Agenda

West Dunbartonshire
Health & Social Care Partnership

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

Date:	Tuesday, 19 September 2023
Time:	13:00
Format:	Hybrid Meeting, Civic Space,16 Church Street, Dumbarton, G82 1QL
Contact:	Lynn Straker, Committee Officer lynn.straker@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.

Members will have the option to attend the meeting in person at the Civic Space, 16 Church Street, Dumbarton, G82 1QL or remotely via Zoom Video Conference.

The business is shown on the attached agenda.

Yours faithfully

JULIE SLAVIN

Chief Financial Officer
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 / Cameron Waddell – Mazars

Date of Issue: 12 September 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, 19 SEPTEMBER 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 carried out by roll call vote to ensure an accurate record.

5 (a) MINUTES OF PREVIOUS MEETING **7 - 14**

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 20 June 2023.

(b) ROLLING ACTION LIST **15 - 16**

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

6 WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) QUARTERLY PERFORMANCE REPORT 2023/24 QUARTER 1 **17 - 40**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing support to Members to fulfil their ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in the new West Dunbartonshire HSCP Strategic Plan 2023-2026: Improving Lives Together.

7 AUDIT PLAN PROGRESS REPORT **41 - 57**

Submit report by Andi Priestman, Chief Internal Auditor, providing an update to enable Members to monitor the performance of Internal Audit and gain an overview of the WD HSCP Board's overall control environment.

8 GOVERNANCE OF HEALTH AND SOCIAL CARE PARTNERSHIP COMMISSIONED SERVICES **59 - 64**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an update to Members on matters relating to West Dunbartonshire Health and Social Care Partnership's (HSCP) current governance process and its plan for improving its governance of externally commissioned health and social care services.

9 MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE: MEASURING PROGRESS UNDER INTEGRATION **65 - 111**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an update to Members on the status of the "Progress with Integration of Health and Social Care, West Dunbartonshire Health and Social Care Partnership Action Plan" [the Action Plan].

10 CARE INSPECTION OF WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) SHELTERED HOUSING: SUMMARY OF THE INSPECTION REPORT **113 - 133**

Submit report by Fiona Taylor, Head of Health and Community Care, summarising the Care Inspectorate report following an unannounced inspection of West Dunbartonshire HSCP Sheltered Housing Service between the 17th and 21st April 2023.

11 CARE INSPECTION OF WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) CARE AT HOME SERVICE: SUMMARY OF THE INSPECTION REPORT **135 - 163**

Submit report by Fiona Taylor, Head of Health and Community Care, summarising the Care Inspectorate report following an unannounced inspection of West Dunbartonshire HSCP Care at Home Services between 15 and 24 March 2023. The paper will also provide assurance to Members that there is an action plan in place to address the three requirements and eight areas for Improvement (AFI) which must be completed by 30 September 2023.

12 CARE INSPECTORATE REPORT – CLYDE COURT CARE HOME **165 - 170**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an update on Care Inspectorate reporting for Clyde Court Care Home which is an independent, private sector residential older peoples' Care Home located within West Dunbartonshire.

For information on the above Agenda please contact: Lynn Straker, Committee Officer, Regulatory, Municipal Buildings, College Street, Dumbarton G82 1NR. Email: lynn.straker@west-dunbarton.gov.uk

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, 20 June 2023 at 1.00 p.m.

Present: Rona Sweeney and Michelle Wailes*, NHS Greater Glasgow and Clyde Health Authority; Michelle McGinty, Martin Rooney and Clare Steel, West Dunbartonshire Council.

*arrived later in the meeting.

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; Gillian Gall, Head of Human Resources; Val Tierney, Chief Nurse; Jennifer Ogilvie, HSCP Finance Manager; Helen Little, MSK Physiotherapy Manager GGC; Andi Priestman, Chief Internal Auditor; Nigel Ettles, Principal Solicitor and Ashley MacIntyre and Nicola Moorcroft, Committee Officers.

