it believes or suspects are false or intentionally misleading? Please provide details.

- Are there particular balances where fraud is more likely to occur? Please provide details.
- Is the Committee aware of any assets, liabilities or transactions that it believes were improperly included or omitted from the accounts of the organisation? Please provide details.
- Could a false accounting entry escape detection? If so, how?
- Are there any external fraud risk factors which are high risk of fraud? Please provide details.

10) Is the Committee aware of any organisational, or management pressure to meet financial or operating targets? Please provide details.

- Is the Committee aware of any inappropriate organisational or management pressure being applied, or incentives offered, to you or colleagues to meet financial or operating targets? Please provide details.

International Standard for Auditing 250 – Consideration of laws and regulations in an audit of financial statements

Background

Under the ISA, in the UK and Ireland, the primary responsibility for ensuring that the entity's operations are conducted in accordance with laws and regulations and the responsibility for the prevention and detection of non-compliance rests with management and ‘those charged with governance’, which for the IJB is the Audit and Performance Committee. The ISA requires us, as external auditors, to obtain an understanding of how the IJB gains assurance that all relevant laws and regulations have been complied with.

What are auditors required to do?

We have to obtain evidence of how management and those charged with governance are discharging their responsibilities, if we are to properly discharge our responsibilities under ISA 250. We are therefore making requests from the Committee, and will be making similar enquiries of management:

11) How does the Committee gain assurance that all relevant laws and regulations have been complied with. For example:

- Is the Committee aware of the process management has in place for identifying and responding to changes in laws and regulations? Please provide details.
- What arrangements are in place for the Committee to oversee this process?
- Is the Committee aware of the arrangements management have in place, for communicating with employees, non-executive directors, partners and stakeholders regarding the relevant laws and regulations that need to be followed? Please provide details.
- Does the Committee have knowledge of actual or suspected instances where appropriate laws and regulations have not been complied with, and if so is it aware of what actions management is taking to address it? Please provide details.

International Standard for Auditing 501 – Specific consideration of the potential for, and actual, litigation and claims affecting the financial statements

Background

This ISA deals with specific considerations by the auditor in obtaining sufficient appropriate audit evidence, in this instance with respect to the completeness of litigation and claims involving the entity. The ISA requires us, as external auditors, to design and perform audit procedures in order to identify litigation and claims involving the entity which may give rise to a risk of material misstatement.

What are auditors required to do?

We have to obtain evidence of how management and those charged with governance are discharging their responsibilities, if we are to properly discharge our responsibilities under ISA 501. We are therefore making requests from the Committee, and will be making similar enquiries of management:

12) Is the Committee aware of any actual or potential litigation or claims that would affect the financial statements? Please provide details.

International Standard for Auditing 570 – Consideration of the going concern assumption in an audit of financial statements

Background

Financial statements are generally prepared on the basis of the going concern assumption. Under the going concern assumption, an audited body is ordinarily viewed as continuing in operation for the foreseeable future. Accordingly, assets and liabilities are recorded in financial

statements on the basis that the audited body will be able to realise its assets and discharge its liabilities in the normal course of its operations.

What are auditors required to do?

If used, we are required to consider the appropriateness of management's use of the going concern assumption in the preparation of the financial statements if we are to properly discharge our responsibilities under ISA 570. We are therefore making the following request from the Committee:

13) How has the Committee assessed and satisfied itself that it is appropriate to adopt the going concern basis in preparing the financial statements?

14) Has the Committee identified any events or conditions since the assessment was undertaken which may cast significant doubt on the organisation's ability to continue as a going concern? Please provide details.

The way forward

The information you provide will help inform our understanding of the IJB and its business processes, prior to the start of the final stage of the audit of the 2022/23 financial statements.

I would be grateful for your responses, which should be formally considered and communicated to us on the Committee's behalf to cover the year to 31 March 2023, by 31 July 2023. In the meantime, if you have any queries, please do not hesitate to contact me.

Yours sincerely,

T. Reid

Tom Reid
Audit Director
Mazars LLP

Item 13

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by: Chief Internal Auditor

Audit and Performance Committee: 20 June 2023

Subject: Internal Audit Annual Strategy and Plan 2023-2024

1. Purpose

1.1 The purpose of this report is to provide the indicative Internal Audit Strategy and Plan for 2023-2024 to Audit Committee for approval.

2. Recommendations

2.1 It is recommended that the Audit Committee approve the indicative Internal Audit Plan for 2023-2024.

3. Background

3.1 Internal Audit is an assurance function that primarily provides an independent and objective opinion to the organisation on the control environment comprising governance, risk management and control by evaluating its effectiveness in achieving the organisation's objectives.

3.2 As stated in the IRAG (Integrated Resources Advisory Group) Guidance, it is the responsibility of the IJB to establish adequate and proportionate internal audit arrangements for review of the adequacy of arrangements for risk management, governance and control of the delegated resources.

3.3 The Public Sector Internal Audit Standards include the requirement fo the Chief Internal Auditor to prepare a risk-based plan to determine the priorities of the internal audit activity, consistent with the organisation's goals.

3.4 The Chief Internal Auditor will prepare an annual internal audit plan which will be subject to consideration and approval by the WD HSCP Board Audit and Performance Committee.

3.5 The provision of Internal Audit services for the IJB is delivered by West Dunbartonshire Council through a directly employed in-house team. From 2018/19 onwards, a recharge of £10,000 has been made from the Council to the IJB to reflect the cost of services provided by the Council's Internal Audit Team. It is proposed that the same recharge be applied in 2023-2024.

4 Main issues

4.1 Internal Audit follows a risk-based approach and it is intended that audit work will be focused on areas of greater risk taking into account management's

own view of risk, previous audit findings and any other internal or external factors affecting the WD HSCP Board.

4.2 The indicative Internal Audit Strategy and Plan for 2023-2024 is set out at Appendix 1.

4.3 The total budget for the Internal Audit Annual Audit Plan for 2023-2024 has been provisionally set at 20 days. The plan does not contain any contingency provision. Where there are any unforeseen work demands that arise eg special investigations or provision of ad hoc advice, this will require to be commissioned as an additional piece of work which will be subject to a separate agreement.

4.4 The Public Sector Internal Audit Standards require that the annual audit plan should be kept under review to reflect any changing priorities and emerging risks. Any material changes to the audit plan will be presented to the WD HSCP Board Audit and Performance Committee for approval.

4.5 The Internal Audit Strategy and Plan for 2023-24 relating to West Dunbartonshire Council was approved at the Audit Committee in May 2023. This plan sets out the operational audits for West Dunbartonshire Council and includes an allocation of staff days to carry out audit work for the West Dunbartonshire Partnership Board.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 The Plan has been constructed taking cognisance of risks which have implications for the WD HSCP Board through discussions with management and review of the WD HSCP Board risk register.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 Discussions have taken place with the IJB's Chief Officer and Chief Financial Officer in relation to the proposed annual audit plan coverage for 2023-2024.

11.2 There will be regular ongoing discussion with External Audit to ensure respective audit plans area reviewed as circumstances change in order to minimise duplication of effort and maximise coverage for the WD HSCP Board.

12. Strategic Assessment

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

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

Date: **25 May 2023**

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

Appendices: Appendix 1 – Internal Audit Annual Strategy and Plan 2023-2024

Background Papers: None

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Appendix 1

INTERNAL AUDIT ANNUAL STRATEGY AND PLAN 2023-2024

1. Introduction

1.1 The Public Sector Internal Audit Standards (PSIAS) set out the requirement for the Chief Internal Auditor to prepare a risk-based audit plan to determine the priorities of the internal audit activity, consistent with the organisation's goals.

1.2 The Chief Internal Auditor must review and adjust the plan as necessary in response to changes in the organisation's business, risks, operations and priorities.

1.3 The audit plan must incorporate or be linked to a strategic or high-level statement of how the Internal Audit Service will be delivered and developed in accordance with the Internal Audit Charter and how it links to the organisational objectives and priorities.

1.4 The strategy shall be reviewed on an annual basis as part of the audit planning process.

2. Internal Audit Objectives

2.1 The definition of internal auditing is contained within the PSIAS as follows:

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

2.2 The primary aim of the internal audit service is to provide assurance services which requires the Chief Internal Auditor to provide an annual internal audit opinion based on an objective assessment of the framework of governance, risk management and control.

2.3 The internal audit service also provides advisory services, generally at the request of the organisation, with the aim of improving governance, risk management and control and contributing to the overall opinion.

2.4 The internal audit service supports the West Dunbartonshire HSCP Board's Chief Financial Officer in her role as Section 95 Officer.

3. Risk Assessment and Audit Planning

3.1 The internal audit approach to annual audit planning is risk-based and aligns to the IJB's strategic planning processes and management's own assessment of risk.

3.2 There will be regular ongoing discussion with External Audit to ensure respective audit plans are reviewed as circumstances change in order to minimise duplication of effort and maximise audit coverage for the West Dunbartonshire HSCP Board.

4 Service Delivery

4.1 The provision of the internal audit service is through a directly employed in-house team from West Dunbartonshire Council.

4.2 In relation to the total staff days allocated to the 2023-2024 plan, each member of staff completes a resource allocation spreadsheet for the year which is split between annual leave, public holidays, training days, general administration and operational plan days. This spreadsheet is reviewed and updated each period by each member of staff against time charged to timesheets.

The operational plan is 20 days which will be resourced as follows:

Team Member

Internal Auditor – 15 days
Chief Internal Auditor – 5 days

The Chief Internal Auditor does not directly carry out the assignments included in the annual audit plan but provides the quality review and delivery oversight of the overall plan. Where there are any resource issues which may impact on delivery of the plan, this will be reported to Audit Committee at the earliest opportunity.

4.3 Given the range and complexity of areas to be reviewed it is important that suitable, qualified, experienced and trained individuals are appointed to internal audit positions. The PSIAS requires that the Chief Internal Auditor must hold a professional qualification such as CMIIA (Chartered Internal Auditor), CCAB or equivalent and be suitably experienced. The internal auditor posts must also be CMIIA/CCAB or equivalent with previous audit experience.

4.4 Internal audit staff members identify training needs as part of an appraisal process and are encouraged to undertake appropriate training, including in-house courses and external seminars as relevant to support their development. All training undertaken is recorded in personal training records for CPD purposes.

4.5 Internal audit staff members require to conform to the Code of Ethics of the professional body of which they are members and to the Code of Ethics included within the PSIAS. An annual declaration is undertaken by staff in relation to specific aspects of the Code.

4.6 Following each review, audit reports are issued in draft format to agree the accuracy of findings and agree risk mitigations. Copies of final audit reports are issued to the WD HSCP Board Chief Officer, HSCP Head of Service and HSCP Service Manager responsible for implementing the agreed action plan. A copy of each final audit report is also provided to External Audit.

4.7 The overall opinion of each audit report feeds into the Internal Audit Annual Report and Assurance Statement which is presented to the Audit Committee and is used by the Chief Financial Officer in the preparation of the Annual Governance Statement.

5 Proposed Audit Coverage 2023-2024

5.1 The proposed audit coverage is set out in the table below.

Risk Register Reference	Previous Assurance Work	Planned Assurance Work 2023-24	Other Assurance Work 2023/24
Financial Sustainability Current Risk Score: High	External Audit Annual Audit Plans 20/21 and 21/22 NHSGGC Internal Audit Plan: 19/20 – IJB Financial Information and Reporting	None	External Audit Annual Audit Plan 22/23
Procurement and Commissioning Current Risk Score: Medium	West Dunbartonshire Council Internal Audit Plan: 15/16 – Procurement – Approved Contractors List 18/19 – Social Work Tendering and Commissioning 22/23 – Procurement – Supplier Management 23/24 – Learning Disabilities Contract Monitoring NHSGGC Internal Audit Plan: 21/22 – IJB Strategic Planning and Commissioning 21/22 – Procurement and Tendering	None	West Dunbartonshire Council Internal Audit Plan: 23/24 – Corporate Procurement
Performance Management Information Current Risk Score: Medium	WD HSCP Board Audit Plan: 21/22 - Performance Management Arrangements	None	
Information and Communication Current Risk Score: Low	West Dunbartonshire Council Internal Audit Plan: 16/17 – ICT Disaster Recovery/ Business Continuity Controls 17/18 –Data and Information Governance 19/20 – Cyber Security NHSGGC Internal Audit Plan: 18/19 - GDPR Compliance 18/19 - Digital Strategy 18/19 - Information Sharing 19/20 – IT Security 20/21 – Digital Strategy 22/23 – Cyber Resilience	None	

INTERNAL AUDIT ANNUAL STRATEGY AND PLAN 2023-2024

Risk Register Reference	Previous Assurance Work	Planned Assurance Work 2023-24	Other Assurance Work 2023-24
Delayed discharge and unscheduled care Current Risk Score: High	NHSGGC Internal Audit Plan: 21/22 – Delayed Discharges 21/22 – Time of Day Discharge 21/22 – Bed Management NHSGGC Internal Audit Plan 22/23 – follow up exercises	None	None
Workforce Sustainability Current Risk Score: High	West Dunbartonshire Council Audit Plan: 19/20 – Social Work Attendance Management 19/20 – Social Work Case Management WD HSCP Board Internal Audit Plan: 22/23 – Workforce Planning Arrangements	WD HSCP Board Internal Audit Plan – follow up process	West Dunbartonshire Council Audit Plan: 2023/24 – Attendance Management
Waiting Times Current Risk Score: Medium	NHSGGC Internal Audit Plan: 18/19 – Waiting Times Audit 19/20 – Mental Health Waiting Times 20/21 – Consultancy Review 22/23 – Waiting List Management West Dunbartonshire Council Internal Audit Plan: 22/23 – Occupational Therapy Waiting Times	None	NHSGGC Internal Audit Plan 23/24 – follow up exercises West Dunbartonshire Council Internal Audit Plan – follow up process
Public Protection – Legislation and Service Risk Current Risk Score: Medium to High	West Dunbartonshire Council Audit Plan: 19/20 – Social Work Case Management NHSGGC Internal Audit Plan: 22/23 – Public Protection Arrangements	None	NHSGGC Internal Audit Plan 23/24 – follow up exercises

Other Work		Days
Best Value Assurance Review	We will undertake a review HSCP Board Best Value arrangements and highlight any areas of improvement to management.	8
CIPFA Audit Committee Guidance October 2022	We will undertake a review of current Audit & Performance Committee arrangements and highlight any areas of improvement to management.	5
Action Plan Follow Up	To monitor the progress of implementation of agreed internal audit action plans by management.	2
Audit Planning and Management	Review and update of the audit universe and attendance at HSCP Board Audit and Performance Committee.	3
Internal Audit Annual Report 2022-2023	Annual report on 2022-2023 audit activity will be provided to CFO to inform the Annual Governance Statement for the IJB.	2
Total Staff Days		**20**

6 Quality and Performance

6.1 The PSIAS require each internal audit service to maintain an ongoing quality assurance and improvement programme based on an annual self-assessment against the Standards, supplemented at least every five years by a full independent external assessment.

6.2 In addition, the performance of Internal Audit continues to be measured against key service targets focussing on quality, efficiency and effectiveness. For 2023-2024 targets have been set as follows:

Measure	Description	Target
1. Final Report	Percentage of final reports issued within 2 weeks of draft report.	100%
2. Draft Report	Percentage of draft reports issued within 3 weeks of completion of fieldwork.	100%
3. Audit Plan Delivery	Percentage of audits completed v planned.	100%
4. Audit Budget	Percentage of audits completed within budgeted days.	100%
5. Audit Recommendations	Percentage of audit recommendations agreed.	90%
6. Action Plan Follow Up	Percentage of action plans followed up – Internal and External Audit.	100%
7. Customer Feedback	Percentage of respondents who rated the overall quality of internal audit as satisfactory or above.	100%
8. Staff compliance with CPD	Number of training hours undertaken to support CPD	20
9. Management engagement	Number of meetings with Chief Officer and Chief Financial Officer as appropriate	2 per year

6.3 Actual performance against targets will be included in the Internal Audit Annual Assurance Report for 2023-2024.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by the Chief Financial Officer

20 June 2023

Subject: Accounts Commission Report – Integration Joint Boards Financial Analysis 2021/22

1. Purpose

1.1 To present to the HSCP Board's Audit and Performance Committee for information, the recently published Accounts Commission report – Integration Joint Boards Financial Analysis 2021/22.

2. Recommendations

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

- Note the contents of the report published in April 2023, recognising the reporting period covering the 2021/22 financial year and some comment on the 2022/23 budget setting.

3. Background

3.1 The Accounts Commission holds councils and other local government bodies in Scotland to account and helps them improve by reporting to the public on their performance. Since the establishment of Integration Joint Board's the Accounts Commission, supported by Audit Scotland, have produced a number of reports on the progress of integration and the performance of Integration Authorities, Local Authorities and Health Boards.

3.2 Their latest report (see Appendix 1) was published in April, and provides a high-level independent analysis of the financial performance of IJBs during 2021/22 and their financial position at the end of March 2022. It also provided some commentary on the financial planning for 2022/23 and over the medium to longer term.

4. Main Issues

4.1 The report recognises the significant pressure IJBs were under in 2021/22, including workforce challenges, demand pressures of an aging population and the disruption to services caused by Covid-19. These pressures have continued throughout 2022/23 and are evidenced locally in West Dunbartonshire through regular service and financial performance reports to the HSCP Board.

4.2 The 2023/24 budget setting exercise also reflected the ongoing impacts of these pressures, requiring the HSCP Board to approve a range of options that finely balance the one-off application of reserves with the anticipated savings from continued turnover and recruitment challenges to offset demographic and inflationary pressures.

4.3 The information contained within the report was mainly drawn from IJBs 2021/22 published annual accounts, Scottish Government funding circulars and the quarterly IJB financial performance returns to the Health and Sport Committee.

4.4. The report sets out at a high level, how IJBs allocate funding across the range of delegated health and care services. This includes the allocation of funding to support Covid-19 costs and the additional funding to support a wide range of Scottish Government policy commitments. It acknowledges the impact Covid-19 had on delivering on a range of commitments and the timing of funding, which led to all IJBs recording an increase to their level of reserves in 2021/22.

4.5 There is also analysis on the delivery of savings programmes and how this varied across IJBs. In particular the risk associated with delivering on savings on a non-recurring basis and carrying forward to future years.

4.6 One of the key messages was the need for IJBs to work with partners to develop revised financial strategies to ensure they remain financially viable. This includes refreshing Medium Term Financial Plans regularly, in particular reflecting the long-term impacts of Covid-19 and increased inflationary cost pressures.

“IJBs face considerable challenges and uncertainties and significant and long-term transformation is required to ensure they have the organisational and financial capacity to ensure high quality services in the longer term.”

4.7 The WD HSCP Board’s Medium Term Financial Plan will be refreshed in the latter part of the year as work progresses on the service redesign and transformation projects currently underway. The refresh will also provide an update on the significant financial gaps reported in March 2023 based on a range of assumptions around future funding from partners and demand and inflationary pressures.

5. Options Appraisal

5.1 None required based on the contents of this report.

6. People Implications

6.1 There are no people implications specific to this report at this time.

7. Financial and Procurement Implications

7.1 There are no financial implications specific to this report at this time. The HSCP Board receives regular financial performance reports which includes progress on savings programmes and the use of reserves.

8. Risk Analysis

8.1 The Accounts Commission report highlights the main risks to IJBs through their key messages that summarise the complex landscape IJBs operate within, the financial and workforce challenges and the medium to longer-term outlook.

8.2 The current WD HSCP Board Medium Term Financial Plan incorporates these risks and through the application of sensitivity analysis presents a range of best, likely and worst case scenarios. The refresh of the Plan will continue to present these options in the context of the economic outlook.

9. Equalities Impact Assessment (EIA)

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

10. Environmental Sustainability

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

11. Consultation

11.1 No consultation required as this report is for noting.

12. Strategic Assessment

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

13. Directions

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

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Chief Financial Officer
29 May 2023

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Appendices: Appendix 1: Accounts Commission Report – Integration Joint Boards Financial Analysis 2021/22

Background Papers: Accounts Commission Reports on Integration Joint Boards.

Item 14
Appendix 1

Integration Joint Boards

Financial analysis 2021/22

Prepared by Audit Scotland
April 2023

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Further information about our work on Transforming health and social care in Scotland is available on the Audit Scotland website as well as the following outputs:

Health and social care integration: Update on progress
November 2018

What is integration? A short guide to the integration of health and social care services in Scotland
April 2018

Health and social care integration
December 2015

Key messages

IJB operating context

- IJBs face increasing demand – Scotland's population is ageing, with increasingly complex health and social care needs.
- The health and social care workforce is under extreme pressure, with continued recruitment and retention challenges.
- IJBs continue to deal with the impacts of Covid-19 on services.
- There remains considerable uncertainty about the planning and delivery of health and social care services whilst the Scottish Government develop plans to create a National Care Service (NCS).

IJB financial and service challenges

- IJBs face considerable financial uncertainties and workforce challenges.
  - Efficiency and transformational savings alone may be insufficient to meet future financial challenges. Significant transformation is needed to ensure financial sustainability and service improvements.
  - The social care sector cannot wait for a NCS to deal with financial, workforce and service demand challenges– action is needed now if we are to improve the outcomes for people who rely on health and social care services.

IJB finances 2021/22

- IJBs returned significant surpluses in 2021/22, mainly due to additional funding received late in the financial year for specific policy commitments, including Covid-19, as well as underspends on the cost of providing services.
- Total IJB reserves have doubled in 2021/22 to £1,262 million largely due to additional funding received late in the financial year for national policy commitments, including the response to Covid-19. Due to changes to future anticipated IJB Covid-19 spend, the Scottish Government are exploring options to recover around two thirds of Covid-19 related reserve balances held at the 2021/22 year end.
- The pandemic continued to impact on the delivery of IJB savings plans, with the Scottish Government providing specific financial support in 2021/22 to support unachieved savings on a non-recurring basis. This typically means that these savings have to be achieved in future years. It is essential that comprehensive plans are in place, demonstrating how IJBs will achieve recurring savings and support required service transformation.

Medium- and longer-term outlook

- IJBs have a projected funding gap of £124 million for 2022/23. Fourteen per cent of the 2022/23 projected funding gap is anticipated to be bridged by drawing on reserves, with other savings delivered on a non-recurring basis. Savings options had not been identified for 28 per cent of the gap. The identification and delivery of recurring savings and reducing reliance on using reserves to fund revenue expenditure is key to ensuring long-term financial sustainability.
- Three quarters of IJBs have recently updated their Medium Term Financial Plans (MTFPs). Doing so allows IJBs to respond more effectively to the long-term impacts of Covid-19, alongside increased cost pressures, including rising demand and inflation.

Introduction

1. This Accounts Commission report provides a high-level independent analysis of the financial performance of Integration Joint Boards (IJBs) during 2021/22 and their financial position at the end of that year. It also looks ahead and comments on the financial outlook for IJBs in 2022/23 and financial planning in the medium and longer terms. The IJB Financial Analysis forms one part of the Commission's wider programme of audit work on IJBs and health and social care integration.

2. IJBs were under significant pressure in 2021/22 – from increasing workforce challenges, the demand pressures of an ageing population and trying to address the disruption caused by Covid-19 on services. The pandemic increased the challenges facing IJBs already trying to respond to financial and demand pressures.

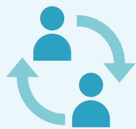
3. Alongside this, all IJBs are having to manage immense pressures on the health and social care workforce. Within social care services in 2021, there were around 208,360 people working across Scotland with a 30 per cent turnover of staff per year. The proportion of care services reporting vacancies increased by 11 per cent to 47 per cent in 2021.[1] The most common reasons for vacancies not being filled were too few applicants, and too few who were experienced and qualified. The effects of the pandemic exacerbated existing pressures on the workforce with low pay, antisocial hours and 'burnout' causing experienced staff to leave their posts.

4. Together with the Auditor General for Scotland and Audit Scotland, we have reported on the significant ongoing challenges which impact the delivery of health and social care services. Most recently, we highlighted this in our 2022 Social care briefing. This will continue to be a focus for our future work.

What is an Integration Joint Board?

5. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) is intended to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act requires councils and NHS boards to work together in partnerships, known as Integration Authorities (IAs). There are 31 IAs, established through partnerships between the 14 territorial NHS boards and 32 councils in Scotland.

There were around 208,360 people working across social care services in Scotland in 2021.

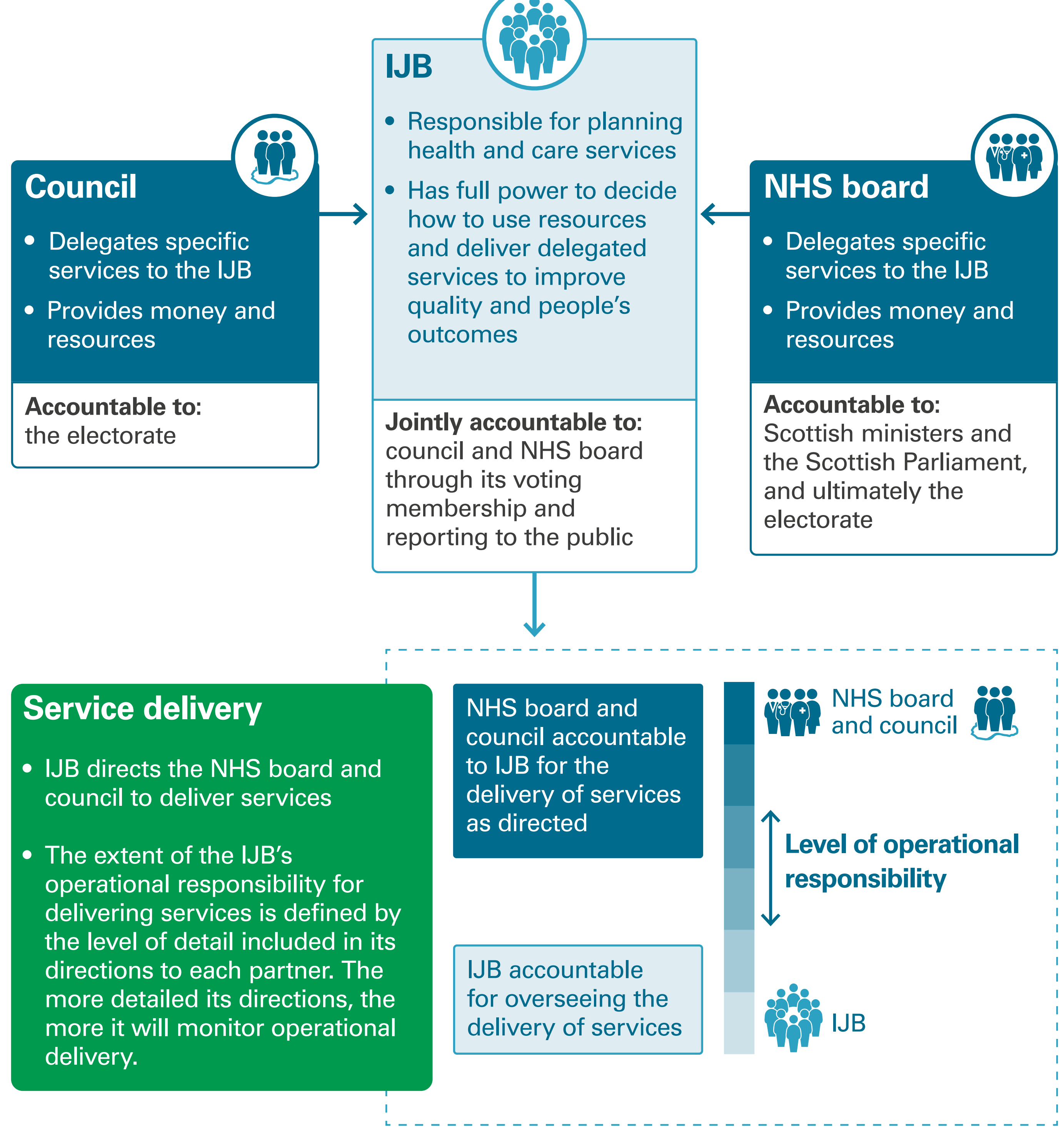


The annual turnover of staff working in social care services was 30%.

Care services reporting staff vacancies increased by 11 per cent to 47 per cent in 2021.

[1] 'Staff vacancies in care services 2021' Scottish Social Services Council

6. As part of the Act, new bodies were created – Integration Joint Boards (IJBs). The IJB is a separate legal entity, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. Of the 31 IAs in Scotland, 30 are IJBs and one area, Highland, follows a Lead Agency model. In Highland, the NHS board and council each lead integrated services. Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley.



Source: What is integration? A short guide to the integration of health and social care services in Scotland, April 2018, Audit Scotland

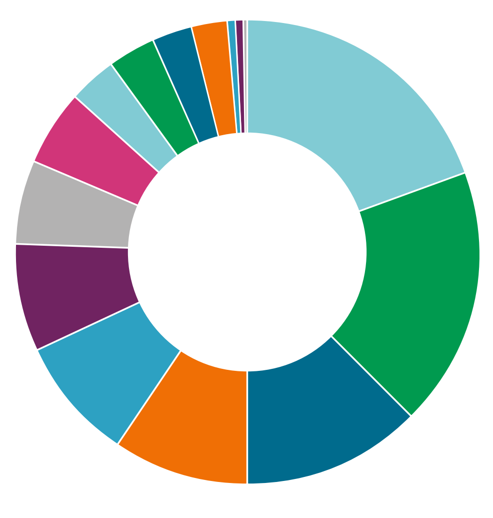
7. IJBs provide a wide range of services to vulnerable members of the community. Each IJB differs in terms of the services they are responsible for and local needs and pressures. The Act sets out the services that are required to be delegated to the IJB as a minimum, with the largest areas including the governance, planning and resourcing of the following:

IJB largest service areas
Adult and older people social work
General practitioner services
Services for adults with physical disabilities
Mental Health services
Drug and alcohol services
Allied health professional services
Pharmaceutical services

8. In some areas, partners have also integrated children's services, social work criminal justice services and some planned hospital services.

9. The budget split varies between IJBs and depends on what services have been delegated. Generally, two-thirds of budgets were for health-related services are provided by the NHS, with the remaining one-third relating to social care services provided by councils and a range of external providers. The exhibit below provides an illustrative example of what IJBs direct money to be spent on, by service:

Illustrative IJB spending	
Community Health Services	19%
Family Health Services	18%
GP prescribing	13%
Hospital and long term care	9%
Resource Transfer and other payments	9%
Adult placements	7%
Older people nursing and residential	6%
Homecare Services	5%
Adult Supported Living	3%
Children's Services	3%
Social Care fieldwork teams	3%
Older people residential and day care	2%
Adults Fife Wide	1%
Housing	0%
Social Care other	0%



Source: Fife IJB revenue budget 2021 to 2024

Funding and expenditure

Overall funding to IJBs increased by seven per cent in 2021/22

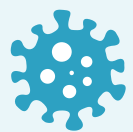
10. Overall funding to IJBs in 2021/22 increased by £704 million in cash terms (or seven per cent) to £11.3 billion. The changes in funding included:

- contributions from councils increasing by two per cent from £2.8 billion to £3.0 billion
- NHS contributions increasing by eight per cent from £6.5 billion to £7.9 billion
- service income increasing from £0.3 billion to £0.5 billion.

11. Scottish Government Covid-19 funding was passed on to IJBs via the NHS, explaining the majority of this increase. The increase in the identified service income was largely due to an improved transparency in the way that this income was presented in the IJB accounts rather than an increase in the amount of service income received.

Over a third of Covid-19 funding received in 2021/22 was carried forward to 2022/23

12. IJBs received £960 million[2] of additional funding in year to support them in responding to Covid-19 related costs. Over a third (37 per cent) of Covid-19 related funding received in 2021/22 was carried forward in ringfenced reserves. This situation has arisen largely from the significant allocation of additional Scottish Government funding received towards the end of the financial year. There was initially an expectation that this would be used to fund ongoing Covid-19 related costs. A significant proportion of this funding is now anticipated to be recovered by the Scottish Government via reductions in the NHS funding allocation to IJBs. More information can be found in paragraph 21.



IJBs received £960 million of additional funding in year to support them in responding to Covid-19 related costs.

All IJBs recorded significant surplus positions in 2021/22 arising mainly from the receipt of additional ringfenced funding

13. All 30 IJBs reported a surplus position for 2021/22, totalling £679 million, representing seven per cent of the 2021/22 net cost of services. The overall surplus position arose from three main areas (Exhibit 1, page 10):

- Non-recurring Covid-19 funding in excess of in-year Covid-19 related expenditure accounted for 52 per cent of the cumulative surplus (three per cent of net cost of services).

[2] £1 billion, when including support for the Highland Lead Agency model.

- Non-recurring Scottish Government funding allocated for specific purposes accounted for 34 per cent of the cumulative surplus (two per cent of net cost of services).
- Underspends on the costs of providing services accounted for 14 per cent of the cumulative surplus (one per cent of net cost of services).

Most IJBs reported an underspend position on the costs of providing services

14. The net underspend position on the costs of providing services across IJBs was £93 million. IJBs reported that these underspends were driven largely by vacancies and staff turnover and pandemic-related reductions in service provision. Three IJBs reported an overspending on service budgets and these were funded largely through additional partner funding allocations.

Delivery of savings continues to be impacted by the pandemic

15. An analysis of a sample of 27 IJBs identified that three-fifths of total planned savings were achieved compared to just over half of planned savings being delivered in 2020/21. It was not possible to determine the proportion of savings that were delivered on a recurring basis as a result of management actions and what proportion related to one off non-recurring savings.

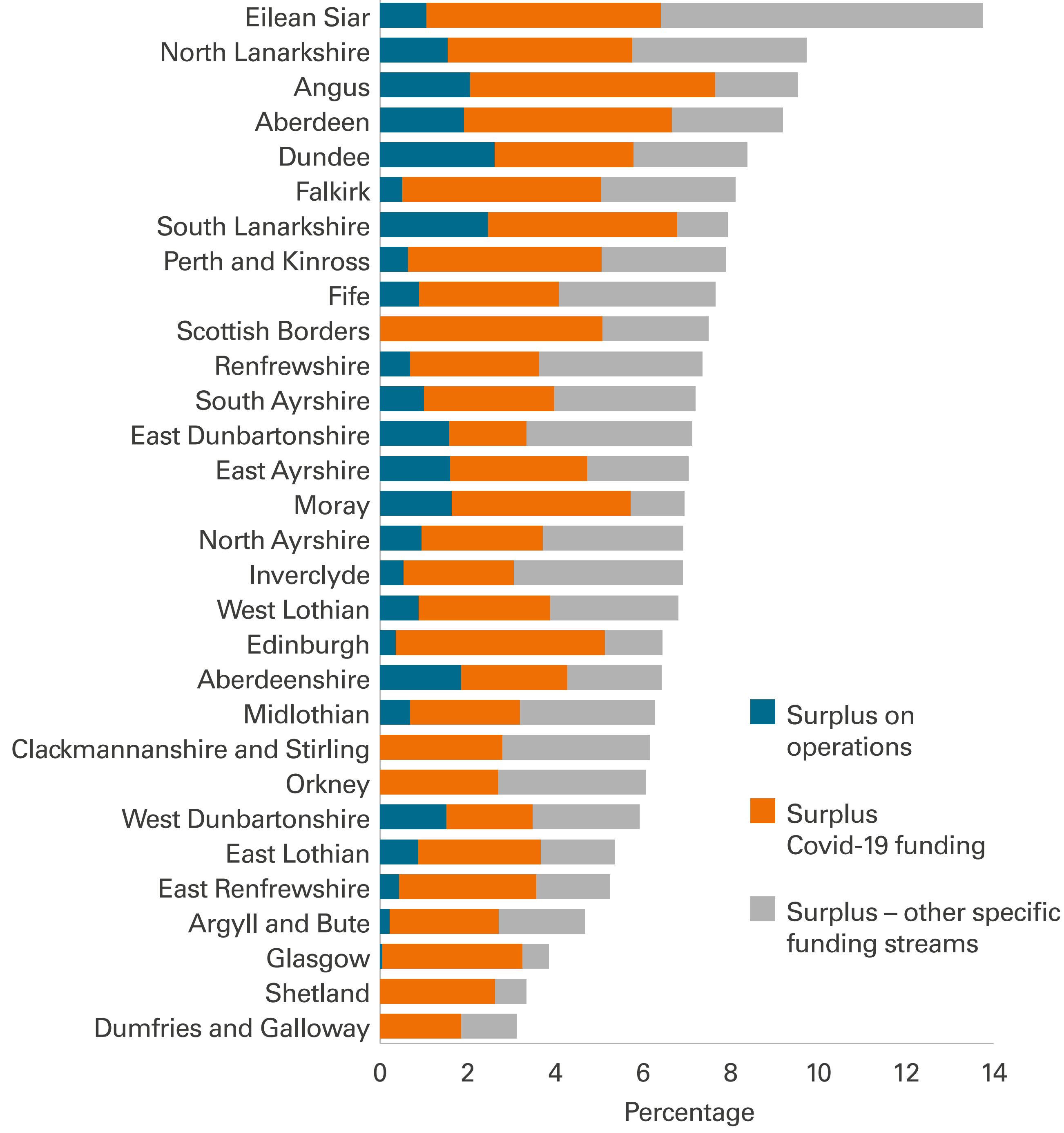
16. The achievement of savings varied significantly, ranging from zero to 100 per cent. Fourteen IJBs achieved over 75 per cent of their savings targets and four IJBs achieving all their required savings in full. Two IJBs either did not achieve any savings or had no savings target in place for the year (Exhibit 2, page 11).

17. Similarly to 2020/21, to reflect the impact of the pandemic on savings plans the Scottish Government provided IJBs with additional funding to cover the projected 2021/22 shortfalls in efficiency savings plans on a non-recurring basis. The total funding to cover this shortfall in 2021/22 was £41.2m. This will have contributed to the IJBs' overall year-end surplus position.

18. Savings delivered, or funded, on a non-recurring basis largely get carried forward to be achieved in future years. It is essential that comprehensive plans are put in place to demonstrate how IJBs intend to achieve ongoing saving requirements on a recurring basis and support required service transformation.

It is essential that comprehensive plans are put in place to demonstrate how IJBs intend to achieve ongoing saving requirements on a recurring basis.

Exhibit 1.
Surplus as a proportion of net cost of services
Most IJBs reported an underspend position on the costs of providing services.



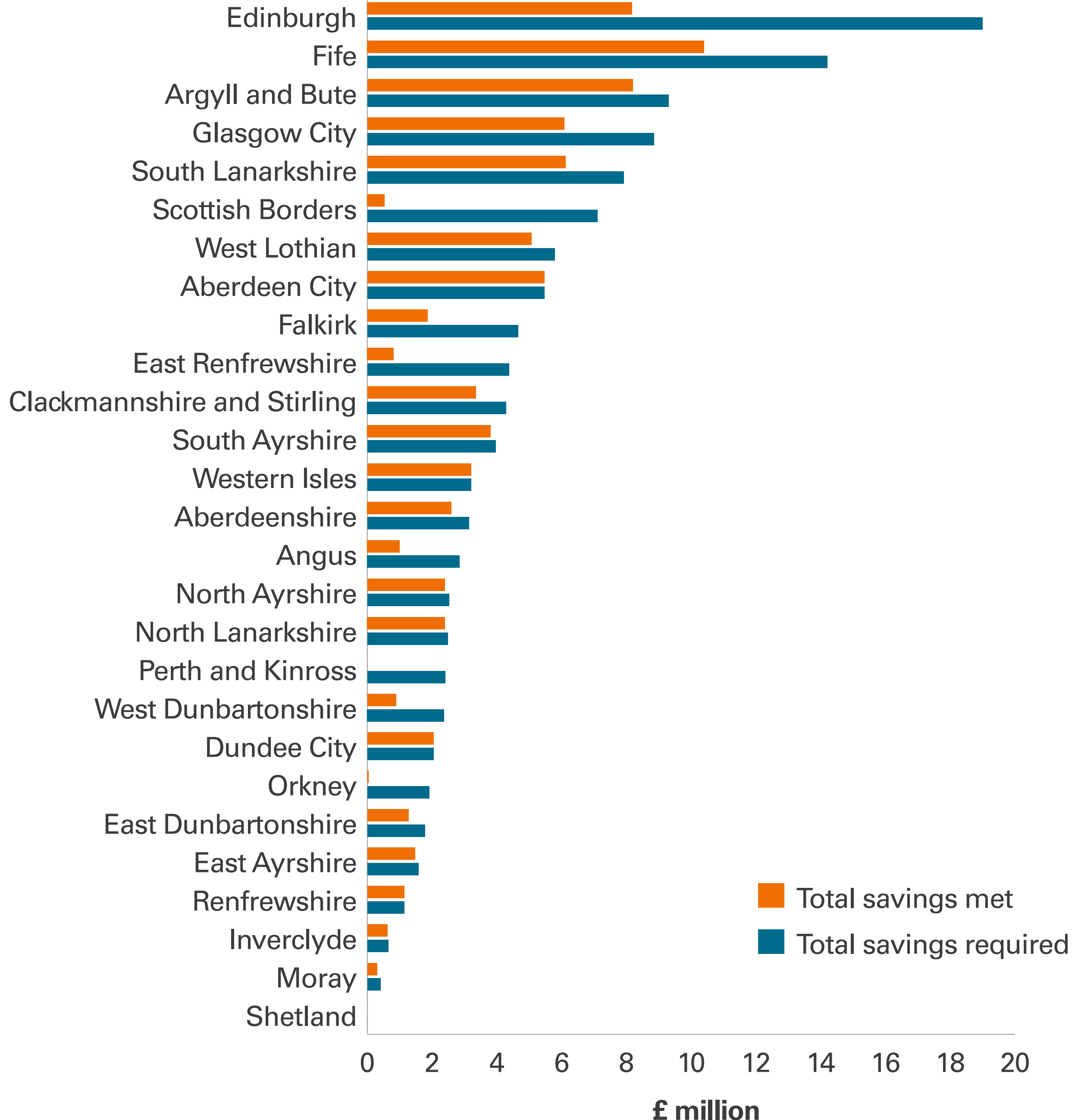
Notes:
1. Dumfries and Galloway, Shetland and Scottish Borders recorded deficits on the costs of providing services, requiring additional contributions from partner bodies.
2. Orkney and Clackmannanshire/Stirling IJBs reported break-even on the costs of providing services.
3. For South Lanarkshire and Glasgow, where the operational surplus/deficit was not reported, the movement in unearmarked reserves was used instead.

Source: 2021/22 Audited Accounts, IJB 2021/22 Outturn reports

Exhibit 2.

2021/22 Savings performance

Three fifths of total planned savings were achieved compared to just over half of planned savings being delivered in 2020/21.



Notes:
1. In some cases savings met may include one-off compensating savings which were not part of the original planned savings.
2. For West Lothian, where the savings achieved have not been reported, the unmet savings have been set to the amount of gross Covid-19 savings funding received.
3. Dumfries and Galloway, East Lothian and Midlothian have been excluded as information on savings performance was not reported.

Source: 2021/22 Audited Accounts, IJB 2021/22 Outturn reports

Reserves

Total reserves held by IJBs have doubled to £1,262 million in 2021/22 largely due to additional funding received late in the financial year

19. In 2021/22, all IJBs recorded an increase in their level of reserves with the overall reserve balance increasing by £679 million (116 per cent) to £1,262 million. Total reserves held at the year-end now represented 12 per cent of the net cost of service. This represents almost an eightfold increase in reserves since the start of the pandemic.