Apologies: Apologies for absence were intimated on behalf of Lesley Rousselet, NHS Greater Glasgow and Clyde Health Authority and lay member Mrs Anne MacDougall, Chair of the Locality Engagement Network, Clydebank

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.

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 14 February 2023, 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.

MSK PHYSIOTHERAPY SERVICE ANNUAL REPORT 2022/23

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

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

(1) to note the contents of the report;

(2) to 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; and

(3) to note that relevant changes would be made to the Annual Report and presented to the HSCP Board.

Note:- Michelle Wailes arrived during consideration of this item.

WEST DUNBARTONSHIRE HSCP ANNUAL PERFORMANCE REPORT 2022-2023

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an overview of the HSCPs performance in planning and carrying out integrated functions. The Annual Performance Report is produced for the benefit of Partnerships and their communities and includes a Complaints management overview for the year 2022/23.

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

(1) that the West Dunbartonshire HSCP Annual Performance Report 2022/23 and the Annual Complaints Report 2022/23 be approved for publication, following the agreed changes being made in line with the legislative timescales; and

(2) to note that the decision will be homologated by the HSCP Board on 15 August 2023.

VARIATION IN ORDER OF BUSINESS

Having heard the Chair, the Committee agreed to vary the order of business as hereinafter minuted.

COMMUNITY PLANNING PARTNERSHIP'S JOINT INSPECTION OF CHILDREN AND YOUNG PEOPLE AT RISK OF HARM IN WEST DUNBARTONSHIRE

A report was submitted 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.

After discussion and having heard the Head of Children's Health, Care and Criminal 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 letter dated 13 April 2023 from the Care Inspectorate on behalf of the Joint Inspection Team. The letter has been published and is available on the Care Inspectorate website;

(2) to note that the Public Protection Chief Officers Group (PPCOG) 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 would be considered by PPCOG at its next meeting in June 2023;

(3) to note the priority actions contained in the Community Planning Partnership's Improvement Action Plan and outlined in section 4.9 of the report (Appendix 3 of the report); and

(4) to note that external support in relation to strategic planning and delivery of services to children and young people at risk of harm, would continue to be provided through the Partnership's Strategic Inspector and Local Area Network arrangements.

INSPECTION OF FOSTERING SERVICES IN WEST DUNBARTONSHIRE

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

The Head of Children's Health, Care and Justice Services and Chief Social Worker advised that the service was inspected in November 2021 and again in November 2022 and that a progress update had been presented to the Committee on a quarterly basis.

The Inspection focussed on:

(1) How good is our leadership;

(2) How good is our staff team; and

(3) How well do we support people's wellbeing

The following requirements were made:

(1) Ensure clear, outcome focused and accessible children's plan's are in place, ensuring the activity within the plans are measurable and time-scaled. This requirement was implemented and rolled out across the service between January and May 2023 and monitored by the PMO team; and

(2) By March 2023, all children in need of permanent foster care have assessment completed and plans carried out.

The Head of Children's Health, Care and Justice Services and Chief Social Worker noted that, the service had worked to strengthen reporting of data to ensure an understanding of the key processes and where delays are occurring to enable efforts to be targeted and that the Care Inspectorate had recognised progress is being made.

Having heard the Head of Children's Health, Care and Justice Services and Chief Social Worker, the Committee agreed:-

(1) to note the update provided; and

(2) that an update would be provided on a 'normal' reporting cycle moving forward.

INSPECTION OF ADOPTION SERVICES IN WEST DUNBARTONSHIRE

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

The Head of Children's Health, Care and Justice Services and Chief Social Worker advised that the service was inspected in November 2021 and again in November 2022 and that a progress update had been presented to the Committee on a quarterly basis.

The Inspection focussed on:

(1) How good is our leadership;

(2) How good is our staff team; and

(3) How well do we support people's wellbeing

The Head of Children's Health, Care and Justice Services and Chief Social Worker noted that, Inspectors found the quality of assessment planning for adoption services as standard, with wider provider led care planning to be inconsistent and that there had been debate and discussion nationally regarding the approach taken by Care Inspectorate. The service is working to ensure a Whole Systems approach with a revised action plan and tight scrutiny in place and continue to work closely with data colleagues in relation to reporting directly from Care First.