20. Reserves largely consisted of four main areas (Exhibit 3, page 13), as follows:

- Covid-19 related reserves of £502 million (£152 million in 2020/21) representing all unspent funding received to support the impact of the pandemic on IJB services.
- Earmarked reserves of £426 million (£201 million in 2020/21) include a wide range of individual IJB specific reserves covering a number of areas, including reserves associated with winter planning and strategic/transformational change.
- Ringfenced reserves of £185 million (£115 million in 2020/21) to support Scottish Government national policy objectives. Examples include the Primary Care Improvement Fund, Mental Health Recovery and Renewal, Mental Health Action 15, Community Living Change Fund and Alcohol and Drug Partnership funding.
- Contingency reserves of £148 million (£112 million in 2020/21), representing reserves that have not been earmarked for a specific purpose. These reserves are used to mitigate the financial impact of unforeseen circumstances.

The Scottish Government is exploring options to recover around two-thirds of 2021/22 year-end Covid-19 related reserve balances

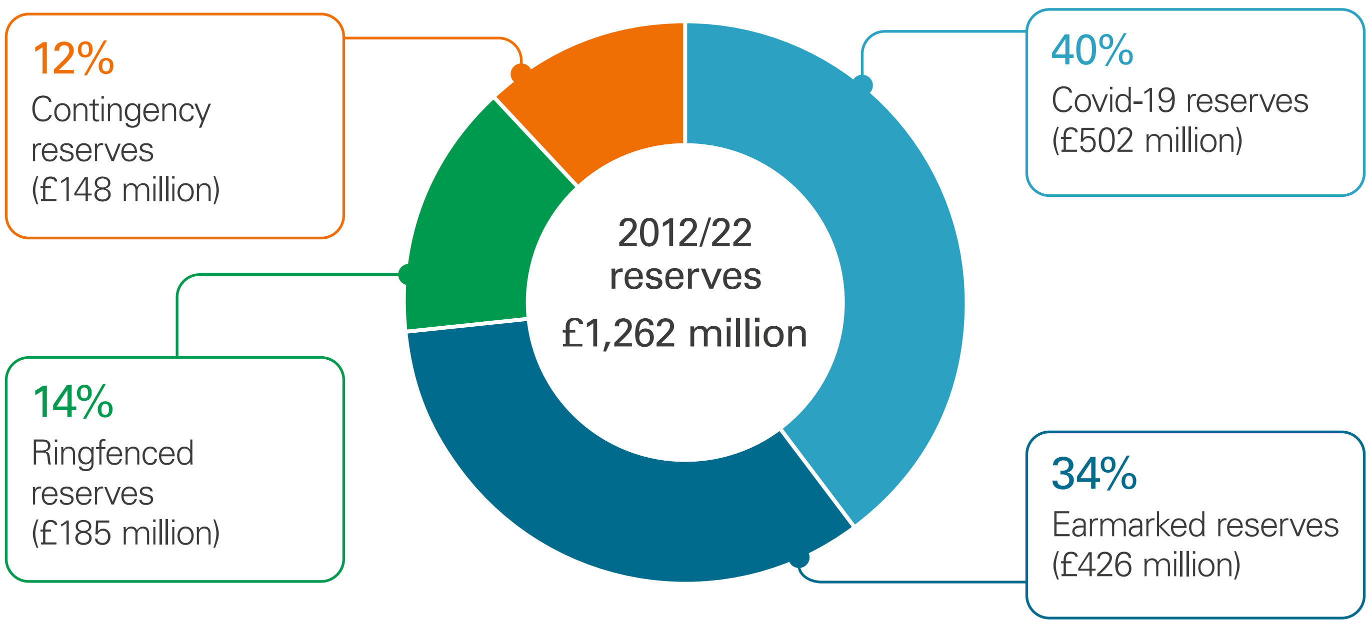
21. The Scottish Government wrote to IJBs in late 2022 highlighting that significant changes to Public Health policies have resulted in the profile of Covid-19 spending decreasing significantly. In response to this reduction in anticipated spending, the Scottish Government confirmed in January 2023 that they planned to recover £321 million (64 per cent) of Covid-19 related reserves held by IJBs at the end of 2021/22. This would have the impact of reducing the total year-end reserves position to £941 million.

22. It is anticipated that there will be engagement with the IJB Chief Finance Officers in April 2023 to determine any adjustments required around Covid-19 related expenditure incurred during the remainder of 2022/23.

The Scottish Government plans to recover £321 million (64 per cent) of Covid-19 related reserves held by IJBs.

Exhibit 3.
2021/22 reserves

Total reserves held by IJBs have doubled to £1,262 million in 2021/22 largely due to additional funding for Covid-19 and other specific purposes received late in the financial year.



Source: 2021/22 Audited Accounts, IJB 2021/22 Outturn reports

Contingency reserves now represent a fifth of the total year-end reserves balance once Covid-19 related balances have been excluded

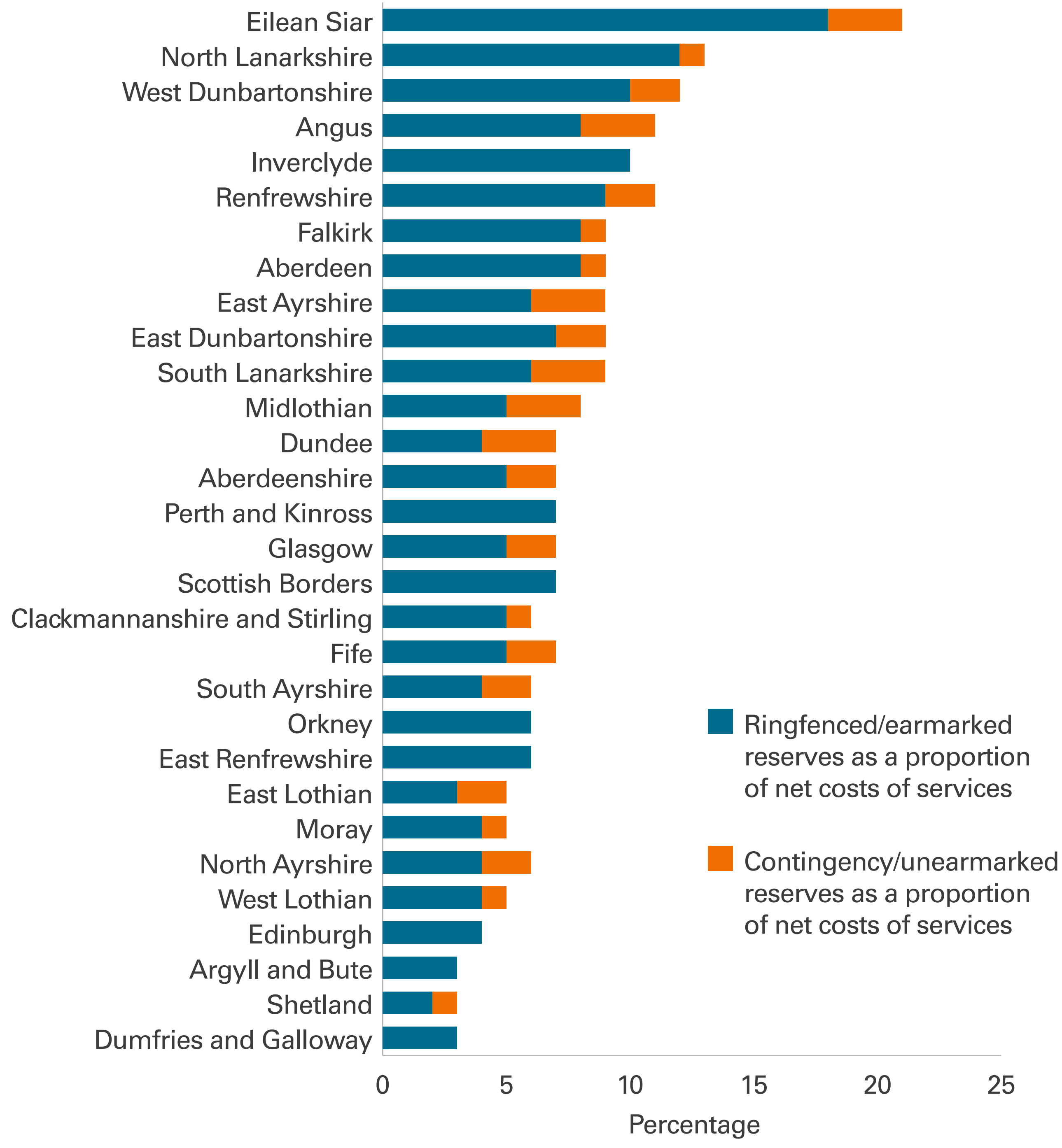
23. Once Covid-19 related reserves are excluded, 19 per cent of reserves were classified as contingency reserves, increasing from 16 per cent in 2020/21. Individual proportions ranged from zero to 43 per cent, with 14 IJBs having contingency reserves representing over 20 per cent of individual IJB total reserves.

24. Contingency reserves are levels of uncommitted funds used to mitigate against the impact of unanticipated events or emergencies. It is considered prudent for IJBs to have access to a level of contingency funds, especially during periods of increased financial uncertainty, and levels will be determined by each individual IJB depending on their circumstances. The level of uncommitted contingency funds held by each IJB will vary depending on individual IJB reserve policy. From a review of a sample of IJB reserve policies, IJBs were determining that a contingent reserve level of around two per cent of annual budgeted expenditure was prudent. Across the IJBs, contingency reserves as a proportion of net cost of services, ranged from zero per cent and three per cent; 27 per cent of IJBs had contingency reserve levels of between two and three per cent of net cost of services. For 43 per cent of IJBs, the level was either less than one per cent or zero (Exhibit 4, page 14).

Exhibit 4.

2021/22 year-end IJB reserves as a proportion of the net cost of services (excluding Covid-19 reserves)

Almost half of all IJBs had contingency reserve levels of less than one per cent of net cost of services.



Source: 2021/22 Audited Accounts

Financial outlook

Most IJBs agreed a balanced 2022/23 budget with partners before the start of the financial year

25. IJBs have a requirement to agree their budgets by 31 March each year. For 2022/23, 23 of the 30 IJBs agreed a balanced budget before the start of the financial year. Delays in the agreement of savings plans and NHS partner funding were the most common reasons for balanced budgets not being agreed at the start of the financial year.

The 2022/23 projected funding gap was £124 million, down from £151 million in 2021/22

26. IJB annual accounts and budget papers identified an overall funding gap of £124 million for 2022/23. This is down from the £151 million funding gap in 2021/22. Individual funding gaps, as a proportion of the net cost of services, ranged from zero per cent to six per cent in Eilean Siar (Exhibit 5, page 16).

27. Of the total funding gap, 57 per cent (72 per cent in 2021/22) is anticipated to be met by identified savings, 15 per cent from the use of reserves, with actions yet to be identified to bridge the remaining gap (Exhibit 6, page 17).

A third of the 2022/23 projected funding gap is anticipated to be bridged on a non-recurring basis

28. The use of reserves makes up 14 per cent of plans to bridge the funding gap. The identified savings also includes a proportion of non-recurring savings. There was a significant proportion of the funding gap that had yet to have planned action agreed at the time of budget setting. The increased reliance on non-recurring sources of income is not sustainable in the medium to long term. The identification and delivery of recurring savings and a reduced reliance on drawing from reserves to fund revenue expenditure will be key to ensuring long-term financial sustainability (Exhibit 6, page 17).

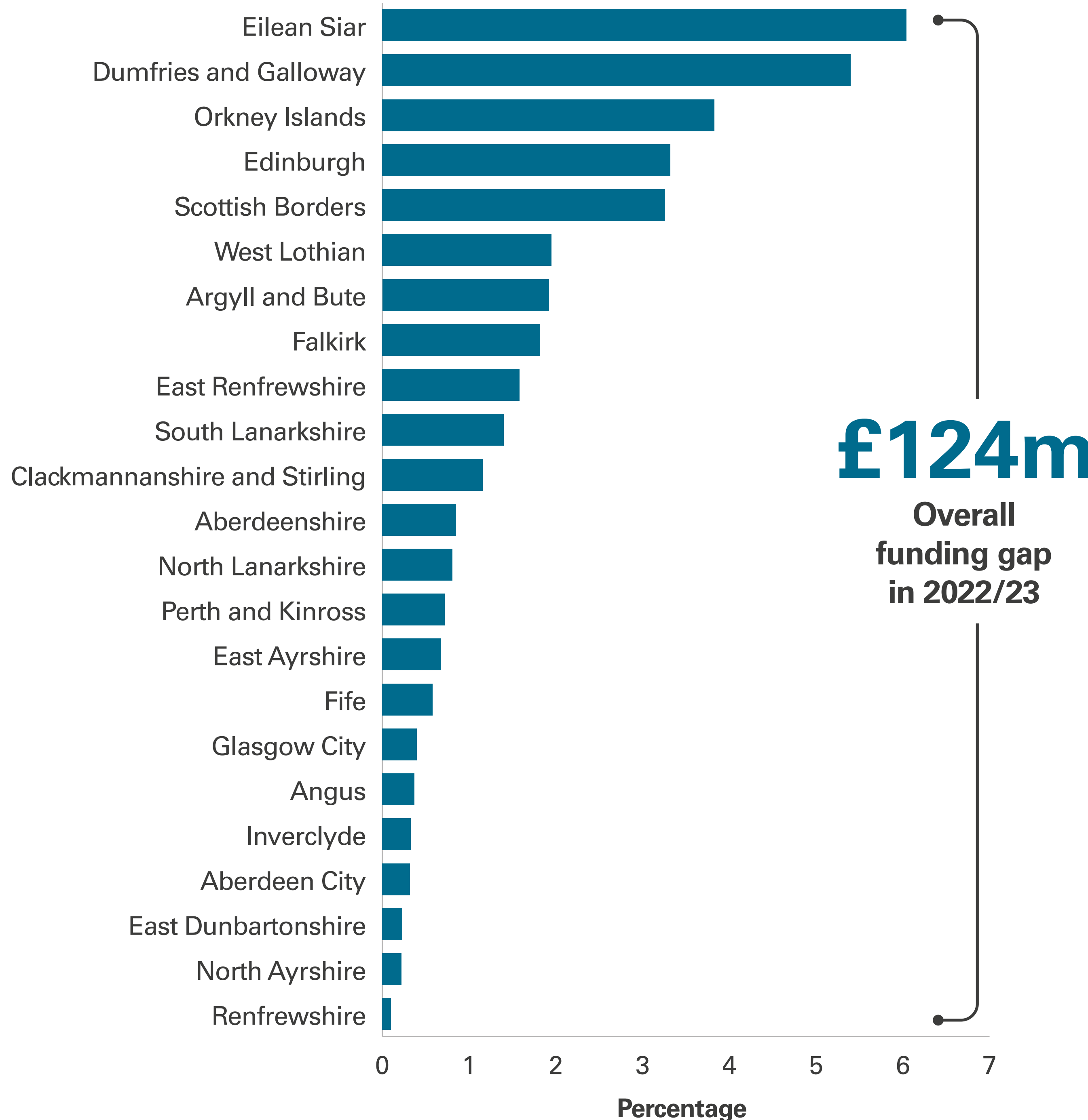
29. From a review of 2021/22 Annual Audit Reports, auditors reported that future funding gaps are unlikely to be addressed through efficiency and transformation savings alone. The scale of the challenges faced by IJBs means that services will need to change if they are to be sustainable in the future. IJBs will need to work with partners to develop revised financial strategies to ensure that they remain financially sustainable.

IJBs will need to work with partners to develop revised financial strategies to ensure that they remain financially sustainable.

Exhibit 5.

2022/23 IJB funding gap, excluding Covid-19 related costs, as proportion of 2021/22 net cost of services

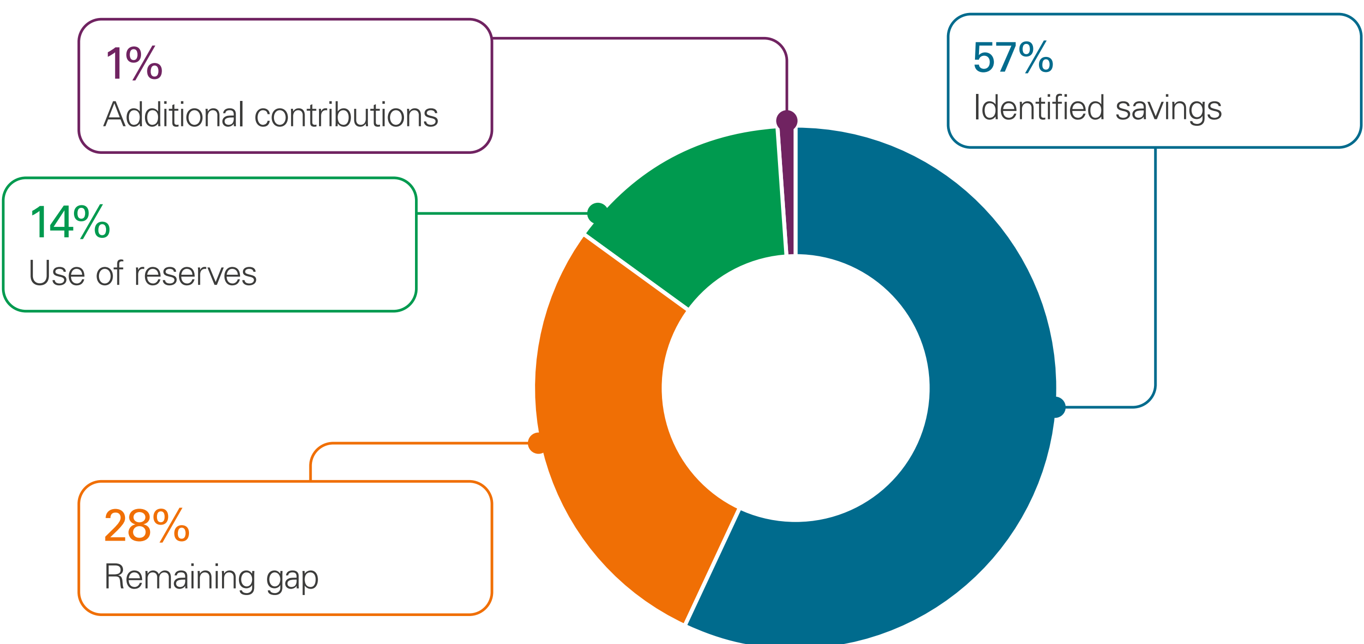
IJB annual accounts and budget papers identified an overall funding gap of £124 million for 2022/23, down from £151 million funding gap in 2021/22. Individual funding gaps, as a proportion of the net cost of services, ranged from zero to six per cent.



Notes:
1. Seven IJBs report no funding gap for 2022/23.
2. In some cases it was not clear from reports whether unachieved savings brought forward were included in the 2022/23 funding gap.

Source: 2021/22 Audited Accounts, IJB 2021/22 Outturn reports, IJB MTFPs

Exhibit 6.
2021/22 IJB funding gap planned action
The use of non-recurring reserves makes up 14 per cent of plans to bridge the funding gap.



Note: It was not clear from reports the proportion of savings that were planned to be delivered on a recurring or non-recurring basis.

Source: 2021/22 Audited Accounts, IJB 2021/22 Outturn reports, IJB MTFPs

Three-quarters of IJBs have revised their medium-term financial plans (MTFP) since 2022

30. Twenty-three IJBs have a MTFP in place that has been updated since 2022, whereas five IJBs do not currently have a MTFP in place. The impact of Covid-19 and the current levels of financial uncertainty was cited as a reason for the delays in developing or updating MTFPs. It is important that IJBs revise their MTFPs to allow them to respond effectively to the long-term impacts of Covid-19 and increased cost pressures, including rising demand and inflation.

31. Some examples of the anticipated funding gaps over the period 2022/23 to 2024/25 included:

- Glasgow anticipating a funding gap of £60 million representing four per cent of their 2021/22 net cost of services
- Renfrewshire anticipating a funding gap between £37 million to £48 million representing 11–15 per cent of their 2021/22 net cost of services
- Eilean Siar anticipating a funding gap of £7 million representing 11 per cent of their 2021/22 net cost of services.

It is important that IJBs revise their MTFPs to respond effectively to the long-term impacts of Covid-19 and increased cost pressures.

32. Common cost pressures and challenges raised in MTFPs included:

- inflationary pressures impacting the cost of providing service
- increasing complexity of care
- staff shortages and difficulty in recruiting leading to increased locum and agency bank costs
- meeting climate change commitments
- uncertainties around the long-term impact of Covid-19 on frailty and its potential impact on demand for services.

Seven IJBs reported a change of Chief Officer or Chief Finance Officer in 2021/22 and instability of leadership continues to be a challenge

33. Seven IJBs reported a change in a senior officer role in 2021/22 compared to changes at 12 IJBs reported in 2019/20. Although this represents an improvement on the 2019/20 position, instability of leadership continues to be a challenge and has the potential to contribute to delays in strategic planning and issues with workforce planning.

34. With the council elections in May 2022, membership of IJBs will have been subject to change. Structured programmes of induction for new members will help ensure they have the skills and knowledge to provide a high standard of scrutiny and decision-making.

IJBs face considerable challenges and uncertainties and significant and long-term transformation is required to ensure they have the organisational and financial capacity to ensure high quality services in the longer term

35. Auditors reported that efficiency and transformational savings alone may be insufficient to meet future financial challenges and that significant and long-term transformation will be needed to ensure financial sustainability. IJBs are facing a range of significant challenges and uncertainties, including:

- level and terms of future funding settlements
- recruitment and retention difficulties, both internally and with external providers
- rising demand, including demographic challenges of an ageing population
- cost of living crisis and inflationary pressures
- ongoing impact of Covid-19
- potential financial implications of the creation of a National Care Service (NCS).

36. The National Care Service (Scotland) Bill (the Bill) was introduced in June 2022, with the policy objective of improving quality and consistency of social services in Scotland. The Scottish Government published a Financial Memorandum to accompany the Bill. This sets out that total estimated cost ranges of the Bill will be £24–36 million in 2022/23, increasing to £241–527 million by 2026/27. Our view, as set out in our NCS Bill – Call for Evidence document is that the potential costs summarised in the financial memorandum are likely to significantly understate the margin on uncertainty and range of potential costs of establishing the NCS.

37. Stage One of the Bill was due to be completed in March 2023 but has been postponed until 30 June. This will allow the Scottish Government time to respond to some of the points raised through the parliamentary scrutiny process to date. The Scottish Parliament's Finance and Public Administration Committee published a report on the Financial Memorandum in December 2022, where it raised significant concerns in relation to costing estimates. The committee has requested that the Scottish Government revises the Financial Memorandum, updating financial costing estimates. The Scottish Parliament's Delegated Powers and Law Reform Committee published its report stating that it does not believe the Bill should progress in its current form. It is concerned that there is currently insufficient detail in the Bill documents to allow for meaningful parliamentary scrutiny.

38. The sector cannot wait for a NCS to deal with the huge challenges it faces and action is needed now. These challenges will have been exacerbated by the further pressures on Scotland's public finances from rising demand and inflation, as set out in our report Scotland's public finances: Challenges and risks. In particular, recent demand pressures, as well as the cost of living crisis has put real pressure on both the demand for services, and the provision of these services – notably the workforce. Recovery from the pandemic is having an ongoing impact, with increasing levels of unmet need having a real impact on the outcomes for individuals.

39. A measure of success for any reforms will be to ensure that a preventative, person-centred approach, as set out by Christie ten years ago, is embedded to improve outcomes and reduce inequalities. To do so, it will be essential that appropriate funding is put in place to deliver on these ambitions.

40. Further information about our work on Transforming health and social care in Scotland is available on the Audit Scotland website as well as the following outputs:

- What is integration? A short guide to the integration of health and social care services in Scotland (2018)
- Health and social care integration (2015)
- Health and social care integration: Update on progress (2018)

Integration Joint Boards

Financial analysis 2021/22

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Item 15

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP AUDIT & PERFORMANCE

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

20 June 2023

Subject: Joint Inspection of Children at Risk of Harm

1. Purpose

1.1 This report provides information on the progress of the Community Planning Partnership's Joint Inspection of children and young people at risk of harm in West Dunbartonshire carried out in three phases from September 2021 until March 2023.

1.2 The Public Protection Chief Officers Group [PPCOG] and interim Executive Oversight Group, set up to oversee the inspection activity, has received regular updates on the Inspection and continues to provide leadership and scrutiny in relation to progress of the Improvement Plan.

1.3 The Joint Inspection was led by the Care Inspectorate and included scrutiny partners drawn from Healthcare Improvement Scotland, Education Scotland and HM Inspectorate of Constabulary. The active period of phase 1 and 2 of the inspection process ran from October 2021 until March 2022 and gathered evidence drawn from a range of sources across a 2 year period prior to the commencement date. The interim report on phases 1 and 2 was published on 24 May 2022 and highlighted areas for improvement. [**Appendix 1**]

1.4 The Partnership engaged in supported improvement activity with the Joint Inspection Team during the third phase of inspection of ongoing monitoring an evaluation between May 2022 and February 2023.

1.5 On 13 April 2023 the Partnership received a letter detailing the outcome from the further period of monitoring and evaluation. The letter highlights a number of areas for continuing focus and improvement which also reflects the Partnership's self-assessment and progress made. Both the interim report and the letter are published on the Care Inspectorate website and together form the outcome and next steps arising from the self-evaluation and inspection process. **[Appendix 2]**

2. Recommendations

2.1 Note the content of the letter dated 13 April 2023 from the Care Inspectorate on behalf of the Joint Inspection Team. The letter is published on the Care Inspectorate website.

2.2 Note that the Public Protection Chief Officers Group (PPCOG) has received regular updates from the interim Executive Oversight Group set up to oversee the inspection activity and progress, and to provide leadership and scrutiny in relation to progress of the inspection improvement plan. A review of the interim governance arrangements will be considered by PPCOG at its next meeting in June 2023.

2.3 Note the priority actions contained in the Community Planning Partnership's Improvement Action Plan and outlined in section 4.9 of this report. **[Appendix 3]**

2.4 Note that external support in relation to strategic planning and delivery of services to children and young people at risk of harm will continue to be provided through the Partnership's Strategic Inspector and Local Area Network arrangements.

3. Background

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

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

3.3 The Inspection process has taken place over an extended period of 18 months running from September 2021 until February 2023 and was carried out across 3 phases.

Phases 1 & 2

3.4 The initial process was impacted by the ongoing pandemic and as a result the Inspection Team had no opportunity, either individually or in groups, to meet with partners, staff, children and young people and their parents. As a result the Partnership did not received an evaluation statement under Quality Indicator 2.1 which considers the impact on children, young people and evaluates the extent to which children and young people in need of protection and at risk of harm are listened to and impact services are able to make in their lives.

3.5 To reach conclusions the Inspection Team based their evidence on the following sources – Partnership's Position Statement of January 2022 and supporting evidence (this is essentially a self-evaluation); staff survey; file reading; children, young people and parent survey (drawn from a sample of 60); the Link Inspector report; outcome from previous Inspections (including

service based inspections); national data returns; Police Scotland and Education services information; and, internet publications such as Council, NHS GG&C and Health and Social Care Partnership Board meeting papers.

3.6 The interim report on phases 1 and 2 was published on 24 May 2022 and highlighted key areas for improvement. The report noted that the Inspection Team were more confident that the Partnership recognised and could identify where changes were required but also stated that they did not think, at that stage, that the Partnership would be able to take all the actions necessary without external support and challenge.

Phase 3

3.7 The Partnership engaged in an agreed programme of improvement activity supported by the Joint Inspection Team during a period of ongoing monitoring an evaluation between May 2022 and February 2023.

3.8 The Partnership developed an Improvement or Action Plan reflecting the areas for improvement highlighted by the self-evaluation and inspection process. The focus areas for improvement activity over the last 12 months have been –

- Key operational processes, particularly IRDs (Initial Referral Discussions);
- Assessment, plans and reviews;
- Participation and engagement with children and young people;
- Self-evaluation including use of data to support quality assurance, improvement and service planning;
- Collaborative Leadership across the partnership

3.9 The Partnership's Executive Oversight and Improvement Action Groups were established as interim, enhanced governance to develop and monitor the delivery of the improvement priorities. As stated The Executive Oversight Group reports progress directly to the PPCOG.

3.10 A series of leadership development; training; and self-evaluation activities (including audit and focused surveys) were undertaken by the Partnership to build skills, knowledge and capacity. The output from the activities contributed to the supporting evidence which was submitted alongside a further Partnership Position Statement on 28 February 2023.

3.11 On 13 April 2023 the Partnership received a letter outlining the outcome from the further period of monitoring and evaluation. The letter contains a number of areas for continuing focus and improvement. Both the interim report and the letter are published on the Care Inspectorate website and together form the outcome and next steps arising from the self-evaluation and inspection process.

3.12 The outcome letter acknowledges the "…considerable effort…" of the Partnership to address the findings arising from the joint inspection. The letter clearly indicates that, over the next 12 months, the Partnership will need to:

- sustain additional investment to address capacity challenges;
- maintain enhanced governance to continue to provide appropriate support and challenge for improvement work;
- refine the existing Improvement Action Plan to provide a greater focus on the outcomes for children and young people at risk of harm;
- build on the work already started to ensure children and young people are meaningfully and appropriately involved in decisions about their lives;
- continue to undertake and place emphasis on self-evaluation activity that focusses not only on how much or well services are delivering, but what difference the support is making; and
- continue to seek external support where this is necessary to achieve change.

3.13 Crucially the letter concludes that the Joint Inspection Team are confident that the Community Planning Partnership has in place the necessary framework to effect improvement. Ongoing support in relation to strategic planning and delivery of services to children and young people at risk of harm will continue to be provided through the Partnership's Strategic Inspector and Local Area Network arrangements.

4. Main Issues and Next Steps

Inspection Process

4.1 As noted above the Inspection process has taken place over three phases and a period of 18 months. The footplate for this strategic inspection has been modified, in part due to the impact of the pandemic, and extended to include a period of improvement activity supported by the Joint Inspection Team.

4.2 The inspection process did not include direct contact by the Inspectors with staff, children and young people and their family/carers. While this is a gap their views are reflected through surveys carried out as part of phase 1 and 2 and focused surveys in phase 3. The voice of children and young people is a core building block to improve outcomes and is an area the Partnership has identified as requiring further work as part of the development and delivery of the Integrated Children's Services Plan.

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

4.4 The Partnership also ran externally facilitated collaborative leadership development sessions; CELCIS supported workshops for the Child Protection Committee and a series of four multi agency workshops focused on building our shared vision, values and actions aligned to GIRFEC, The Promise and our approach to continuous improvement.

4.5 It is important to continue to build on the work to date and that supporting partnership collaborative leadership and professional development programmes are developed to align to the improvement priorities and external support is put in place where this is appropriate.

Improvement Action Plan

4.6 In common with all other Joint Inspections an Improvement Action Plan has been developed to prioritise activity and address the areas identified through self-assessment activity and the conclusions from phase inspection process. The Improvement Action Plan draws on other strategic planning and operational review activity in relation to services for children and young people at risk of harm.

4.7 The Improvement Action Plan is a 'live' tool and now submission of the Position Statement and receipt of the outcome letter in April 2023, will be reviewed and focused on the continuing key priorities for improvement across services supporting children, young people and their families.

4.8 The programme for improvement is long term. A number of activities are at an early stage of development and it takes time to achieve and embed a shift in culture and practice to achieve sustainable improvement. The recovery from the pandemic, financial pressures and the issues relating to recruitment and retention of staff all impact on capacity. It is important to recognise this and to continue to focus on the key priorities to maximise our resources and impact.

4.9 The Partnership priorities contained within the self-assessment submitted to the inspection team echoes those highlighted within the outcome letter. The proposed priorities for the next 12 months are –

Key operational processes:

- further develop and evaluate our approach to IRDs and chronologies;
- embed integrated assessment, planning and reviews;
- refresh and develop our approach to GIRFEC.

Participation and engagement with children and young people:

- build our vision through engagement with children and young people through the Champions Board and Youth Forum;
- further develop our approach to The Promise, including the development of a multi-agency Delivery Plan;
- strengthen the role of the Champions Board;
- embed Viewpoint (a tool to gather views of children and young people).

Self-evaluation including use of data to support quality assurance, improvement and service planning:

- further develop the data sets for the PPCOG and CPC;
- continue to develop self-evaluation with a focus on outcomes for children and young people.

Collaborative Leadership:

- a review of the Improvement Action Plan to reflect priorities and progress;
- develop access to independent advocacy;
- review output from the recent staff survey to inform engagement and planning;
- refresh Violence Against Women and Girls;
- Develop a communications strategy and user friendly online presence.

Governance

4.10 As part of the response to inspection the Partnership established additional short to medium term governance arrangements in March 2022. The multi-agency Executive Oversight Group, chaired by the Chief Officer, reports directly to the PPCOG and has provided leadership, guidance and support to deliver the improvement actions arising from the self-assessment and inspection process.

4.11 Across the Partnership work has taken place to strengthen the assurance and risk management processes and better align strategic planning priorities to reflect the needs of children and young people at risk of harm. Work is currently taking place to refresh the Nurtured DIG and develop the next iteration of the Integrated Children's Service Plan. The Child Protection Committee has reviewed the sub group structure to reflect the development priorities and has had two additional posts established to support the work of the independent chair and the lead officer in relation to learning and development and quality assurance.

4.12 The framework for improvement is now in place and there is confidence that the alignment of strategic planning priorities will support the delivery of a refreshed Improvement Action Plan. A review of the interim governance arrangements will be considered by PPCOG at its next meeting in June 2023. PPCOG will consider incorporating the planning and improvement actions for children at risk of harm within the existing strategic planning groups of the Child Protection Committee and the Nurtured DIG, which leads on the development of the integrated children's services plan. Oversight of progress of improvement actions will continue to be held by PPCOG.

5. Options Appraisal

5.1 No options appraisal required.

6. People Implications

6.1 In order to strengthen scrutiny, management oversight and collaborative leadership additional fixed term posts have been funded from the Health and Social Care Partnership's reserves. These include:

- Independent Review Co-ordinators to enhance scrutiny of Looked After Children's planning arrangements and to ensure children and young people are at the centre with their views being actively sought and heard;
- An additional senior manager on a fixed term 2 year contract to support improvement and scrutiny across the children and families service;
- Integrated Children's Services Lead (GIRFEC) to support the Nurtured DIG and the work of the Integrated Children's Services planning across the Community Planning Partnership;
- Two additional posts to support the work of the Child and Adult Protection Committees in relation to Learning and Development and Quality Assurance;
- The establishment of a Promise Lead.

6.2 The need for further additional resources may be identified by the Community Planning Partnership, as well as by individual partners, as actions arising from the delivery of the Action Plan are further embedded and reviewed.

7. Financial and Procurement Implications

7.1 It is anticipated that any additional fixed term resources required to support the Community Planning Partnership to deliver the improvement actions will be met from within existing budget allocation.

8. Risk Analysis

8.1 The Community Planning Partnership will require to maintain focus on the delivery of the improvement actions to embed the improvement in service delivery and strategic planning for children and young people at risk of harm.

9. Equalities Impact Assessment (EIA)

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

9.2 The Improvement Action Plan will be subject to an EIA as the Plan matures. The Plan is designed to support those with protected characteristics.

10. Environmental Sustainability

10.1 None required.

11. Consultation

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

12. Strategic Assessment

12.1 This report outlines the improvement activity relating to the strategic inspection of the Community Planning Partnership's services for children and young people at risk of harm.

12.2 The Community Planning Partnership's Improvement Action Plan has been developed to prioritise activity and address the areas identified through the self-evaluation process, the conclusions contained within the Interim Report and the letter dated 13 April 2023 from the Care Inspectorate on behalf of the Joint Inspection Team. The framework for improvement is now in place and there is confidence that the alignment of strategic planning priorities will support the delivery of a refreshed partnership Improvement Action Plan.

12.3 The improvement priorities for services to children and young people at risk of harm in West Dunbartonshire reflect the national strategies, legal framework and good practice guidance.

13. Directions

13.1 None required.

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Designation	Head of Children's Health, Care and Criminal Justice Services and Chief Social Work Officer.
Date	22nd May 2023

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Appendices:	1. Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire. 2. Letter dated 13 April 2023 from the Care Inspectorate on behalf of the Joint Inspection Team

3. Community Planning Partnership Children's Joint Inspection Improvement Action Plan

Background Papers

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

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

24 May 2022

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Introduction

Our remit

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

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

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

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

The terms that we use in this report

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

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

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

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

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

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

Our approach

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

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

How we conducted this inspection

Our joint inspection process normally consists of three phases:

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

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

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

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

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

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

Key facts

Total population: 88,340 people

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

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

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

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

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

Key Messages

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

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

Key messages

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

Response during the Covid-19 pandemic

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

Identification of concerns

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

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

Effectiveness of response

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

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

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

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

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

Staff competence and confidence

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

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

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

Performance management and quality assurance

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

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

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

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

Key messages

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

Staff survey feedback

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

Assessing risk and need and planning

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

Support for children and young people at risk of harm

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

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

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

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

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

Quality improvement leading to better outcomes

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

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

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

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

Key Messages

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

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

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

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

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

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

Key messages

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

Impact of leaders on staff

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

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

Governance arrangements

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

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

The Child Protection Committee

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

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

Conclusion

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

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

What happens next?

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

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

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

Appendix 1: Key Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Cllr Martin Rooney
Chair of West Dunbartonshire Community Planning Partnership
16 Church Street
Dumbarton
G82 1QL

13 April 2023
Our Reference: HH

Dear Cllr Rooney,

I am writing to you in your role as Chair of the West Dunbartonshire Community Planning Partnership on behalf of the scrutiny bodies that supported your improvement work following our joint inspection last year. These are the Care Inspectorate, Education Scotland, His Majesty's Inspectorate of Constabulary in Scotland and Healthcare Improvement Scotland.

As you are aware, our main contact has been with Beth Culshaw, Chief Officer of West Dunbartonshire HSCP, in her role as Chair of the West Dunbartonshire Children and Young People Executive Oversight Group. This letter outlines what we did, and our observations of your improvement progress led by the Children and Young People Executive Oversight Group between May 2022 and February 2023. It will be published on the Care Inspectorate website.

Our observations of your improvement progress are based on:

- discussions with senior leaders and observations of improvement and evaluation activity between May 2022 and February 2023; and
- review of a position statement and supporting evidence provided on 28 February 2023 by the partnership to demonstrate progress made in taking forward improvements.

Background

We carried out an inspection of services for children at risk of harm in the West Dunbartonshire community planning partnership area between October 2021 and March 2022. Due to constraints presented at that time by the Covid-19 pandemic, we were unable to undertake the engagement phase with West Dunbartonshire that was planned for February 2022. This meant that we did not have the opportunity to meet children, young people and families or conduct focus groups with staff. The **joint inspection report** was published in May 2022.

We decided that the most appropriate course of action thereafter was to support the partnership to undertake improvements in the areas we identified in the inspection report. While we were confident the partnership knew where changes needed to be made, we were not confident that the partnership would be able to take all the actions necessary without external support and challenge.

What we did

We asked the leadership team in West Dunbartonshire to provide an improvement plan which they did, and it included areas highlighted in the inspection report.

Between May and June 2022, inspectors from the Care Inspectorate, Education Scotland, His Majesty's Inspectorate of Constabulary in Scotland and Healthcare Improvement Scotland worked in collaboration with the children and young people partnership. Together, we delivered nine sessions to a range of multi-agency staff to help focus the direction of improvement activity.

Thereafter, we agreed a range of activities and milestones, with the intention of partners reporting on their progress to the Care Inspectorate by the 28 February 2023. Inspectors from the Care Inspectorate continued to work with the partnership, providing improvement support where this was requested by partners.

The partnership's approach to improvement

The partnership put in place governance arrangements to oversee its improvement action planning. A multi-agency improvement action group was established to take forward the inspection improvement plan, with an executive oversight group comprised of senior leaders providing oversight, support and challenge.

The partnership built on the original nine multi-agency sessions facilitated by scrutiny partners, delivering a further four development sessions. These focussed on developing a shared vision, values and actions aligned to Getting it Right for Every Child (GIRFEC), The Promise and their approach to continuous improvement. Evaluation activity was undertaken alongside improvement actions to determine progress. This included reviews of children and young people's records, other audit activity and seeking the views of some staff, children, young people and their parents and carers.

The partnership used the Care Inspectorate tools for multi-agency record reading and surveys of staff, children and young people and parent and carer views. Guidance and training were provided by the Care Inspectorate at the request of the partnership. Using the tools, the partnership reviewed 35 children and young people's records on a multi-agency basis and of that sample received: eight survey responses from parents and carers; nine responses from children and young people; and 86 responses from staff who provide support to children and young people at risk of harm.

The partnership also commissioned external support as part of their improvement activity. This included support for staff training as well as work to strengthen strategic collaborative working. The children's services partnership had made additional investment to strengthen

quality assurance and improvement capacity. While recruitment challenges impacted progress, appointments were subsequently made to key posts.

The identification of and response to, children and young people at risk of harm

Concerns about children and young people were responded to promptly. This was a finding of our joint inspection and confirmed by the partnership's review of records and their survey responses from parents and carers.

The position statement and supporting evidence highlighted that the Inter- agency Referral Discussion (IRD) had been a key area of improvement activity. The partnership helpfully established an IRD steering group to monitor and progress improvement actions. The partnership's review of records showed some early signs of improvement in the number of IRDs recorded. More work is now needed to reassure partners that IRDs are routinely taking place where a concern may indicate a risk of significant harm. The partnership indicated that the risks and needs of unborn children will now be considered within the IRD process as part of a review of their Special Needs in Pregnancy service.

It was still too early to determine improvements in relation to the overall quality of IRDs. The partnership's review of records provided a mixed picture of quality. Helpfully, the partnership had undertaken further work to better understand and address those circumstances where quality needed to improve. A test of change had been initiated to improve the timeliness of IRDs. While early indications are positive, further time will be needed to be able to evidence progress. The partnership intended to implement a new IRD template and guidance in March 2023 to strengthen practice. The IRD steering group will be critical to driving forward improvement.

Partners had undertaken a number of improvement activities, including strengthening staff training and improved supervision for children's social work staff. However, the partnership's review of records showed that effectiveness continued to be variable. Although most of the children and young people who responded to the partnership's survey felt safe where they lived all or most of the time and had a trusted adult they could talk to, more work will be required to embed changes.

The partnership's staff survey found that while staff remained confident in their own knowledge, skills and abilities, they were less confident in relation to multi-agency planning for children and young people and capacity to meet needs. Though it was clear that there is more to do, partners demonstrated that they had engaged with staff in a variety of ways to ensure they are contributing to improvement actions.

The planning and support for children and young people at risk of harm

As the partnership acknowledged, the quality of chronologies, assessments and plans requires continued prioritisation and focus to improve practice. In our joint inspection we found that while chronologies, assessments and plans were being completed, the quality needed to improve. The partnership's review of records highlighted that this continued to be an area that required further development. Through their GIRFEC refresh, there was multi-agency development work on-going to support improvement in the quality of written assessments, plans and chronologies. Helpfully, partners had made additional investments including externally commissioned staff training and the creation of a Child Protection Committee (CPC) learning and development post. Having identified challenges for staff involved in the GIRFEC work due to competing demands, the partnership had recently appointed a GIRFEC lead officer to provide additional support and co-ordination.

Continued prioritisation and focus will be needed in respect of the quality of reviews. The partnership's review of records highlighted that the content and quality of reviews continued to be variable. Partners had introduced training for chairs of meetings and the recent appointment of independent chairs may better support progress in this area.

The partnership's approach to learning from audits, scrutiny and quality assurance had improved. There had been strengthened efforts from partners to drive and direct improvement work which had directly arisen from audits and scrutiny. This was particularly evident in relation to work to strengthen the assessment and planning framework for children and young people.

Our joint inspection found that while there were a range of support services in place for children and young people, it was difficult to understand what difference these were making. The partnership's staff survey showed a mixed picture of views in relation to improvements in children and young people's lives. While evaluative evidence remains very limited, partners had helpfully highlighted that most children and young people who accessed school counselling support (Lifelink) reported an improved outcome. It would be useful for partners to consider more widely how they can better help services, in particular those focussed on children and young people at risk of harm, understand the difference that their support is making.