Having heard the Head of Children's Health, Care and Justice Services and Chief Social Worker, the Committee agreed:-

(1) to note the update provided; and

(2) that an update would be provided on a 'normal' reporting cycle moving forward.

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 and having heard the Chief Internal Auditor in further explanation of the report, the Committee agreed to note the progress made in relation to the Internal Audit Annual Plan for 2022/23.

REVIEW OF CIPFA FINANCIAL MANAGEMENT CODE

A report was submitted by Julie Slavin, Chief Financial Officer presenting the CIPFA Financial Management Code, which applies to all local government bodies, including Integration Joint Boards (IJB) and a self-assessment of compliance recommending actions for improvement.

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

(1) to note the key principles and requirements of the CIPFA Financial Management Code; and

(2) to note the self-assessment of compliance and the actions to be progressed to support improvement.

AUDIT ANNUAL REPORT AND ASSURANCE STATEMENT

A report was submitted by Andi Priestman, Chief Internal Auditor presenting 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, containing 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.

After discussion and having heard the Chief Internal Auditor in further explanation of the report, the Committee agreed to note the contents of the report.

ADJOURNMENT

The Chair adjourned the meeting for a short recess. The meeting reconvened at 2.35 p.m. with all those listed in the sederunt present.

REVIEW OF THE LOCAL CODE AND DRAFT ANNUAL GOVERNANCE STATEMENT

A report was submitted by Julie Slavin, Chief Financial Officer (CFO) presenting the outcome of the self-evaluation of compliance of the HSCP Board's Code of Good Governance and associated improvement actions and the Annual Governance Statement, for inclusion in the HSCP Board's 2022/23 Unaudited Annual Accounts and informing of the requirement to complete a response to the external auditor on compliance with International Auditing Standards (ISAs) in relation to fraud, litigation, laws and regulations.

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

(1) to note the outcome of the annual self-evaluation and the update of the improvement actions;

(2) to consider the detail of the 2022/23 Annual Governance Statement and approve its inclusion in the 2022/23 Unaudited Annual Accounts; and

(3) that the CFO would work with the Chief Internal Auditor, the Chair and Vice Chair of the HSCP Audit and Performance Committee to prepare a response to our external auditor by the 31 July 2023 deadline.

UNAUDITED ANNUAL REPORT AND ACCOUNTS 2022-2023

A report was submitted by Julie Slavin, Chief Financial Officer requesting that the HSCP Board's Audit and Performance Committee consider the unaudited Annual Report and Accounts for the HSCP Board covering the period 1 April 2022 to 31 March 2023 and approve the unaudited Accounts and associated working papers to be passed to our external auditors for review.

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

(1) to consider the 2022/23 unaudited Annual Report and Accounts;

(2) to approve the submission to the HSCP Board's external auditors for review by 30 June; and

(3) to note that the audited Accounts are anticipated to be presented, for final approval, to the HSCP Board by the 30 September statutory deadline, prior to submission to the Accounts Commission.

INTERNAL AUDIT ANNUAL STRATEGY AND PLAN 2023-2024

A report was submitted by Andi Priestman, Chief Internal Auditor seeking approval for the indicative Internal Audit Strategy and Plan for 2023-2024.

After discussion and having heard the Chief Internal Auditor, in further explanation of the report and in answer to Members' questions, the Committee agreed to approve the indicative Internal Audit Plan for 2023-2024.

ACCOUNTS COMMISSION REPORT – INTEGRATION JOINT BOARDS FINANCIAL ANALYSIS 2021/22

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

After discussion and having heard the Chief Financial Officer in further explanation of the report, the Committee agreed 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.

CARE INSPECTORATE INSPECTION REPORT FOR AN OLDER PEOPLE'S CARE HOMES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE

A report was submitted 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 – Strathleven Care Home, Hillview Care Home and Castle View Nursing Home.

After discussion and having heard the Chief Nurse in further explanation of the report, the Committee agreed to note the contents of the report.