We are not able to comment on improvements in relation to children and young people's lives and their experiences of sustained and loving relationships, as we had not heard directly from children, young people and their families. The partnership had engaged via surveys with a small number of children and young people and their parents and carers to better understand their experiences.

The engagement and participation of children and young people

The strategic prioritisation of the participation and involvement of children and young people had improved. The partnership had developed an overarching participation and engagement strategy that outlines the importance of listening to the views and experiences of children, young people and their families. We heard from senior leaders how children and young people had been involved in the development of this.

There were a few examples of partners encouraging the participation of children and young people in shaping future service delivery, such as a consultation about their experiences of family support and the influence of children and young people on community mental health supports. However, it was too early to determine whether this had led to overall improved influence on service planning and delivery. It was not yet clear to what extent children and young people at risk of harm were specifically being engaged.

The partnership's review of records highlighted that further improvements needed to be made to meaningfully and appropriately involving children and young people in decisions about their lives. Importantly, partners had committed to hearing the views of children and young people as a central part of their GIRFEC refresh work to improve assessment and planning. There was some evidence of actions towards improved involvement of children and young people in decisions about their lives. An example of this was the re-introduction of Viewpoint to support children and young people to give their views.

Collaborative strategic leadership, operational management and strategic planning arrangements

Collaborative, multi-agency working between senior managers had improved. Minutes of key strategic forums including the CPC, children's services planning Nurture Development and Improvement Group (NDIG) and Public Protection Chief Officers Group (PPCOG) were better reflecting multi-agency attendance, shared workloads and a greater emphasis on progressing actions. External collaborative working arrangements were supporting partners with the implementation of the National Guidance for Child Protection in Scotland (2021). Multi-agency development sessions had taken place with staff to build a shared vision. Staff feedback from the development sessions indicated that most attendees felt there had been an improvement or partial improvement in collaborative working. A newsletter had been created to keep staff informed of the work of the CPC, though this was not yet evaluated.

There was a clearer articulation of the strategic framework in relation to support for children and young people. Some structures had been revised to better support improvement for example CPC subgroups. Minutes of key strategic meetings, for example the CPC and the NDIG, reflected greater alignment between the overall work of the strategic groupings and progression of improvement actions. More recent strategic planning activity was helpfully cross-referencing areas of work to avoid duplication. There now needs to be a greater

emphasis on the outcome measures necessary to demonstrate what difference improvement actions are making to the lives of children and young people.

Although at an early stage of development, there was a strengthened approach to the collation and analysis of data for the purposes of improving services. The partnership had undertaken a number of activities to begin to better quality assure and understand how services were performing. This included seeking the views of some children, young people and their parents and carers. While most actions had been multi-agency, some single agency activity was undertaken. The CPC had recently introduced a quality assurance and self-evaluation framework, though it was not clear to what extent this will align activity and support improved outcomes for children and young people.

To strengthen their expertise, the CPC had helpfully sought external support from CELCIS to better develop their use of the national minimum data set. CPC minutes reflect some improvement in the scrutiny of data. There was also some evidence of a greater maturity of focus for example the work to understand child protection thresholds; re-registrations; and length of registration. However, it was too early to determine how effectively partners were using this knowledge to inform their improvement of services.

The partnership had experienced significant changes at a leadership level, including the chief social work officer and the chief executive of the council and chair of PPCOG being relatively new in post. The PPCOG helpfully sought external support to improve collaborative working. This work had included a revisiting of the role and function of the PPCOG, as well as greater alignment of risk registers and reporting. There is some indication from minutes of strategic groups that staff capacity to attend for example CPC subgroups had at times impacted progress. While the PPCOG had supported additional investment in key posts to progress improvement actions, funding and recruitment issues meant that posts were only recently appointed to.

More widely, the partnership was continuing to experience staffing challenges in relation to staff turnover, absence and recruitment. This had been a particular issue for the Health and Social Care Partnership (HSCP) children's social work service. A new workforce strategy was developed for the HSCP in 2022 and reporting to PPCOG was in place. However, like many other partnership areas, staffing continued to be a challenge.

Capacity for improvement

Senior leaders had taken on board the joint inspection findings and there was an acceptance of the need to drive forward improvement. Partners had communicated the outcomes of the joint inspection and worked with staff to develop and take forward actions relevant to areas for improvement identified by the joint inspection.

The partnership had established collaborative multi-agency approaches to planning and monitoring improvements. An appropriate governance framework was in place, providing support and challenge from senior leaders in response to changes in performance, capacity and resource needs. The identification of an inspection improvement action lead had supported co-ordination of efforts.

Partners were beginning to use a range of approaches to hear the views of key stakeholders and were starting to utilise these to evaluate and better understand their progress and performance. There were also more targeted approaches to audit and data capture beginning to emerge. If sustained, these actions will provide a baseline for performance monitoring.

Strategic priorities were being expressed more clearly and supporting a shared vision for implementing change. However, there now needs to be a greater emphasis in strategic plans on the intended outcomes for children and young people. This would better support the refinement of improvement actions as intended by partners.

Partners had made efforts to appropriately target their resources to implement required improvements. Senior leaders recognised the impact of wider capacity issues and had indicated their support for continued investment to maintain their pace of improvement.

Next steps

Partners have made considerable effort in addressing the findings of the joint inspection. This had included additional investment and pro-actively seeking external support. Although it is too early to determine to what extent their actions had improved outcomes for children and young people at risk of harm in West Dunbartonshire, we are confident that the partnership has in place a strengthened approach to self-evaluation and improvement.

Change remains at an early stage and continuing focus will be necessary to consolidate progress and drive forward further improvement. To achieve this, over the next 12 months, the partnership will need to:

- sustain additional investment to address capacity challenges;
- maintain enhanced governance to continue to provide appropriate support and challenge for improvement work;
- refine the existing Inspection Improvement Plan to provide a greater focus on the outcomes for children and young people at risk of harm;
- build on the work already started to ensure that children and young people are meaningfully and appropriately involved in decisions about their lives;
- continue to undertake and place emphasis on self-evaluation activity that focusses not only on how much or how well services are delivering, but what difference the support is making; and
- continue to seek external support where this is necessary to achieve change.

In making this commitment, we are confident that the partnership has in place the necessary framework to continue to effect improvement.

This concludes our public reporting in relation to the findings of the joint inspection. We will continue to offer support for improvement and monitor progress through our link inspector arrangements.

Yours Sincerely,

Helen Happer
Chief Inspector
Direct: 01786 432948
Email: Helen.Happer@careinspectorate.gov.scot

Copy to:
Beth Culshaw, Chief Officer West Dunbartonshire HSCP
Peter Hesset, Chief Executive of West Dunbartonshire Council
Jane Grant. Chief Executive of NHS GGC
Lynn Ratcliff, Police Divisional Commander for West Dunbartonshire

Item 15
Appendix 3

Joint Children's Services Inspection Action Plan

West Dunbartonshire Health & Social Care Partnership

Title
HSCP - Joint Children's Services Inspection Action Plan

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

1. Feedback from the inspection and priorities for improvement are understood

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.1.1	Develop a Communication Plan to promote staff knowledge and understanding of the feedback from the inspection and the priorities for improvement.		100%	Euan McLean	Beth Culshaw	24-May-2022	27-Feb-2023	

2. Staff are aware of and understand the learning from the Inspection process, GIRFEC and the Partnership Model for Improvement

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.2.1	Develop a Community Planning Partnership communication plan which includes: learning from the Inspection process; CI Model for Improvement; GIRFEC practice model; regular updates on progress; Circulation to: staff, trade unions, and communication to service users.		100%	Euan McLean	Beth Culshaw	15-Mar-2022	27-Feb-2023	

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.2.2	Implementation of 9 Care Inspectorate Development Sessions to staff across CPP. Training programme to include specific sessions on quality framework and use of quality indicators. Sessions will include strategic leaders and operational staff..		100%	Shiona Strachan	Lesley James	24-Jun-2022	27-Feb-2023	Development Sessions took place between 24/05 & 24/06 require write up from evidence session to identify themes.
JCSIAP/1.2.3	Practice improvement will be driven by a targeted programme of feedback sessions on the findings of the Staff Survey and Case File Audit with a clear focus on recording practice		100%	Natasha MacPherson	Paula Godfrey	30-Jun-2022	27-Feb-2023	Training 29/06/2022 - further session to take place in 6 months.

LO **3. Staff are, and feel, supported to carry out their role**

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.3.1	Develop and deliver a partnership training programme to include the findings of the staff survey and case file audit report. The medium to long term training plan must incorporate sessions across CPP staff groups. Sessions to include recording practice.		100%	Tracy King; Natasha MacPherson	Paula Godfrey	31-Dec-2022	27-Feb-2023	Lesley James updating case recording Policy for sign off at SMT 09/11.
JCSIAP/1.3.2	Recruitment of a Learning and Development Officer and an Audit & Performance Officer to support improvements in practice.		100%	Leeanne Galasso	Lesley James	31-Oct-2022	27-Feb-2023	Approved at SRRG 07/09/22. Posts blocked re clarification of line management process.
JCSIAP/1.3.3	Update and relaunch case recording standards within children's social work services ensuring consistency across the social work workforce.		100%	Sylvia Chatfield; Fiona Taylor	Lesley James	26-Aug-2022	27-Feb-2023	Case recording policy to be approved at SMT.

4. Children young people and families are at the centre of practice & have clear assessments, plans &

	reviews in place to deliver high quality services & supports

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.4.1	Review of Partnership approach to and implementation of GIRFEC, project plan will include: integrated assessment; risk management tools; integrated chronology; wellbeing assessments; outcome focused SMART plans; request for assistance.		50%	Lesley James	Laura Mason	30-Dec-2022		Evidence documents to be provided (LJ)

	5. Partnership staff, providers of services, carers are confident, competent, and supported to identify and respond to risk of harm

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.5.1	Undertake a training needs analysis and review single agency and multi agency training requirements. Aligned with national and local priorities.		100%	Claire Cusick; Moira Wilson	Margaret-Jane Cardno	30-Jul-2022	19-Jan-2023	I am not leading on this work and have no responsibility for it. I am aware that this training needs analysis has been carried out as part of the Inspeciton Action plan. I have requested this is re-assigned to a more appropriate manager. 19/1/23
JCSIAP/1.5.2	Based on the above training needs analysis implement revised multi-agency child protection training programme which should include further development of online training and a self-learning pack.		100%	Margaret-Jane Cardno; Claire Cusick; Natasha MacPherson	Paula Godfrey	30-Dec-2022	27-Feb-2023	This is not an area of work I have responsibility to lead on. I am aware a multi-agency CP programme is being developed and

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								implemented. I have asked for this to be re-assigned to a more appropriate manager.
JCSIAP/1.5.3	Establish and develop quarterly Third Sector Well Start Forum to promote and develop Third Sector engagement in service delivery.		100%	Margaret-Jane Cardno; Claire Cusick; Natasha MacPherson	Selina Ross	30-Jun-2022	30-Sep-2022	The Start Well Forum is operating on a quarterly meeting cycle. The meeting plan for the year, generated by members, includes child protection and GIRFEC awareness refresh.

LO	6. Initial response to concerns and IRDs are timely, proportionate and decisions clearly recorded

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.6.1	Undertake audit of current performance of IRD to inform baseline data to enable scrutiny through CPC.		100%	Natasha MacPherson	Paula Godfrey	31-May-2022	27-Feb-2023	The Start Well Forum is operating on a quarterly meeting cycle. The meeting plan for the year, generated by members, includes child protection and GIRFEC awareness refresh.
JCSIAP/1.6.2	CPC to implement recommendations from multi agency Audit of IRD		100%	Lesley James	Paula Godfrey	29-Jul-2022	27-Feb-2023	IRD Report presented to CPC, agreement at CPC & PPCOG in June 2022. Steering group recommended

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								to progress actions and improvements for IRD, meetings of steering group have commenced. Minutes of IRD Steering Group have been requested
JCSIAP/1.6.3	Establish an IRD Steering Group to progress improvements in relation to : timescales, recording, partnership working, including the voices of children and families and development of eIRD.		100%	Natasha MacPherson	Lesley James	16-Jun-2022	27-Feb-2023	The draft guidance has been provided to the Steering Group for comments. Consideration is required to the links between IRDs and the Scottish Child Interview Model, which will be progressed in West Dunbartonshire in Spring 2023. Police system is being used as a measure for the number of IRDs being completed due to this system being the most accurate. Improvements in the social work system continue to be progressed. Scoping is being completed in relation to multi agency IRD info to establish a multi agency IRD dataset. UPDATE: Meeting taking place

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								21/10/22
JCSIAP/1.6.4	Develop IRD data set to support performance monitoring in addition to the national data set		20%	Lyn Slaven	Margaret-Jane Cardno	31-Aug-2022		
JCSIAP/1.6.5	Review process, guidance and procedures in relation to initial response to concerns including recording of decisions.		0%	Jacqueline Carson	Lesley James	31-Oct-2022		
JCSIAP/1.6.6	Social work services- review initial response to concerns and duty process using baseline information from Appreciative Enquiry		100%		Lesley James	30-Jan-2023	27-Feb-2023	Interim progress report October 2022.
JCSIAP/1.6.7	Conclude current review of "access to services' for the duty systems for CYP to ensure streamlined, timely and proportionate response		0%	John Burns	Lesley James	30-Dec-2022		

7. The Community Planning Partnership is able to identify strategic and operational risks - and to put in place relevant mitigation actions

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.7.1	Review and update service and strategic risk registers to ensure they appropriately include risks in relation to services for CYP and their families.		0%	Margaret-Jane Cardno; Rona Gold		29-Jul-2022		PPCOG process has been documented and signed off by PPCOG on the 13th September 2022. Natasha Macpherson and Kate Kerr will now lead and manage going forward. Operational and strategic risk process for HSCP is in place and is overseen by Heads of Service. Query 20/10 Exception

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								Report on the supporting evidence from MJC presentation from PPCOG requested from Christine McAffray re Risk Register (RR Rec'd 20/10)
JCSIAP/1.7.2	Highlight reports presented to strategic groups are aligned to and reflect risk register priorities.		0%	Rona Gold		31-Aug-2022		
JCSIAP/1.7.3	Review and develop the CPP data reporting to strategic planning groups including the CPC the data will include: establish baseline data; benchmark data; outcomes measures; performance and improvement data; direct observation of practice; review of documents; views of service users lived experience; views of stakeholders and professionals.		0%	Rona Gold		31-Oct-2022		
JCSIAP/1.7.4	Review the third sector annual census to support analysis of training needs and identify practice development requirements		100%	Rona Gold	Selina Ross	31-Oct-2022	27-Feb-2023	

LO **8. The Community Planning Partnership understands our performance and can identify strengths & areas for improvement**

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.8.1	For children and young people at risk of harm of the Care Inspectorates 'Self-evaluation for improvement' guidance to support the development of data will be adopted.		90%	Natasha MacPherson	Paula Godfrey	31-Aug-2022		Care Inspectorate QIF framework is being adopted for use in QA & evaluation by CPC. Framework and plan for audit to be

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								presented at CPC on 5/9/22.
JCSIAP/1.8.2	Develop a reflective practice approach in social work services to support implementation of practice and supervision standards.		0%		Lesley James	29-Jul-2022		
JCSIAP/1.8.3	Evaluate case recording standards and use of reflective supervision through planned case file audit activity within children's social work services.		75%	Paul Kyle; Annie Ritchie	Lesley James	26-Nov-2022		Work has been considered by Paul Kyle and Annie Ritchie and while this as stalled fro a while there was further investment towards the end of 2022. It is considered that this will be picked up again in janaury 2023.
JCSIAP/1.8.4	Review the data set used by the CPC and ensure routine analysis to inform priorities and actions.		100%	Natasha MacPherson	Paula Godfrey	31-Aug-2022	27-Feb-2023	Minimum dataset in place. Consideration being given to the implementation of Version 2 of the dataset. Scrutiny meeting takes place quarterly to review dataset and make recommendations to Committee.
JCSIAP/1.8.5	Review local data set aligned to the QIF, service area and national reporting.		80%	Natasha MacPherson	Paula Godfrey	31-Aug-2022		Care Inspectorate QIF framework is being adopted for use in QA & evaluation by CPC. Framework and plan for audit to be presented at CPC on 5/9/22.

9. Community Planning Partnership is a learning organisation where plans and implementation activity reflect good practice guidance and national developments

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/1.9.1	Child Protection Committee will continue to engage in the West of Scotland forum to develop joint procedures and protocols aligned to the National Guidance for Child Protection in Scotland [2021]		75%	Natasha MacPherson	Paula Godfrey	31-Oct-2022		
JCSIAP/1.9.2	Adopt and implement the Learning Review national guidance to replace Initial Case Review and Significant Case Review guidance, and included in Training Schedule for Partnership staff.		100%	Natasha MacPherson	Paula Godfrey	30-Jun-2022	29-Aug-2022	Completed and guidance established 22/08/2022
JCSIAP/1.9.3	Review output from staff survey to further explore variation between staff groups and build actions into staff development programme and service design		50%	Natasha MacPherson		29-Jul-2022		

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

1. Community Planning Partnership Model for Improvement in place

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.1.1	In relation to children at risk of harm the Care Inspectorate model for improvement will be adopted by all relevant Community Planning Partners. Community Planning to agree the reporting and assurance arrangements.		100%	Lesley James	Beth Culshaw	31-Aug-2022	27-Feb-2023	

2. Community Planning Partnership Self-Evaluation Framework is in place, used and regularly updated

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.2.2	Strategic agreement required on Self-Evaluation framework in relation to children and young people at risk of harm. Framework must include the views and lived experience of children, young people and their families.		100%	Lesley James	Beth Culshaw	30-Jun-2022	27-Feb-2023	
JCSIAP/2.2.3	Develop and agree Partnership SMART Improvement Plan template – use at strategic & operational level Set implementation review date		0%	Lesley James	Beth Culshaw	30-Apr-2022		

3. Community Planning Partnership has oversight of child protection practice

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.3.1	Annual programme of audit activity in place, reviewed & agreed by strategic planning groups, CPC, governance groups and Corporate/SMT		50%		Lesley James	29-Sep-2022		
JCSIAP/2.3.2	Review of integrated Children's Services Plan and sub group structure. Further develop outcomes focused framework and evaluation		100%	Claire Cusick	Laura Mason	20-Jan-2023	20-Jan-2023	ICSP reviewed to reflect positive SG feedback and identified next steps. Outcomes identified and included.

4. Strategic Community Planning Groups & service areas are supported to carry out the self-evaluation activity

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.4.1	The CPC audit plan specifies the resources identified to support partnership and service area activity.		100%	Natasha MacPherson	Lesley James	29-Sep-2023	27-Feb-2023	

LO 5. Our self-evaluation approach is outcomes focused and has lived experience at the core

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.5.1	Develop and embed a consultation model to gather experience from CYP and parents family/unpaid carers to support QA and inform service development		0%	Nicholas Gallacher	Margaret-Jane Cardno	29-Oct-2022		
JCSIAP/2.5.2	Develop and implement a programme of face-to-face supported sessions with CYP and family/unpaid carers to gather lived experience to support QA and inform Partnership priorities and developments.		0%	Nicholas Gallacher	Margaret-Jane Cardno	29-Oct-2022		
JCSIAP/2.5.3	Develop evaluation framework to focus on outcomes - Aligned to Action 2.5.2		100%	Nicholas Gallacher	Margaret-Jane Cardno	30-Mar-2023	27-Feb-2023	

LO 6. Governance is clear & includes professional oversight

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.6.1	Clinical & Care Governance Group Terms of Reference to be reviewed and include oversight of all service inspections and improvement plans,		100%	Val Tierney	Fiona Wilson (HSCP)	30-Sep-2022	27-Feb-2023	Report on the CP inspection and Action plan to NHSGGC PPF for noting Sept 2022– as part of our oversight

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								arrangements – PPF have agreed to act as a critical friend and we also secured support from NHSGGC PPU with respect to our improvement activity .
JCSIAP/2.6.2	Review Terms of Reference for Improvement Action group [previously Oversight Group]		100%		Beth Culshaw	29-Apr-2022	27-Nov-2022	
JCSIAP/2.6.3	Establish Executive Oversight Group with Terms of Reference in place		100%		Beth Culshaw	29-Apr-2022	27-Nov-2022	

7. Strategic Community Planning Partners are aware of self-evaluation activity and actions arising from findings to support improved outcomes for CYP at risk of harm

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.7.1	Report annually self-evaluation for consideration at: PPCOG, CPC, CPP Annual Report, CSWO annual report and HSCP Board.		0%	Natasha MacPherson; Lyn Slaven	Paula Godfrey; Lesley James	31-Oct-2022		

LO

8. Assessment, planning tools and intervention support outcomes focused, child centred practice

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.8.1	Conclude current revision of Integrated assessment tools and child plans in children's services social work.		100%	Annie Ritchie	Lesley James	31-Aug-2022	27-Feb-2023	This work was initially supported by Children's Hearings Scotland

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								and SCRA via a Short Life Working Group. The SCRA element will be reviewed within Better Hearings meetings – about to re start- however SLWG will require to be refreshed to support entire roll out and launch. Report to EOG meantime, progress to Nurture DIG.
JCSIAP/2.8.2	Multi agency learning, and development sessions delivered to practitioners on Child Centred assessment and SMART planning		100%	Natasha MacPherson	Paula Godfrey	30-Sep-2022	27-Feb-2023	Plan agreed to firstly complete single agency social work training for all social work staff in relation to multi-agency assessment and SMART planning. This is planned for all Social Work staff on the following dates – 10/10. 12/10, 09/11. Consider multi-agency training, following the conclusion of the single agency training planned.
JCSIAP/2.8.3	Review adult parenting capacity assessment to include recording and evaluation of impact to strengthen focus on early identification and intervention.		0%	Barry Sheridan	Sylvia Chatfield	30-Dec-2022		BS has left post. S Chatfield to provide update.
JCSIAP/2.8.4	Deliver trauma informed practice programme and further develop trauma champions as part of		100%	Paul Kyle; Lesley Sherwood	Laura Mason	31-Aug-2022	27-Feb-2023	Links have been made with the

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
	Keeping the Promise implementation plan.							health Improvement team and the focus of this work has been discussed as part of The promise sub group. Staff across all of Children's Houses have been trained in DDP. An application for funding to build upon this work was rejected, however we remain involved in activity along with the health Improvement Team.

9. Information, early intervention and support services are outcomes focused

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/2.9.1	Review contract schedule for commissioned services and develop audit and outcomes focused evaluation.		25%		Margaret-Jane Cardno	30-Dec-2022		New person taken up post January 2023.
JCSIAP/2.9.2	Review and further develop evaluation framework aligned to the interventions within the Wave Trust campaign.		25%		Margaret-Jane Cardno	30-Dec-2022		Person took up post January 2023, work has started.

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

	1. Children and Young People and their families lived experience, are at the centre of service delivery and improvement

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/3.1.1	Review and implement the "Practice guide: Involving children and young people in improving children's services" Care Inspectorate and audit current practice against the guidance and Quality Improvement Framework		0%			01-Apr-2023		
JCSIAP/3.1.2	With support from Corporate SMT and governance groups develop with Children young people and families a 'Consultation, Participation, and Involvement Plan for services and strategic planning groups' to include systematic gathering of feedback and a co design approach		75%	Claire Cusick; Gillian Kirkwood	Laura Mason	30-Mar-2023		Strategy gpr established- multi agency Draft Strategy Produced and being consulted on Consultation with range of partners/yp/Youth Council Undertaken Survey of chn/yp and parents undertaken to inform strategy Good practice being identified UNCRC professional learning sessions planned and underway
JCSIAP/3.1.3	Using national and local good practice develop good practice guidance to support co design of services. Aligned to Action 3.1.2 systematic gathering of feedback and a co design approach		75%		Margaret-Jane Cardno	30-Dec-2022		

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/3.1.4	Review the role, function, and operational support for the Champion's Board		75%	Paul Kyle	Lesley James	30-Sep-2022		Awaiting the return of the champions board manager and the associated team leader to take this forward. Both off work at the moment. Some links have been made with The Promise lead and the champions board support worker.
JCSIAP/3.1.5	Develop Champions Board role to include active involvement in tests of change in relation to service development to ensure the voice of care experienced young people is incorporated into service design. Current focus is on the introduction of Viewpoint		60%	Paul Kyle	Lesley James	30-Sep-2022		Work has been carried out across WDC to consider how to increase the opportunities to listen to and record the views of children and young people. All staff across SW have been invited to attend the VIEWPOINT training. This opportunity has been provided to a range of other agencies, who have learnt how to navigate/use the associated systems and mobile Apps. As an addition to this, mobile Apps are being considered for usage in adoption cases and life story work.

2. Children, young people and their family members are supported to participate and are able to express views

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/3.2.1	Identify and supply digital solutions for services to enable children, young people and families to fully participate in individual and strategic planning meetings.		80%	Alastair Handley	Lesley James	28-Oct-2022		
JCSIAP/3.2.2	Review of independent Advocacy services for children, young people and families		90%		Margaret-Jane Cardno	31-Mar-2023		Currently being reviewed by NMcK and LJ
JCSIAP/3.2.3	Review social work services minute taking and recording standards, to ensure that the views of children, young people and family members are routinely requested and recorded in minutes of meetings, plans and children's records.		0%	Annie Ritchie	Lesley James	30-Jun-2023		

3. West Dunbartonshire is a positive and active corporate parent and supports full implementation of The Promise

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/3.3.1	Review current Corporate Parenting activity		80%	Paul Kyle; Annie Ritchie	Lesley James	31-Oct-2022		Awaiting the return of the team leader and Corporate parenting manager, following a period of ill health.
JCSIAP/3.3.2	Following review of local practice and good practice guidance in relation to corporate parenting develop an options paper and action plan for further approval by Nurture DIG and wider corporate parents.		0%	Paul Kyle	Lesley James	31-Oct-2022		Awaiting the return of the corporate parenting manager and the associate team leader

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								following a period of ill health.
JCSIAP/3.3.3	Implement revised approach to corporate [good] parenting		50%	Laura Mason	Lesley James	30-Dec-2022		
JCSIAP/3.3.4	Develop a communications plan to support wider understanding of the role of corporate parents across the Community Planning Partnership		1%	Paul Kyle	Lesley James	30-Dec-2022		A plan was agreed with the corporate parenting manager and this was made a part of a working plan to progress this. However, the manager went off sick before this could be commenced. The Team leader overseeing this matter also went off sick and this remains an outstanding task. This is an area of work that requires further discussion to see how we manage the input required, however this can be achieved.

LO	**4. Children, young people, families and the wider public have easy access to information on service delivery and developments**

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/3.4.1	Review and audit of current web-based public information from		25%	Euan McLean	Margaret-Jane Cardno	31-Aug-2022		Currently recruiting to job role

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/3.4.2	Develop web based resources working with children and young people to inform the content and the design process. Aligned to Action 3.4.1		0%	Alastair Handley	Margaret-Jane Cardno	30-Mar-2023		

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

1. We have a shared vision for services supported by aligned strategies and service plans

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/4.1.1	Develop and deliver a workshop for Community Partnership's senior leaders to reflect, consider and develop a shared vision, values and outcomes for services to CYP at risk of harm		100%	Rona Gold	Beth Culshaw	31-Aug-2022	27-Feb-2023	
JCSIAP/4.1.2	Review of DIG Implementation Plans to ensure they reflect national agenda and local priorities for children and young people.		0%	Rona Gold		31-Oct-2022		
JCSIAP/4.1.3	Review operational and strategic support for the Child Protection Committee, ensuring that all partners are fully represented and participate in the work of the committee.		100%	Lesley James		31-Oct-2022	27-Feb-2023	
JCSIAP/4.1.4	Ensure all partners are fully represented and participate in the child protection committee and the work identified within the work identified in sub group structures. Routine progress updates to PPCOG		100%	Lesley James		31-Oct-2022	27-Feb-2023	
JCSIAP/4.1.5	Develop HSCP Board Strategic Plan to align with national developments and Integrated Children's Services Plan		0%	John Burns	Margaret-Jane Cardno	31-Mar-2023		
JCSIAP/4.1.6	Develop and recruit a GIRFEC Lead Officer to		30%	Laura Mason	Lesley James	01-Nov-2022		Job at job

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
	support partnership working aligned to Integrated Children's Services Planning (ICSP)							evaluation panel.

	2. Risk to children and young people is effectively identified and assessed with plans focussing on improving outcomes.

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/4.2.1	Develop and implement independent chairing arrangements for Looked After Children including Independent Fostering and Adoption Panel Chair.		100%		Lesley James	01-Jul-2022	27-Feb-2023	Approved at IJB June 2022.
JCSIAP/4.2.2	Review child protection chairing arrangements to ensure appropriate scrutiny, focus on outcomes and children's representation and views are included.		80%		Lesley James	01-Jul-2022		Approved at IJB June 2022.
JCSIAP/4.2.3	As key part of independent review role ensures children and young people and family are fully involved in participation and planning.		100%	Paul Kyle	Lesley James	30-Sep-2022	27-Feb-2023	Interviews fro the four independent reviewing officers will take place in January 2023 and it is hoped that provision of this role will commence in March/April 2023.
JCSIAP/4.2.4	Permanency planning process and monitoring is tracked in line with Looked After Children Regulations, and scrutiny is supported with the development of a core dataset.		100%	John Burns; Paul Kyle	Lesley James	30-Dec-2022	27-Feb-2023	There is now a monthly permanency tracking process in palce, with both senior mamangers and al lteam leaders involved. This has allowed scoping of the drift and delay

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
								noted and allows fro individual plans to be taken forward. The development of the tracking meeting have allowed an opportunity for creative thinking around how we meet expectations. Our data set is managed by business support and all records and decisions of the tracking meeting are updated on our CAREFIRST system.
JCSIAP/4.2.5	Review interagency approach to Chronologies across all education, health and social care services to ensure reflects good practice [links to statement 1 - risk management]		0%	Kate Kerr; Elaine Smith	Laura Mason	30-Sep-2022		Multi agency training has been developed with a planned roll out early 2023. Guidance is currently being updated. This work is also being progressed via GIRFEC refresh work group
JCSIAP/4.2.6	Develop and deliver interagency training on the use of chronologies as part of the CPC programme		0%	Kate Kerr; Clare McKendrick	Lesley James	31-Oct-2022		
JCSIAP/4.2.7	Audit schedule of wellbeing assessments undertaken by Health Visitors is in place with monitoring in place through C&CG and as integrated part of partnership audit activity		0%	Elaine Smith	Val Tierney	30-Dec-2022		Ongoing activity via GGC and HSCP to provide assurance of quality care

3. Performance reporting, policies and procedures support staff to deliver high quality outcomes focused services

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/4.3.1	Review HSCP policies & procedures to align with good practice guidance in relation to children at risk of harm.		100%	Karen Marshall	Lesley James	31-Mar-2023	27-Feb-2023	
JCSIAP/4.3.2	Service KPIs and impact measures further developed with staff to support understanding and embedding of self-evaluation approach and performance reporting		0%			31-Mar-2023		
JCSIAP/4.3.3	Refresh training and development programme for members of the Child & Adult Protection Committees to develop their skills and knowledge in relation to their role to provide oversight and scrutiny of data.		0%	Natasha MacPherson	Paula Godfrey	30-Nov-2022		

4. Staff are able to access policies, procedures, good practice examples and national information easily

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/4.4.1	Audit of current web-based intranet information (links to 3.4.1 - review of public facing web based information)		100%	Euan McLean	Margaret-Jane Cardno	31-Aug-2022	27-Feb-2023	
JCSIAP/4.4.2	From audit baseline develop web based resource through commissioned design resource		0%	Alastair Handley	Margaret-Jane Cardno	30-Dec-2022		

5. Leadership teams are more visible to staff

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/4.5.1	Develop Community Partnership Communication and engagement plan		0%	Euan McLean	Beth Culshaw	31-May-2022		
JCSIAP/4.5.2	iMatters Plan in place to address visibility of Corporate/SMT [HSCP] assisted by easing of Covid regulations		100%	Moira Wilson	Beth Culshaw	31-Aug-2022	20-Dec-2022	iMatter action plan in place.
JCSIAP/4.5.3	Develop communications plan for the CPC including regular newsletters to staff on the areas for improvement; improvement stories; news items as part of wider Community Planning Partnership communications		90%	Euan McLean	Paula Godfrey	30-Jun-2022		Communication Strategy to be presented to CPC on 5th September 2022.

6. Practitioners are supported to develop skills and knowledge through multi agency, peer led learning and development opportunities

Action Code	Action Description	Status Status Icon	Progress Bar	Assigned To	Managed By	Due Date	Completed Date	Latest Note
JCSIAP/4.6.1	Further develop multi agency practice forums to incorporate learning from audit, evaluation activity and national practice.		75%	Natasha MacPherson	Paula Godfrey	30-Dec-2022		

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Report by: Val Tierney Chief Nurse

HSCP Board Audit and Performance Committee : 20 June 2023

Subject: Care Inspectorate Inspection report for 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 three independent sector residential older peoples' 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, 2 – Weak, 3- Adequate, 4 – Good , 5- Very Good, 6 – Excellent.

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:

- Strathleven Care Home;
- Hillview Care Home;
- Castle View Nursing 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

Strathleven Care Home

4.1 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 17 residents being supported in Strathleven Care Home.

4.2 This Care Home was inspected between 24 and 25 January 2023 and the report issued in February 2023. 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**
26.01.23	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**
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**
07.06.22	3	3	3	Not Assessed	Not Assessed

4.3 The grade of '3 – Adequate' received for the Key Question 1, 2 and 3 is an increase from the previous inspection. In this recent inspection report there were no requirements highlighted for remedial action by the service.

4.4 This visit was to follow-up on the previous inspection in September 2022 where the service received grades of 2 in Key Questions 1, 2 and 3 and had 6 requirements to be met by 23 December 2022. All requirements were met within the allocated timescale.

4.5 The Home Manager works closely with the HSCP and Care Home Collaborative to ensure that the standard of care and support continues to improve.

Castle View Nursing Home

4.6 Castle View Nursing Home is owned by HC-One Limited. Castle View Nursing Home is registered with the Care Inspectorate for a maximum of 60 residents – including 10 residents under the age of 65 with physical disabilities. At the time of inspection there were 54 residents being supported in Castle View Nursing Home.

4.7 This Care Home was inspected between 25 and 30 January 2023 and the report issued in February 2023. The table below summarises the grades awarded to Castle View Nursing 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**	
31.01.23	3	4	3	4	4	
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**	**How good is our care and support during COVID**
23.08.21	4	Not Assessed	Not Assessed	Not Assessed	Not Assessed	4
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**	**How good is our care and support during COVID**
27.08.20	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed	4

4.8 This was a full inspection focussing on all 5 Key Questions. The grade of '3 – Adequate' received for the Key Question 1 was a decrease from the previous inspection. In this recent inspection report there were no requirements highlighted for remedial action by the service.

4.9 A new Care Home Manager took over late December 2022. Since taking up post the Manager had been working on building relationships with staff, residents and relatives. She was reviewing practices throughout the home and developing an action plan. During the inspection Inspectors highlighted some 'Areas for Improvement' many of which the Manager had already picked up and included in her action plan.

4.10 Inspectors noted the positive impact the new Manager was having on the service and this had been echoed staff, residents and relatives during the inspection.

4.11 Management and staff continue to work to improve the service.

Hill View Care Home

4.12 Hill View Care Home is owned by Davina Care Homes Limited. Hill View Care Home is registered with the Care Inspectorate for a maximum of 150 residents – including 8 under the age of 65 with physical disabilities. At the time of inspection there were 142 residents being supported in Hill View Care Home.

4.13 This Care Home was inspected between 8 and 10 March 2023 and the report issued at end of April 2023. The table below summarises the grades awarded to Hill View 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**	
13.03.23	3	4	4	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**	**How good is our care and support during COVID**
01.04.22	3	3	Not Assessed	Not Assessed	Not Assessed	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**	**How good is our care and support during COVID**
25.06.20	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed	4

4.14 This was a full inspection focussing on all 5 Key Questions. The grade of '4 – Good' received for the Key Question 2 was an increase from the previous inspection. In this recent inspection report there were 5 requirements which were highlighted for remedial action by the service by 1 August 2023, these are:-

1. The provider must ensure service users experiencing falls or similar experiences with the potential for harm:
   (a) Receive assessment of their condition immediately after the experience by a suitably qualified staff member;
   (b) Receive appropriate reassessments in line with good practice;
   (c) Have their condition, following assessment and reassessments, clearly and accurately recorded.

2. The provider must ensure that restraint of service users is only considered or used where it is the only practicable means of securing the welfare and safety of service users and there are exceptional circumstances. To achieve this, the provide must, at a minimum:
   (a) Ensure staff involved in decision making on restraint are aware of and compliant with relevant legislation and good practice guidance including that of the Mental Welfare Commission for Scotland;
   (b) Involve service users and their representatives in discussions and decisions relating to use of restraint and gain their consent, where reasonably practicable;
   (c) Maintain full and accurate records that detail the circumstances leading to concerns, decision arrived at; and
   (d) Review the use of restraints, including impact on service users, no less than every six months.

3. The provider must ensure that people's care and support needs are reviewed not less than six-monthly or more frequent if required. Reviews must ensure:
   a) All information relating to the individual is accurate and up-to-date;
   b) Risk assessments are accurate and up to date;
   c) Service users and families are supported to be fully involved;
   d) Identify actions to be followed to improve outcomes for people.

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

5. The provider must ensure that the environment is clean and all mattresses, chairs and other equipment is regularly cleaned and checked. In order to achieve this, the provider as a minimum must:
   a) Carry out deep cleaning of the environment to support good infection control practices and ensure the environment is pleasant place to live for people experiencing care. Particular attention must be given to assure the cleanliness of chairs and mattresses and all equipment in use and to replace items that cannot be sufficiently cleaned.
   b) Implement a robust quality assurance system which would ensure regular checks are carried out on such equipment and an action plan developed in order to make improvements

4.15 Whilst the Home Manager is awaiting the Care Inspectorate Action Plan she has developed her own internal care plan to ensure that the service is actively working towards meeting the timescales for these requirements.

4.16 The Manager is keen to work alongside any supporting agencies to improve the service being delivered within Hill View. She is awaiting a date to begin working alongside the Care Inspectorate on a Quality Improvement Project within the Service.

4.16 The Home Manager is working with the HSCP and Care Home Collaborative to progress work to meet the requirements within the specified timescale of 1 August 2023.

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 There are no financial or procurement implications with this report.

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 The HSCP Senior Management Team, the Monitoring Solicitor and the Chief Finance Officer have all be consulted in the production of this report and their comments incorporated accordingly.

12. Strategic Assessment

12.1 On the 15 March 2023 the HSCP Board approved its Strategic Plan 2023 – 2026 “Improving Lives Together”. The Plan outlines sustained challenge and change within health and social care, these changes bring with them a host of governance implications: cultural, operational, structural, ethical, care and clinical. Good governance and a robust approach to clinical and care governance which includes quality assurance, is essential to ensure the actions within the Strategic Plan are implemented effectively and efficiently in a way which promotes safe and effective care whilst achieving best value

13. Directions

13.1 Not required for this report.

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Date: **06.06.2023**

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Appendices:
Appendix 1 – CI Report Strathleven Care Home
Appendix 2 – CI Report Hillview Care Home
Appendix 3 – CI Report Hillview Care Home

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

Wards Affected: All

Item 18
Appendix 1

Castle View Nursing Home
Care Home Service

200 Castlegreen Street
Dumbarton
G82 1JU

Telephone: 01389 764 700

Type of inspection:
Unannounced

Completed on:
31 January 2023

Service provided by:
HC-One Limited

Service provider number:
SP2011011682

Service no:
CS2011300851

About the service

Castle View is a purpose-built two storey care home situated in a quiet residential area of Dumbarton. The service was registered with the Care Inspectorate in October 2011.

The home is set within its own grounds with ample parking facilities to the front and spacious secure garden areas surrounding the home. It is close to local amenities and transport.

The service provides nursing care for a maximum of 60 people. This is for 10 people under the age of 65 with physical disabilities and 20 older people with physical frailty on the ground floor. The second floor supports 30 people living with dementia.

At the time of the inspection, there were 54 people living in the home.

There are lounges, dining rooms and adapted bathrooms and showers on each floor.
All bedrooms are single bed accommodation and have en suite facilities.

The aim of the provider, HC-One Limited, is to 'have the kindest homes in the UK with the kindest and most professional staff, we are a company founded on the principles of involvement, accountability and partnership'.

About the inspection

This was a full inspection which took place on site, between 25 and 26 January 2023. A review of further documentation, that was sent electronically, took place between between 27 and 30 January. The inspection was carried out by three inspectors from the Care Inspectorate.
To prepare for the inspection we reviewed information about the service. This included information submitted by the service and intelligence gathered since the last inspection.
In making our evaluations of the service we spoke with 12 residents and 6 relatives, to gather their views and observed care provision for those who were unable to communicate with us. We considered resident, relative and representatives' feedback and spoke with 15 staff and the management team. We also spoke with 3 visiting professionals to the service.
We observed staff practice, daily life for residents, reviewed documents and spoke with external professionals who support the home.

Key messages

- Their had been a recent appointment of an experienced manager, and staff spoke positively about the impact they had made on the home.
- The service had met five of the seven previous areas for improvement. Two outstanding areas for improvement relating to activities, and staff supervisions have been repeated at this inspection.
- There were a number of areas for improvement made at this inspection however, we were assured by the management's commitment and vision in how to make improvements within the service.

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?	4 - Good
How good is our staff team?	3 - Adequate
How good is our setting?	4 - Good
How well is our care and support planned?	4 - 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 made an evaluation of adequate for this key question, which meant we identified some strengths that just outweighed weaknesses.

1.3 People's health benefits from their care and support

The service had made sufficient progress to meet five areas of improvement made at or since the previous inspection. These were relating to noise levels, protection of people from harm, reporting unexplained bruising, involving families and duty of candour.

Feedback from relatives we spoke with was positive about the care and support their family members received. Comments included:

"Staff are great with him; they know him well".
"So far, she has settled well and started to gain weight, staff have been really good".

Meetings held throughout the day made sure important information was discussed among staff about the health needs of residents. This meant that staff were kept informed about the residents and any changing needs.

Clinical assessments were in place to help identify risks for residents. Regular updates made sure information was up to date about residents' health and preferences. Advice and assistance had been sought from external clinical staff and instructions had been followed. This showed that residents had received the right care at the right time.

Medication Administration Records were completed well, which meant that residents had received the medication as they were prescribed.

Residents were generally supported by knowledgeable staff in a warm and respectful way. However, we observed two occasions where residents had been asked to leave communal areas to accommodate staff discussions. This is subject to an area for improvement.
(See area for improvement 1 under Key Question 3).

People could benefit from the dining experience being improved upon in relation to hand hygiene, support offered and meal choices. Specific information was provided at feedback.
(See area for improvement 1)

Daily charts were not always completed well such as, the recording of personal hygiene and oral health. This meant important information about how people were being supported and monitored may be missed.
(See area for improvement 2)

We found that language recorded was not always dignified within the behaviour recording charts. There was also a lack of analysis of the information which meant effective management strategies may have been missed.
(See area for improvement 3)

We saw evidence of a range of group and individual activities which had taken place however, records of these were not always completed well. While some records showed regular and individual engagement with people, some showed a number of days between. We also found that activities did not consider supporting people in maintaining and developing skills and independence. The service planned to recruit additional activities staff as well as provide activities training.
An area for improvement previously made has therefore been repeated.
(See area for improvement 4).

We discussed how there were no separate 'aims and objectives' for younger adults being supported. The manager assured us this would be actioned.