The meeting closed at 3.20 p.m.

WEST DUNBARTONSHIRE HSCP AUDIT AND PERFORMANCE COMMITTEE
ROLLING ACTION LIST

Agenda Item	Decision/ Minuted Action	Responsible Officer	Timescale	Progress/ Update/ Outcome	Status
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 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	Ongoing	Update: The progress of the 3 Service Redesign Reviews are progressing with Care at Home Redesign presented on 19 September 2023 meeting. The Financial Performance Report will track the progress made on savings attached to these reviews. The Chief Officer will agree a timescale with the Chair and Vice Chair.	**Open**
UNAUDITED ANNUAL REPORT AND ACCOUNTS 2022-2023	Audited Accounts to be presented for final approval to the HSCP Board by 30 September statutory deadline, prior to submission to the Accounts Commission.	Julie Slavin	November 2023		**Open**

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

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

Audit and Performance Committee - 19 September 2023

Subject: West Dunbartonshire Health and Social Care Partnership (HSCP) Quarterly Performance Report 2023/24 Quarter One

1. Purpose

1.1 The purpose of this report is to support the West Dunbartonshire HSCP Audit and Performance Committee to fulfil 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 new West Dunbartonshire HSCP Strategic Plan 2023-2026: Improving Lives Together.

1.2 This report presents the HSCP performance information reported against the strategic priorities for the period April to June 2023 (Appendix I) for the Committees consideration.

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

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

2. Recommendations

It is recommended that the Audit and Performance Committee:

2.1 Comment on the content of the HSCP Quarterly Performance Report 2023/24 Quarter One and performance against the Strategic Plan 2023 - 2026 by exception.

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

3. Background

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

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

3.3 Performance information and targets have been reviewed alongside the development of the new Strategic Plan and reflect our aims to improve or sustain performance using 2022/23 as a baseline. The report includes narrative showing key highlights and challenges within the services.

4. Main Issues

4.1 The West Dunbartonshire HSCP performance indicators include a suite of challenging targets. Following the publication of the Strategic Plan 2023 – 2026: Improving Lives Together, informal sessions were held with the HSCP Senior Management Team and HSCP Board members to develop a new framework and agree targets for each of the measures.

4.2 It should be noted that due to timing issues this report presents partial Quarter One data.

4.4 The HSCP have 46 performance indicators. Of the 35 reported on in Quarter one, 9 indicators are in Red Status which is out with target tolerances. These exceptions are detailed in Appendix 1 together with information about improvement actions currently being taken to address these performance issues.

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

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

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

5. Options Appraisal

5.1 Not required for this report.

6. People Implications

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

7. Financial and Procurement Implications

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

8. Risk Analysis

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

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

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

9. Equalities Impact Assessment (EIA)

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

10. Environmental Sustainability

10.1 Not required for this report.

11. Consultation

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

12. Strategic Assessment

12.1 Not required for this report.

13 Directions

Not required for this report.

Name: Margaret-Jane Cardno
Designation: Head of Strategy and Transformation
Date: 22 August 2023

Person to Contact:	Margaret-Jane Cardno Head of Strategy and Transformation West Dunbartonshire Health and Social Care Partnership 16 Church Street Dumbarton G82 1QL *(Working From Home)* Email: Margaret-Jane.Cardno@west-dunbarton.gov.uk
Appendices:	Appendix 1: West Dunbartonshire HSCP Performance Report 2023/24: Quarter One April to June 2023
Background Papers:	None

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership Performance Report 2023/24: Quarter 1 April to June 2023

This report will outline the HSCP's performance against the priorities set out in our new Strategic Plan 2023-2026: Improving Lives Together.

Local targets set in 2019/20 were retained in 2020/21 through to 2022/23 in light of the unpredictability of the pandemic. These targets have been reviewed alongside the development of the new Strategic Plan and reflect our aims to improve or sustain performance using 2022/23 as a baseline.

Key Highlights/Challenges

In this first quarter the current year to date position as at 30th June 2023 is an overspend of £0.741m (1.59%) with the annual projected outturn position being a potential overspend of £2,983m (1.50%). Approximately 51% of savings in the agreed savings programme have been achieved or are on track.

Sustained improvement in waiting times for Child and Adolescent Mental Health Services. During the pandemic the percentage of children seen within 18 weeks fell as low as 23.5%. Significant efforts to tackle waiting lists meant that the service has been well over the target of 90% since February 2021 and has been achieving between 96% and 100% since that point. At June 2023 98.6% of children had been seen within target timescale with an average wait of 9 weeks.

Introduction of an Older People's Community Mental Health triage procedure underway to ensure appropriate referrals to psychological therapy treatments.

Additional Sheriff and Jury trials scheduled to reduce Covid backlog adding to the demand for Justice Social Work reports.

Slight improvement in MSK Physiotherapy waiting times.

While recruitment remains an issue across most service areas, some progress has been made to recruit to key posts. Within Mental Health Services 2 Band 7 Clinical Associates in Applied Psychology and a Clinical Psychology post have been appointed while approval of a new Band 7 Cognitive Behavioural Therapist role profile means it can now proceed to recruitment. Recruitment is well underway to fill vacant posts within Criminal Justice Social Work and the vacant Band 5 posts within MSK Physiotherapy have been filled.

A proportion of hospital data at NHS Greater Glasgow and Clyde level has yet to be verified and this, along with the timing of quarterly Ministerial Steering Group data submissions from Public Health Scotland, means we are unable as yet to report emergency admissions and unscheduled bed days from January 2023.

Strategic Plan Performance Indicators

Due to timing issues some data is not yet available and it should also be noted that Unscheduled Care data, i.e. hospital data, is subject to change historically.

PI Status	
	Alert – Target missed by 15% or more
	Warning – Target narrowly missed
	OK – Target achieved
	Data Only – no target set

Short Term Trends	
	Improving*
	No Change
	Getting Worse*

*Where an indicator is Data Only with no target set, the up and down arrows denote whether the number or percentage is increasing (up) or decreasing (down).

Caring Communities

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
1	Percentage of carers who feel able to continue in their caring role when asked through their Adult Carer Support Plan	97%	95%			92.3%	
2	Percentage of carers who feel willing to continue in their caring role when asked through their Adult Carer Support Plan	98.5%	95%			92.3%	New PI
3	Number of Adult Carer Support Plans completed	67	N/A			40	
4	Balance of Care for looked after children: % of children being looked after in the Community	89%	90%			88.7%	
5	Number of Looked After Children	474	N/A			478	
6	Number of Looked After children looked after in a residential setting	52	N/A			50	
7	Number of Looked After children looked after at home with parents	63	N/A			65	
8	Number of Looked After children looked after by foster carers	117	N/A			113	
9	Number of Looked After children looked after in other community settings	242	N/A			250	
10	Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	98.6%	90%			99.1%	
11	Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	9	18			9	
12	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	53.2%	90%			41.4%	
13	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	Published September	90%	Not yet available	Not yet available	96.4%	

Safe and Thriving Communities

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
14	Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%			100%	
15	Percentage of child protection investigations to case conference within 21 days	90.5%	95%			72.7%	
16	Number of Child Protection investigations	71	N/A			75	
17	Number of children on the Child Protection Register at end of reporting period (Excluding temporary and transfers in)	60	N/A			51	
18	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on non-offence (care and protection) ground	179	N/A			163	
19	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on offence grounds	37	N/A			36	
20	Percentage of Adult Support and Protection clients who have current risk assessments and care plan/protection plan	Not yet available	100%	Not yet available	Not yet available	100%	
21	Number of delayed discharges over 3 days (72 hours) non-complex cases	19	0			14	
22	Number of bed days lost to delayed discharge 18+ All reasons	3,581	2,781			3,631	
23	Number of bed days lost to delayed discharge 18+ Complex Codes	1,568	1,406			1,691	
24	Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over	2,996	2,278			3,249	
25	Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	1,387	983			1,410	
26	Number of clients receiving Home Care Pharmacy Team support	285	312			268	
27	Number of people receiving Telecare/Community Alarm service - All ages	1,856	1,942			1,942	
28	Number of people receiving homecare - All ages	1,429	1,200			1,416	
29	Number of weekly hours of homecare - All ages	10,535	9,000			10,386	
30	Percentage of people who receive 20 or more interventions per week	40.2%	40%		New PI	New PI	New PI
31	Percentage of homecare clients receiving personal care	99.2%	99%		New PI	New PI	New PI