1.4 People experience meaningful contact that meets their outcomes, needs and wishes

The service was operating in line with Scottish Government's 'Open with Care' guidance relating to supporting visits within the home. Relatives spoke to us how they were supported with this. We saw evidence of how the service responded well to outbreaks in line with Infection Prevention and Control guidelines. This helped to protect people and limit further spread while supporting essential visiting. Relatives spoke to us about how well they had been supported with visiting.

1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure

Residents were supported by staff trained in infection prevention and control (IPC). Personal protective equipment and handwashing stations helped staff to follow appropriate IPC practices.

Posters reminded staff of current IPC guidance and we saw staff following this. The service had IPC champions to also help promote good practice throughout the home.
However, as mentioned under 1.3, residents were not supported with handwashing before meals which would help reduce the risk of infection spread. This is included within area for improvement 1, relating to the dining experience.

Records of cleaning and maintenance showed how regular cleaning and repairs had been undertaken. Housekeeping staff were observed throughout the day cleaning communal areas, touch points and bedrooms. The service was not working to its full complement of housekeeping staff however, this was being addressed.

IPC audits helped make sure infection control measures worked well.
Although the environment was mostly clean, we found some chairs, cushions, mattress covers and underneath tables within communal areas were marked. We also found one soiled mattress although this was quickly replaced. We suggested making mattress checks more frequently to help identify any issues promptly.
(See area for improvement 5)

The service had been responsive to outbreaks and responded quickly to reduce the risk of infections spreading.

Areas for improvement

1. To promote the health and wellbeing of people, the dining experience should be improved upon relating to meal choices and support provided by staff. The service should make sure that hand hygiene is supported prior to and after eating food.
This ensures care and support is consistent with the Health and Social Care Standards, 1.19 which states 'My care and support meets my needs and is right for me' and 1.37 'My meals and snacks meet my cultural and dietary needs, beliefs and preferences'.

2. The completion of daily care charts should be improved upon. These should include, but not be limited to, personal care and oral care to help demonstrate how people's needs are being met in full.
This ensures care and support is consistent with the Health and Social Care Standards, 1.19 which states 'My care and support meets my needs and is right for me'.

3. The completion of behavioural recording charts should be improved upon. These should demonstrate how effective analysis of information has led to people's stress and distress needs being met in full. In doing so, the language used within the records should be more respectful and dignified.
This ensures care and support is consistent with the Health and Social Care Standards, 1.19 which states 'My care and support meets my needs and is right for me'.

4. The provider should further develop the range and availability of meaningful activities offered in the home considering the abilities, preferences and choices of everyone living in the home. Staff would benefit from training to ensure that they understand the importance of engaging people with meaningful activity.
This is to ensure care and support is consistent with the Health and Social Care Standards, 1.25 which states: 'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day'.

5. To minimise the risk of infection, there should be more attention to detail with cleaning tasks, to include chairs, cushions, mattress covers and underneath tables within communal areas.
This ensures care and support is consistent with the Health and Social Care Standards, 4.11 which states 'I experience high quality care and support based on relevant evidence, guidance and best practice'.

How good is our leadership? 4 - Good

We made an evaluation of good for this key question. We identified a number of important strengths which, taken together, clearly outweigh areas for improvement.

Staff spoke positively about the management and leadership within the service and how approachable and supportive management were.

Quality assurance systems helped identify any concerns about practices or record keeping. Action plans showed what steps the service had taken on areas needing improvement. Information formed part of the Home Improvement Plan which demonstrated the service's future plans for development.

Residents benefitted from a well organised staff group who knew them well. Units were managed individually and well led by more senior staff. Management had a good overview of the service including any health concerns of residents.

There were some incidences where the service had not advised the relevant agency of notifiable events.

Although, we acknowledged that some of these appeared to be a genuine oversight by the management team, an area for improvement has been made.
(See area for improvement 1)

Management had worked hard to make sure that they always had the right number of staff on duty. Agency staff had been used to help cover staff absences. Where possible, the service had tried to be consistent with the same agency staff they requested, to care for and support residents in the home.

Dependency assessments were completed each month. These were used to calculate how many staff were needed to meet residents' needs each day. However, these calculations did not take account of all the non-direct care tasks staff completed. This meant we could not be fully assured that there were enough staff working at any one time.
(See area for improvement 2)

Areas for improvement

1. The provider should ensure that the relevant agencies are advised about notifiable events timeously. This ensures care and support is consistent with the Health and Social Care Standards 4.11 which states "I experience high quality care and support based on relevant evidence, guidance, and best practice".

2. A review of staff tasks should be completed to make sure there are enough direct care hours carried out by the right number of staff to meet residents' needs. In doing so, this should take account of the non-direct care tasks that more senior staff undertake on a daily basis.
This ensures care and support is consistent with the Health and Social Care Standards 4.11 which states "I experience high quality care and support based on relevant evidence, guidance, and best practice".

How good is our staff team? 3 - Adequate

We made an evaluation of adequate for this key question, which meant we identified some strengths that just outweighed weaknesses.

Residents benefitted from a responsive staff team who sought clinical advice from healthcare professionals for people's changing needs. We observed staff supporting and engaging with residents and visitors in a warm and respectful way. Residents and relatives spoke very highly of the staff.

Staff knew, and could discuss, the needs of residents well. This meant people could be confident that staff were aware of important information needed to support them safely.

The recording of recruitment information demonstrated that best practice had been followed and showed that relevant checks had been completed.

The service regularly checked that staff were up to date with their professional registration. Staff were supported to work towards meeting any conditions indicated on their professional registration.

We found some gaps in staff training and not all staff were confident in describing the training they had received. This meant that we could not be assured all staff were trained in all residents' needs. A number of staff were unaware of or did not follow best practice guidance. This included, the Mental Welfare Commission's 'Rights, Risks and Limits to freedom' and 'Safe to Wander' guidance. We also found staff

unaware of relevant strategies and standards such as 'Keys to Life', 'My Home Life' and the Health and Social Care Standards.

The new manager discussed plans they had to address training shortfalls however, an area for improvement has been made.
(See area for improvement 1)

Staff supervision sessions required further development in order to provide support and identify development needs. This could have helped to assess staffs' skills and knowledge, reinforce best practice, and help inform training needs as well as providing individual support.
An area for improvement previously made has therefore been repeated.
(See area for improvement 2)

Areas for improvement

1. The manager should develop and maintain staff knowledge and practice to make sure they are competent and skilled to support residents effectively. This should include staff awareness of people's rights and best practice documents.
In doing so, staff competencies and knowledge should be carried out to ensure staff have understood their training.
This is to ensure care and support is consistent with the Health and Social Care Standards, 3.14 which states: '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'.

2. Staff should have access to regular supervision and appraisal. Examples of actions required to progress this area should include;

(a) Combining observations of staff competency, supervision and appraisal into the new 'supervision and appraisal' process.
(b) Developing supervision further to afford people using the service the opportunity to share their opinion about the support they receive from staff.

This is to ensure care and support is consistent with the Health and Social Care Standards, 3.14 which states: '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'.

How good is our setting? 4 - Good

We made an evaluation of good for this key question. We identified a number of important strengths which, taken together, clearly outweigh areas for improvement.

Where assistance was required from staff, residents could seek this through a pull cord system which was regularly maintained. Secure door entry systems also helped keep people safe.
Where people required specific equipment to meet their needs, this was in place. These measures had helped to make sure residents were secure and safe.

The regular maintenance programme and repairs made sure residents had equipment that was in good condition and worked properly.

There was a range of communal as well as private areas for residents to use, which were well presented, tidy and clutter free.
Residents had lockable single rooms, with en-suite toilet facilities, and could personalise their rooms as they wished. Lockable drawers for the safe storage of valuables were also available within bedrooms. This all had a positive impact on people's wellbeing and sense of belonging.

Some of the environment did not meet the needs of people living with dementia. This meant some residents could not move around safely and with confidence. Signage, fitting and fixtures should be improved and adapted to be in line with best practice guidelines.
Additionally, residents had limited access to facilities and/or support with daily living skills such as cooking and laundry. This meant residents were de-skilled and had limited choices.
(See area for improvement 1)

We took other information about the environment, reflected elsewhere within this report, into consideration when grading this Key Question.

Areas for improvement

1. To support people living with a learning disability and dementia, the service should ensure that the environment is developed to meet the needs of people living there. This should include but not be limited to ensuring the environment:

- Has appropriate and recognisable signage for easier navigation
- Encourages independence and social interaction.

This is to ensure good practice in line with 'My new home' Supporting people with an intellectual/learning disability and advanced dementia moving into a care home. Guidance for staff, section 'Environment' and in line with The Health and Social Care Standards (HSCS) 'The premises have been adapted, equipped and furnished to meet my needs and wishes'. (HSCS, 5.16)

How well is our care and support planned? 4 - Good

We made an evaluation of good for this key question. We identified a number of important strengths which, taken together, clearly outweigh areas for improvement.

There was some good person-centred information contained within care plans about each person's wishes and preferences. Most monthly evaluations had been completed which helped make sure information recorded was up to date and accurate. Clinical care plans and assessments were in place to help guide staff, to support people the right way to meet their needs and preferences.
However, we found that the quality of some of the care plans varied, and some lacked detail. Examples of this included, support with independent living and maintaining/developing skills, support during mealtimes and weight management.
Care plan audits had been effective in identifying sections not completed satisfactorily, however, there was not always a note to demonstrate that these issues had been rectified.
(See area for improvement 1)

Information recorded within the 6 monthly care review records could be improved upon. Specific examples were provided about this during feedback at the end of the inspection; this included poor recording of the

involvement of residents and their relatives and missing signatures.
(See area for improvement 1)

Areas for improvement

1. The service should make sure information recorded about residents is consistent and accurate. In doing so, care plans should clearly direct staff on the care and support to be provided. This should include, but not be limited to the support required:

- To maintain independence and develop skills
- During mealtimes
- To manage weight

Additionally, the recording of information and involvement of people within the 6 monthly care review minutes should also be improved upon.

This is to ensure care and support is consistent with the Health and Social Care Standards, Standard 1.15 which states that: "My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices".

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 further develop the range and availability of meaningful activities offered in the home, considering the abilities, preferences and choices of everyone living in the home. Staff would benefit from training to ensure that they understand the importance of engaging people with meaningful activity. This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day.' (HSCS 1.25).

This area for improvement was made on 23 August 2021.

Action taken since then

The service still required to make improvements on the provision of activities. More information is recorded under Key Question 1.

This area for improvement has not been met.
(See area for improvement 4, Key Question 1)

Previous area for improvement 2

The provider should take steps to reduce noise levels in the upstairs unit of the home. This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells'. (HSCS 5.18).

This area for improvement was made on 23 August 2021.

Action taken since then

Noise levels had been addressed and were no longer excessive.

This area for improvement has been met.

Previous area for improvement 3

The service should ensure people continue to be protected from harm, neglect, and abuse. This must include ongoing Adult Support and Protection training for all staff. Putting in place a system for the oversight of any accidents/incidents and appropriate actions to reduce risk, including timeous referral to external bodies such as, the Care Inspectorate and the Health and Social Care Partnership. This is in order to ensure care and support is consistent with the Health and Social Care Standards which state: 'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities'. (HSCS 3.20) 'I am protected from harm because people are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk of harm'. (HSCS 3.21) 'I am listened to and taken seriously if I have a concern about the protection and safety of myself or others, with appropriate assessments and referrals made'. (HSCS 3.22)

This area for improvement was made on 14 September 2021.

Action taken since then

Adult Support and Protection training had been provided and there was a system to oversee accidents and incidents with appropriate actions to reduce risk.
There were some incidences where the service had not advised the relevant agency of notifiable events. This element is now subject to a separate area for improvement.
(See area for improvement 1, Key Question 2)

This area for improvement has been met.

Previous area for improvement 4

Staff should have access to regular supervision and appraisal. Examples of actions required to progress this area should include;

(a) Combining observations of staff competency, supervision and appraisal into the new 'supervision and appraisal' process,

(b) Developing supervision further to afford people using the service the opportunity to share their opinion about the support they receive from staff.

This is to ensure care and support is consistent with the Health and Social Care Standards which 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'. (HSCS 3.14)

This area for improvement was made on 14 September 2020.

Action taken since then

We found that Staff supervision sessions required further development in order to provide support and identify development needs. The new system was still to be fully introduced.

This area for improvement has not been met.
(See area for improvement 2, Key Question 3)

Previous area for improvement 5

In order to support good outcomes for people experiencing care, all reports of unexplained bruising or new pain, should be taken seriously. People's symptoms should be assessed, properly documented and, if required, medical advice and/or attention should be sought promptly. This is to ensure care and support is consistent with Health and Social Care Standard 1.13: I am assessed by a qualified person, who involves other people and professionals as required.

This area for improvement was made on 1 September 2021.

Action taken since then

We saw where there had been concerns surrounding unexplained bruising and/or new pain, these had been acted on appropriately and recorded accurately. Where required, medical advice had been sought promptly.

This area for improvement has been met.

Previous area for improvement 6

In order to support good outcomes for people experiencing care, the manager should ensure that all staff understand their role and responsibility in respecting the rights of families/carers to be informed about important changes. This is to ensure care and support is consistent with Health and Social Care Standard 3.13: I am treated as an individual by people who respect my needs, choices and wishes, and anyone making a decision about my future care and support knows me.

This area for improvement was made on 1 September 2021.

Action taken since then

From a review of relevant records we found that where required, families had been informed about any important changes to their loved ones. Feedback was positive from families we spoke with about the level of communication with the home .

This area for improvement has been met.

Previous area for improvement 7

In order to promote good outcomes for people experiencing care, and their family/carers, the manager should ensure that people receive an apology when things go wrong. This is to ensure care and support is consistent with Health and Social Care Standard 4.4: I receive an apology if things go wrong with my care and support or my human rights are not respected, and the organisation takes responsibility for its actions.

This area for improvement was made on 1 September 2021.

Action taken since then

We saw relevant duty of candour records.

This area for improvement has been met.

Complaints

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

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate
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	4 - Good

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement is led well	4 - Good

How good is our staff team?	3 - Adequate
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate

How good is our setting?	4 - Good
4.1 People experience high quality facilities	4 - Good

How well is our care and support planned?	4 - Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	4 - Good

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অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

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本出版品有其他格式和其他語言備索。

Na życzenie niniejsza publikacja dostępna jest także w innych formatach oraz językach.

Item 18
Appendix 2

Hillview Care Home
Care Home Service

36 Singer Road
Dalmuir
Clydebank
G81 4SB

Telephone: 01419 413 456

Type of inspection:
Unannounced

Completed on:
13 March 2023

Service provided by:
Advinia Care Homes Limited

Service provider number:
SP2017013002

Service no:
CS2017361014

About the service

Hillview Care Home is a purpose-built care home in the Dalmuir area of Clydebank. Good public transport provides 15-20 minute links to the main Clydebank shopping centre. The care home is close to local shops and facilities.

The care home is registered to provide support to up to 150 older people, including eight with physical disabilities. Five houses, accommodating 30 people each, provide en-suite bedrooms as well as communal areas and dining rooms. A separate building houses the main kitchen, laundry and administration offices.

The service has extensive communal garden areas and people living on the ground floors of the five houses are usually able to access garden space directly from their bedrooms.

The provider is Advinia Care Homes Limited. The service's aim is to 'focus on respect, dignity and quality of life.'

About the inspection

This was an unannounced inspection which took place on 8, 9 and 10 March 2023. 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 seventeen people using the service and sixteen family members
- spoke with fourteen staff and management
- observed practice and daily life
- reviewed documents.

Key messages

- People were generally very satisfied with the care they received.
- Family members reported a high level of satisfaction with the service.
- People had access to safe, outside area.
- Planned and informal activities were taking place.
- Staff were committed to and enjoyed their work.
- Infection prevention and control practice did not follow good practice.
- Use of seat restraints were not properly assessed and recorded.
- Reviews of care and support were out of date.
- Personal plans, including risk assessments were not always accurate and up to date.

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?	4 - Good
How good is our staff team?	4 - Good
How good is our setting?	4 - Good
How well is our care and support planned?	3 - Adequate

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

Key question 1: How well do we support people's wellbeing?

We made an overall evaluation of adequate for this key question. This means we saw strengths that outweighed some weaknesses, but some work was required to improve outcomes for people.

1.3 People's health and wellbeing benefits from their care and support
People were generally happy with the care and support they received. Family members mentioned the positive approach of staff in caring for and engaging with their loved ones. Residents told us they were satisfied living in the care home. One said, 'The staff are really good.' Another said, 'Happy here, they do a good job, can't complain.'

We saw staff engaging with people in respectful, patient ways. Mealtimes were well organised and peaceful.. People were provided with choices and a number told us they enjoyed the food. This meant that people's dietary needs were being met in order to maintain or improve their health.

To help to give purpose to individuals' day and support their well-being, residents should have opportunities to take part in meaningful activities. We were concerned that the number of activities staff had significantly reduced since our last inspection. The provider advised us of plans to change their approach to activities, but these were not yet in place. While there was some evidence of activities having happened, records of activities undertaken was limited. There was a lack of information about how activities related to people's interests, preferences and life histories. **See area for improvement 1.**

The service had systems in place to support people who needed assistance with medicines. This included ensuring accurate ordering of supplies, appropriate storage and correct recording. The electronic care system provided alerts to remind staff when medication was due. This approach helped ensure people's health benefitted from receiving the right medication, in the right dose at the appropriate time.

There was a lack of evidence at times to demonstrate that people who had fallen had appropriate checks undertaken. This puts the person who has fallen at risk of further harm to their health and wellbeing. **See requirement 1.**

Where people experienced distressed reactions, records were at times lacking information and not all care plans had strategies to achieve the best outcomes for people recorded. This meant we could not be assured how effectively people were being supported during times of distressed reactions. **See area for improvement 2.**

There was a lack of correct documentation to support where people were being restrained to avoid harm. This meant that we were not assured that management and senior staff were fully aware of the legislation and their duties. **See requirement 2.**

1.4 People experience meaningful contact that meets their outcomes, needs and wishes
We previously made an area for improvement around management and senior staff understanding the Scottish Government's care home visiting guidance. This was to ensure that visitors and people living in the care home were supported to visit when convenient for them. Families we spoke to confirmed they were able to visit when they wanted, for as long as they wanted. This area for improvement has been met.

1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure

There was some good practice in reducing the risk of infection to people and staff. For instance, some staff had been observed by senior staff when putting on and taking off personal protective equipment (PPE) and all staff underwent assessment of their hand hygiene. However, there was not sufficient progress made on a requirement we had made on infection prevention and control. We found care equipment that had been identified as being cleaned after use, dirty. There was a limited range of glove sizes available to staff to help protect them and the people they supported. When we examined beds, mattresses and mattress covers we found soiling that should have been seen and acted on by staff. We were concerned enough about this to request that all mattresses and covers in one specific unit be examined by management before the end of our visit. Together with our own findings, this concluded that around one-third of mattress covers were not fit for purpose and required replacing. We have repeated our previous requirement on infection prevention and control and extended the deadline for full compliance.

Requirements

1. By 1 August 2023, the provider must ensure service users experiencing falls or similar experiences with the potential for harm:

(a) receive assessment of their condition immediately after the experience by a suitably qualified staff member;
(b) receive appropriate reassessments in line with good practice
(c)have their condition, following assessment and reassessments, clearly and accurately recorded.

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulation SSI 2011/210 Regulation 4(1)(a) - welfare of service users, and
Health and Social Care Standards which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11)

2. By 1 August 2023, the provider must ensure that restraint of service users is only considered or used where it is the only practicable means of securing the welfare and safety of service users and there are exceptional circumstances. To achieve this, the provide must, at a minimum:

(a) ensure staff involved in decision making on restraint are aware of and compliant with relevant legislation and good practice guidance including that of the Mental Welfare Commission for Scotland;
(b) involve service users and their representatives in discussions and decisions relating to use of constraint and gain their consent, where reasonably practicable;
(c) maintain full and accurate records that detail the circumstances leading to concerns, decision arrived at; and
(d) review the use of restraints, including impact on service users, no less than every six months.

This is to comply with Regulation 4(1)(a) and (c) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 1.3 If my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified, kept to a minimum and carried out sensitively. (HSCS 1.3).

Areas for improvement

1. To improve the physical and mental wellbeing of people, the provider should develop its approach to activities by ensuring people's individual preferences are clearly noted in support plans and the impact of activities on them are clearly recorded.

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

2. To improve outcomes for people who may become distressed the provider should review and reissue guidance to staff, ensure strategies to support people include guidance their support plans include alternative or additional actions where initial ones are not successful.

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state: 'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty'. (HSCS 3.18).

How good is our leadership? | 4 - Good

Key question 2: How good is our leadership?

We made an evaluation of good for this key question because we saw a number of strengths leading to positive outcomes for people and outweighing areas for improvement.

2.2 Quality assurance and improvement is led well
The service's electronic care system provided managers with an overview of what support people required and when it was provided. It also gave alerts if care had not occurred when scheduled. This helped ensure that people's wellbeing benefitted from getting the care and support they had been assessed for.

Quality audits for a range of areas from how well pressure sores are managed to safety of water temperatures for people gave reassurances that people people's health and wellbeing was monitored. It was not always clearly recorded what actions were taken at times when audits indicated planned actions had not taken place, for instance, when people refused support. The service has agreed to consider how this aspect of monitoring can be improved.

Monthly checks with the Nursing and Midwifery Council and Scottish Social Services Council ensured nurses and care staff were compliant with their regulatory bodies. This meant people could be confident that staff caring for them were conducting themselves professionally and in line with good practice.

The service had a comprehensive improvement plan in place. This included improving staff capabilities on areas like moving people safely and assessing people's care needs. Plans were in place to improve the quality of furnishings and enhancing landscapes in some units. The improvement plan also included increasing residents' participation in the home by having representatives on a residents' council and improving the availability of meals for people with special dietary needs. Date for completion and progress updates on each area were clear. The provided a service-wide view of actions required. It would benefit from being specific when any of the five units require to make improvements. We make an area for improvement on this. **See area for improvement 1.**

Areas for improvement

1. The service should enhance its improvement plan to include, were appropriate, actions and developments required to be taken by specific units to improve outcomes for people.

This is in order to comply with: Health and Social Care Standard 4.19: I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.

How good is our staff team? 4 - Good

Key question 3: How good is staff team?

We made an evaluation of good for this key question because we saw a number of strengths leading to positive outcomes for people and outweighing areas for improvement.

3.2 Staff have the right knowledge, competence and development to care for and support people
Staff told us they enjoyed their work and felt supported by management. Organisation of shifts and workloads meant that they were clear on what they were expected to do. Handover information between one shift and the next meant that staff were supported in their work by having up-to-date information on people.

A comprehensive training plan helped ensure staff had the skills required to support people to achieve good outcomes. Training included supporting people with personal care and to move safely. We saw some evidence showing how staff benefitted from training and put it into use in their day to day work. Staff were observed on how well they performed in handwashing and use of personal protective equipment (PPE). This helped confirm their understanding of what had been taught on hygiene and infection control.

Supervision provides staff and management opportunities to discuss how staff are undertaking their roles and what might be required to support and improve their work. It can also provide time for staff to express challenges that might affect their work and for management to ensure staff are up to date with important policy or practice developments. We saw some staff had received recent supervision but that was not consistent across the staff group and we make an area for improvement on this. **See area for improvement 1.**

There was a recruitment policy in place that reflected good practice when selecting new staff. However, when we examined files of people recruited by the service it was clear that the policy was not always being followed in practice. This included action to ensure references and work histories were fully checked. We make an area for improvement on this. **See area for improvement 2.**

Areas for improvement

1. The provider should ensure staff receive supervision on a regular, scheduled basis.

This is to ensure that care and support is consistent with the Health and Social Care Standard (HSCS) which state that 'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11) and
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. (HSCS 3.14) and
Scottish Social Services Council (SSSC) code 2.2 which states 'as a social service employer you must

effectively manage and supervise staff to support effective practice and good conduct and support staff to address deficiencies in their performance'

2. The provider should ensure all staff recruitment follows the provider's own recruitment policy.

This is in order to comply with: Health and Social Care Standards (HSCS): I am confident that people who support and care for me have been appropriately and safely recruited. (HSCS 4.24).

How good is our setting? 4 - Good

Key question 4: How good is our setting?

We made an evaluation of good for this key question because we saw a number of strengths leading to positive outcomes for people and outweighing areas for improvement.

4.1 People experience high quality facilities
The home generally clean, tidy and welcoming. People had access to safe, outdoor areas.

We looked at maintenance and safety records including water and fire safety audits. A number of these were considerably out of date or not available at the time of our inspection. We were supplied with these shortly after our visit and are satisfied that they confirm that people are kept safe. The provider should ensure that these records are better organised and readily available for review by ourselves and other relevant bodies. We make an area for improvement on this. **See area for improvement 1.**

Some people's bedrooms had memory boxes outside the doors. These contain items like photos and ornaments personal to the individual and, for people with memory challenges, can provide reminders of which room is theirs. The memory boxes were not in place throughout the service.

Signs for places like toilets, lounges and dining areas were not always clear or well placed. This would present challenges to people with vision problems, dementia or other cognitive issues.

The King's Fund is a charity that has developed assessment tools and guidance for organisations providing support to people with dementia and other cognitive issues. People's outcomes would benefit from these being applied in the service and we have made an area for improvement on this. **See area for improvement 2.**

Areas for improvement

1. The provider should ensure records relating to the environment and safety of the care home are up to date and available for inspection by relevant agencies.

This is to ensure that care and support is consistent with the Health and Social Care Standard (HSCS) which state that ' I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment.' (HSCS 5.22)

2. The provider should make use of the Kings Fund assessments and tools with view to improving the design of the care home and the environment for people with dementia and other cognitive challenges.

This is to ensure that care and support is consistent with the Health and Social Care Standard (HSCS) which state that 'The premises have been adapted, equipped and furnished to meet my needs and wishes.' (HSCS 5.16)

How well is our care and support planned? 3 - Adequate

Key question 5: How well is our care and support planned?

5.1. Assessment and personal planning reflects people's outcomes and wishes
We made an evaluation of adequate for this key question. This means we saw strengths that outweighed some weaknesses, but some work was required to improve outcomes for people.

The service's electronic care plans provided a useful basis to ensure people received the care and support they required to achieve positive outcomes. Each plan had photo of the individual which helped staff confirm who they were supporting. Essential information, for instance on dietary needs, allergies and health conditions were at the front of the plans. This helped staff find critical information quickly.

We found a number of areas for attention in some care plans. They were not always consistent in the information provided. For instance, some plans had differing information on which care equipment should be used for the individual concerned. Others used medical terminology for health conditions which may not be understood by all staff. This could be resolved by having plain English explanations.

Risk assessments are used when there might be a risk to the person, staff or others in certain circumstances like be supported to move safely, being at risk of falls or becoming distressed. Risk assessment reduce or eliminate the risk of harm by providing guidance to staff. This can include stating that more than one staff member is required to support an individual to transfer from one place to another and what equipment is to be used and how. Risk assessment for people who are liable to fall identify areas that might increase the risk, like not using walking aids and what might be done to improve outcomes, including involving specialist health care professionals.

A number of risk assessments were not completed fully or properly and some were out of date. This increases the risk of harm to people and others.

People living in care homes should have their care and support reviewed on a six-monthly basis. This ensures all the information about a person and their needs remains up to date and identifies any changes required to keep them safe and healthy. We saw some good examples of completed reviews which had family involvement and clear actions to be followed.

A significant number of people had not had their care reviewed within a six-month period. We had made this an area for improvement at a previous inspection. We have now made a requirement on this. **See requirement 1.**

Requirements

1. By 1 August 2023, the provider must ensure that people's care and support needs are reviewed not less than on a six-monthly basis or more frequent if required. Reviews must ensure:

a) ensure all information relating to the individual is accurate and up-to-date
b) risk assessments are accurate and up to date

c) service users and families are supported to be fully involved
d)identify actions to be followed to improve outcomes for people.

This is to comply with Regulation 5(2)(a) (Personal plans) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and

To ensure care and support is consistent with Health and Social Care Standards: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices'. (HSCS 1.15) 'I am fully involved in developing and reviewing my personal plan, which is always available to me.' (HSCS 2.17).

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

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

This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/2010) Regulation 3 - Principles; Regulation 4(1)(a) - Welfare of users.

This requirement was made on 1 April 2022.

Action taken on previous requirement
Service has quality audits in place, but provider was unable to show how these are acted on to improve outcomes for people. Audit tools captures non-compliance for instance with safe transfer of people, but no follow up actions to correct and avoid repetition. Mattress audits carried out by service were found to be failing to identify areas for action.

Timescale extended to 1 August 2023

Not met

Requirement 2

By 3 June 2022, the provider must review and revise its procedures relating to infectious outbreaks. This must include:

- briefings to all staff on roles and responsibilities in line with current guidance and good practice. How people isolating are identified and supported must form part of these briefings.

• ensuring consistent practice throughout the service in how potential outbreaks are identified and confirmed.

This is in order to comply with Regulations 4(1)(a) and (d) and 10(2)(d) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This requirement was made on 1 April 2022.

Action taken on previous requirement

Senior staff on responsibilities regarding outbreaks. Manager has improved oversight. Guidance to unit managers in place.

Met - outwith timescales

Requirement 3

By the 6 February 2023, the provider must ensure that the environment is clean and all mattresses, chairs and other equipment is regularly cleaned and checked. In order to achieve this, the provider as a minimum must:

a) carry out deep cleaning of the environment to support good infection control practices and ensure the environment is pleasant place to live for people experiencing care. Particular attention must be given to assure the cleanliness of chairs and mattresses and all equipment in use and to replace items that cannot be sufficiently cleaned.
b) implement a robust quality assurance system which would ensure regular checks are carried out on such equipment and an action plan developed in order to make improvements.

To be completed by: 06 February 2023

This is in order to comply with: Health and Social Care Standard 4.23: I use a service and organisation that are well led and managed. Regulation 10(1) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011 No. 210 Social Care).

This requirement was made on 1 November 2022.

Action taken on previous requirement

Evidence that cleaning schedules were being completed but requires more detail to provide reassurance. Direct observations of staff donning and doffing PPE was taking place. Some care equipment, including hoists were not properly cleaned. Serious issues relating to standard of mattress cleanliness; mattress checks by Care Inspectorate found soiled mattresses and covers. Inspectors requested urgent check, by unit manager, of all mattresses in one unit, resulting in an additional number of failing checks.

PPE stations had limited range of glove sizes. Disposable aprons were jammed into the stations making it difficult for staff to get these.

Timescale extended to 1 August 2023

Not met

Requirement 4

By 6 February 2023, the provider must ensure that people are supported safely with their mobility and transfers, including where equipment is used. To do this, the provider must, at a minimum:

a) ensure all current staff undertake practical moving and handling training by a suitably qualified person.
b) ensure the moving and handling practice of staff is observed and evaluated by a competent person, and records kept to evidence this.
c) ensure that every person who receives support with moving and handling has been appropriately assessed by a suitably qualified person to determine the support they require.
d) ensure that care plans and risk assessments contain detailed information on how the person is to be supported with their moving and handling.
e) ensure there is an appropriate level of moving and handling equipment to support people effectively and safely.

To be completed by: 06 February 2023

This is in order to comply with: Health and Social Care Standard 1.24: Any treatment or intervention that I experience is safe and effective. Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011 No. 210 Social Care).

This requirement was made on 1 November 2022.

Action taken on previous requirement
Risk assessments in care plans for mobility. Manager provided evidence on staff practice being observed when supporting people to move and transfer. Sufficient equipment in place to support people. Service has high compliance rate (97%) for staff completing moving and handling training.

Met - outwith timescales

Requirement 5

In order to promote the health, well being and safety of service users, the provider must ensure that the level of staffing is adequate to provide the assessed level of support to service users at all times. Deployment of staff must be accurately recorded.

To be completed by: 06 February 2023

This is in order to comply with: Health and Social Care Standard 1.19: My care and support meets my needs and is right for me.
Regulation 15(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011 No. 210 Social Care).

This requirement was made on 1 November 2022.

Action taken on previous requirement
Staffing schedules viewed by inspectors. Sufficient staff in place to support people. Dependency assessment tool used to inform staffing levels.

Met - outwith timescales

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 service should ensure that families are involved with the creation and maintenance of inventories and are informed of the options available to them with regards to labelling personal items.

This area for improvement was made on 21 November 2022.

Action taken since then

The service had an option of recording of personal effects as part of the electronic system. There was no evidence provided to show that this was used or there was any alternatives used.

This area for improvement has not been met and remains in place.

Previous area for improvement 2

To support people's nutritional requirements, the provider should ensure that staff have the relevant guidance and information available. This should include, but is not limited to, updating care plans with relevant guidance and information, completing assessments fully and in detail, training staff in current guidance, ensuring that information is being recorded and monitored effectively to ensure that action is taken in a timely manner.

This is in order to comply with:

Health and Social Care Standard 3.18: I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty.

MET

This area for improvement was made on 2 August 2022.

Action taken since then

Support plans had relevant information on individuals' support needs and preferences. This detailed what kind of diet, preferences and support required. Records show appropriate communication between health care professionals and the service regarding people's dietary issues. Records clearly showed which residents had specific diets to follow with some information on these. Where required staff recorded people's inputs.

Previous area for improvement 3

To support people with their fluid intake, the service should ensure that they have sufficient monitoring and recording in place. This should include, but is not limited to, identifying clear target daily amounts of fluids for people and reviewing that this is being met on a regular basis.

This is in order to comply with:

Health and Social Care Standard 4.11: I experience high quality care and support based on relevant evidence, guidance and best practice.

MET

This area for improvement was made on 2 August 2022.

Action taken since then

The service had systems in place to identify people who required assistance and/or monitoring of fluids. Records were generally up to date and showed most people had been assisted to meet or exceed targets to help keep them healthy.

Previous area for improvement 4

To support people and their families to be informed about people's health and wellbeing, the provider should ensure that families and significant others are being kept informed and up to date. This should include, but is not limited to, ensuring that all communication between the service and significant others is recorded and that staff are aware of who has responsibility to contact people and when.

This is in order to comply with:

Health and Social Care Standard 2.12: If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account.

MET

This area for improvement was made on 2 August 2022.

Action taken since then

Families confirmed that the service kept them up to date with anything affecting their loved ones. This included when falls occurred and healthcare appointments. Service records confirmed these kind of contacts.

Previous area for improvement 5

To support people with their health, dignity and wellbeing, the provider should ensure that staff are supporting people well with all aspects of their personal care. This includes, but is not limited to, reviewing each individual's care plan to ensure that all care tasks are recorded, and monitoring that tasks are completed and recorded as frequently as required.

This is in order to comply with:

Health and Social Care Standard 1.4: If I require intimate personal care, this is carried out in a dignified way, with my privacy and personal preferences respected.

This area for improvement has not been met and remains in place.

This area for improvement was made on 1 April 2022.

Action taken since then

The service was unable to provide sufficient evidence that the people's support needs were regularly reviewed.

Previous area for improvement 6

The provider should ensure that people's personal care plans are reviewed on a six-monthly basis or more often if needs change. Reviews should take into account the views and preferences of the people supported and their families.

This is to ensure care and support is consistent with Health and Social Care Standards: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices'. (HSCS 1.15) 'I am fully involved in developing and reviewing my personal plan, which is always available to me.' (HSCS 2.17). 2.

This area for improvement is no longer in place and has been incorporated into a new requirement under key question 5.

This area for improvement was made on 1 April 2022.

Action taken since then

Reviews not consistently happening, with some considerably out of date. Requirement made to replace this area for improvement.

Previous area for improvement 7

The provider should ensure that all management and senior staff have a clear understanding of the Scottish Government's guidance on visiting in care homes. All people supported and their visitors should be provided with clear, accurate and up-to-date information on visiting.

This is to ensure care and support is consistent with Health and Social Care Standards: ' If I am an adult living in a care home and restrictions to routine visiting are needed to prevent infection, I can nominate relatives/friends (and substitutes) to visit me. My nominated relatives/friends will be supported by the care home to see me in person day-to-day and to be directly involved in providing my care and support if that is what I want.' HSCS 5.6)

Met

This area for improvement was made on 1 April 2022.

Action taken since then

Senior staff now clear on responsibilities to encourage and facilitate visiting. Care and nurses knowledgeable about guidance. Families report no issues in being able to visit.

Previous area for improvement 8

The provider should ensure all relevant management and senior staff are aware of their responsibilities to comply with 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'. This should include ensuring clear understanding of responsibilities to notify the Care Inspectorate of concerns of people being at risk of harm.

This is to ensure compliance with Health and Social Care Standards which state that: 'If I might harm myself or others, I know that people have a duty to protect me and others, which may involve contacting relevant agencies' (HSCS 3.24), and 'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities' (HSCS 3.20).

Met

This area for improvement was made on 1 April 2022.

Action taken since then

Improved understanding by senior staff of their role in initiating notifications. Notifications to CI more frequent and improved.

Complaints

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

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate
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	3 - Adequate

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement is led well	4 - Good

How good is our staff team?	4 - Good
3.2 Staff have the right knowledge, competence and development to care for and support people	4 - Good

How good is our setting?	4 - Good
4.1 People experience high quality facilities	4 - Good

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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Strathleven Care Home
Care Home Service

30 Strathleven Place
Dumbarton
G82 1BA

Telephone: 01389 742 286

Type of inspection:
Unannounced

Completed on:
26 January 2023

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 four shared bedrooms. Some of the single bedrooms offer en suite 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 to use when undertaking one to one activities.

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 a follow up inspection which took place on the 24th and 25th of January 2023. 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 four people using the service and one of their family members. We spoke with five staff and management; observed practice and daily life and reviewed documents.

Key messages

There is now more meaningful activity taking place for people.

Management of medication has improved.

Records of people's health needs are better.

People are beginning to participate in the daily routine of the home.

Relatives and visiting professionals describe positive experiences for people living in the home.

Rooms are keep clean 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?	3 - Adequate
How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate

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

At the previous full inspection we found a number of issues with the support that people received and as a result we made the following 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 active

d 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 of consideration 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 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.

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)

All of the above requirements have been met within timescales.

How good is our leadership? 3 - Adequate

At the previous full inspection we found a number of issues with quality assurance and as a result we made the following requirements:

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).

This requirement was met within timescales.

How good is our staff team? 3 - Adequate

At the previous full inspection we found a number of issues with staff support and as a result we made the following requirements:

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 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.

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)

This requirement was met.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 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 active

d) 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)

This requirement was made on 16 September 2022.

Action taken on previous requirement

At this inspection we found that the service had made improvements in this area.
The activity coordinator had spoken to all the residents individually to obtain their wishes about which activities they would like to participate in. When people were unable to communicate their views, she had sought information from their care plan to inform her as to their likes and dislikes.

Based on this information she was planning weekly group and individual activities for people. The programme included a range of activities both indoors and outdoors, active and passive. There was evidence that people were participating in activities out in the community as well as within the home. We seen photographs of people participating in activities with local children and of outings in the community which clearly demonstrated that people were enjoying these activities.

The activity coordinator was also looking at people's level of participation and enjoyment of these activities and amending the programme accordingly. There was also evidence from a recent survey that relatives had completed that demonstrated that relatives were happy with the activity programme being provided for their loved ones.

As a result of these measures this requirement has been met.

Met - within timescales

Requirement 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 of consideration 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).

This requirement was made on 16 September 2022.

Action taken on previous requirement

At this inspection we reviewed the MAR charts for people being prescribed 'as required' medication. We found that there were improvements in the recordings of individual protocols for people which better informed staff of when the 'as required' medications should be used. In instances when these medications were used to manage people's stress and distress we found that non pharmacological techniques were outlined which if implemented could reduce the need for pharmacological interventions.

There was evidence that pharmacy reviews had been undertaken for all residents and there were examples of beneficial changes to people's medication regime as a result.
We also found evidence that internal audits of medication recordings were taking place.

Senior staff have received refresher training in the administration of medications and this has supported staff to better understand the use of 'as required' medications.

We felt it would be helpful if the information about 'as required' medications could be brought together in one place. At the inspection, elements of stress and distress management were found to be detailed in the care plans but only referred to in a more generic way in the medication protocols. However, all the information required is available.

This requirement has been met.

Met - within timescales

Requirement 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 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.

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).

This requirement was made on 16 September 2022.

Action taken on previous requirement

We saw evidence at the inspection of daily recordings of bowel movements and food and fluid charts. These charts were on the whole completed very well and there was a marked improvement in the recordings in general.

We saw evidence that daily recordings were being audited during the case file audits that had been undertaken by the management team. Any actions picked up at these audits such as discrepancies in the charts were discussed with keyworkers.

Given the above improvements to the recording and auditing of daily health charts, this requirement has been met.

Met - within timescales

Requirement 4

By the 23rd December 2022 the provider must ensure that the home is clean and free from avoidable and 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)

This requirement was made on 16 September 2022.

Action taken on previous requirement

During the inspection we found that there was no unpleasant odour in the activity room. We were told that a chair had been the source of the unpleasant smell and it had subsequently been removed.

We walked around the home and found it to be generally clean and free from odours. Equipment was generally clean although we found a shower chair that was stained on the underside and brought this to the attention of the manager. More attention to detail could be paid during cleaning of equipment.

Regular environmental audits were now in place. There could be some improvement to the audits by adding a column indicating when actions were carried out and by whom. Nevertheless, there was clear evidence that staff took appropriate action to address any issues identified in the audit.

There was also evidence that spot checks of staff infection prevention and control practice were now taking place.

This requirement has therefore been met.

Met - within timescales

Requirement 5

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).

This requirement was made on 16 September 2022.

Action taken on previous requirement

During this inspection we found a significant improvement in the quality assurance system. There were systems in place to audit healthcare records such as bowel movements and weights. We also found evidence that regular environmental audits were taking place and any issues arising were actioned by staff. Spot checks of staff practice were being carried out in relation to infection prevention and control. Case file audits had been undertaken.

Substantial progress had been made in the development of quality assurance and audits and the requirement has been met.

It would be good to see these processes become embedded in practice and audits expanded to include other areas of practice.

Met - within timescales

Requirement 6

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 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.

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)

This requirement was made on 16 September 2022.

Action taken on previous requirement

During the inspection we found that the dependency levels in the home were in the upper average for the month of January. During the inspection we observed a sufficiency of staff on shift, with staff observed to have time to have good interactions with residents. Senior staff indicated that they believed that there were adequate numbers of staff on shift and believed that staff were now working better as a team.
The activity coordinator stated that staff had time to support her programme of activities with people. We observed good, person centred interactions by staff with residents.

Overall, we found evidence that level of staffing identified in the dependency tool reflected the time needed to spend with people to meet their care needs.

This requirement was met.

Met - within timescales

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

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)

This area for improvement was made on 16 September 2022.

Action taken since then

Since the last inspection there is evidence that staff have been supporting people to participate in daily tasks such as napkin folding. There is room for further improvement in this area as there are people who are able to participate in a variety of tasks within the home should they so wish. The manager could take further steps to evaluate which residents are capable and would wish to participate in activities of daily

living such as laundry, table setting, bed making. The manager has a plan to discuss this with staff at a forthcoming staff meeting and during supervision to ensure staff participation.

We have repeated this area for improvement.

Previous area for improvement 2

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)

This area for improvement was made on 16 September 2022.

Action taken since then

Since the last inspection the activity coordinator has obtained the views of people and has devised an activity plan which takes peoples wishes in consideration. Some broader evaluations of people's experiences have been undertaken by asking residents to complete a questionnaire about their experience of living in the home. This work is ongoing and the service could explore ways of obtaining the views of people who can't communicate in writing. The manager could also provide an evaluation of the responses from people and an action plan to implement any changes to practice arising from the surveys.

This area for improvement has been repeated.

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	3 - Adequate
1.2 People get the most out of life	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate
1.4 People experience meaningful contact that meets their outcomes, needs and wishes	4 - Good
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	4 - 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?	3 - Adequate
3.1 Staff have been recruited well	4 - Good
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate

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