Equal Communities

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
32	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	63.3%	98%			71.7%	
33	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	92.2%	80%			83.5%	
34	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	41.7%	80%			48.4%	
35	Percentage of children from BME communities who are looked after that are being looked after in the community	88%	90%			86.2%	
36	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	67%	80%			50%	

Healthy Communities

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
37	Number of emergency admissions 18+	Not yet available	2,295	Not yet available	Not yet available	Not yet available	
38	Number of emergency admissions aged 65+	Not yet available	1,134	Not yet available	Not yet available	Not yet available	
39	Emergency admissions aged 65+ as a rate per 1,000 population	Not yet available	67	Not yet available	Not yet available	Not yet available	
40	Number of unscheduled bed days 18+	Not yet available	17,735	Not yet available	Not yet available	Not yet available	
41	Unscheduled acute bed days (aged 65+)	Not yet available	12,156	Not yet available	Not yet available	Not yet available	
42	Unscheduled acute bed days (aged 65+) as a rate per 1,000 population	Not yet available	726	Not yet available	Not yet available	Not yet available	
43	Number of Attendances at Accident and Emergency 18+	Not yet available	5,005	Not yet available	Not yet available	5,219	
44	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	46%	90%			43%	
45	Prescribing cost per weighted patient (Annualised)	Not yet available	£187.73	Not yet available	Not yet available	£185.96	
46	Compliance with Formulary Preferred List	Not yet available	78%	Not yet available	Not yet available	77.65%	

Financial Update

The current year to date position as at 30th June 2023 is an overspend of £0.741m (1.59%) and an annual projected outturn position being a potential overspend of £2.983m (1.50%) with the main reasons being the impact of continued significant demand for children and families residential and community placements, external older people's residential placements and increased volumes partially offset by ongoing recruitment and retention challenges. The potential overspend takes into account the progress on agreed savings programmes and £3.418m of expenditure to be drawn down from earmarked reserves. In this first quarter approximately 51% of savings have been achieved or are on track to be achieved, with the remainder requiring further action.

The September meeting of the IJB will consider the position to 31 July 2023 and a revised projection in line with the first quarter's projection.

The Chief Officer and Chief Financial Officer have had initial meetings with Heads of Service and operational managers to set-out the scale of the challenge and what is required from a recovery plan. The plan will have to mitigate the in-year pressure and be sufficiently robust to minimise the impact on future year budget setting. The recovery plan is likely to include a recommendation in relation to the further application of earmarked reserves with all efforts made to minimise the impact on un-earmarked reserves.

The main financial risks to the 2023/24 projected outturn position relate to:

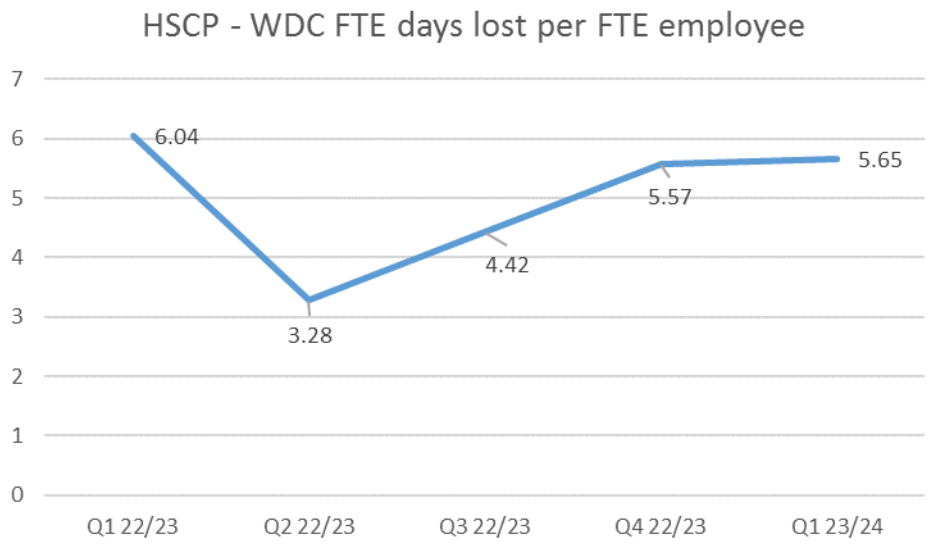
- Anticipated increases in demand for some key services, such as mental health, complex care packages and prescribing costs, and the uncertainty around pay award negotiations for Local Authority staff.
- While inflation has fallen, it is unclear at this time what impact this will have on the future of the UK Economy for the remainder of this financial year which may have a detrimental impact on public sector funding. Now that the HSCP is in the recovery phase of the Covid-19 pandemic the wider impacts of Britain's exit from the European Union are beginning to reveal themselves.
- The Minister for Social Care, Mental Wellbeing and Sport, announced in July that the proposed model for a National Care Service would be based on a shared accountability with Scottish Ministers, Local Government and NHS Boards. This effectively removes any probability of direct allocations to Integration Authorities and retains the current model of negotiating annual financial allocations with partners, who also face significant financial challenges and risks to financial sustainability.

Some additional financial information is included within the Exceptions Report below.

Absence

West Dunbartonshire Council and NHS Greater Glasgow and Clyde report staff absence for West Dunbartonshire HSCP staff in different ways: WDC by Full Time Equivalent (FTE) lost per FTE employee each quarter and NHS by the percentage of rostered hours lost to staff absence.

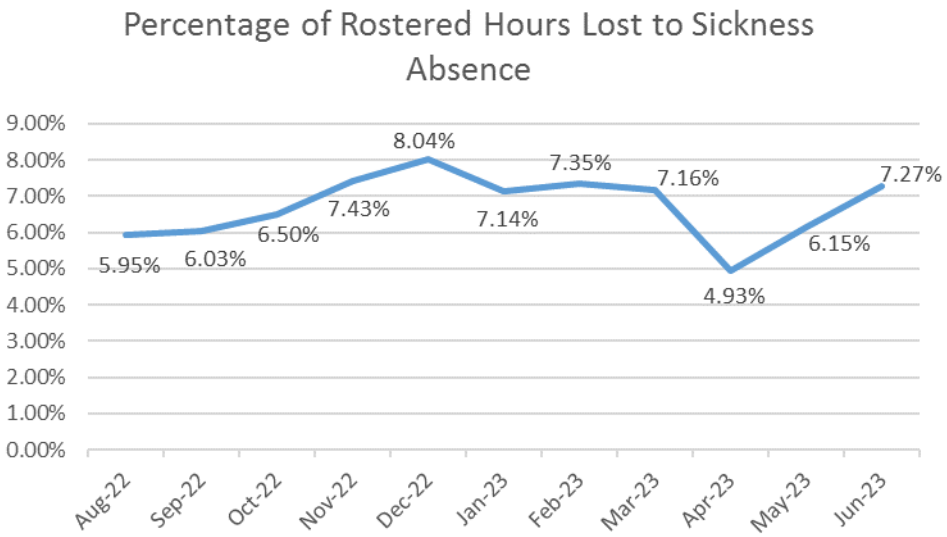
WDC HSCP staff absence was slightly higher in April to June 2023 than in the previous quarter but down on the same period in 2022.



Nationally, West Dunbartonshire Council (all non-teaching staff) absence is published by the Improvement Service through the Local Government Benchmarking Framework. Latest figures are for 2021/22 where WDC had a higher number of Full Time Equivalent (FTE) days lost per employee than the Scotland figure and had dropped from 8th lowest number of days in 2020/21 to the 23rd lowest (or 10th highest) in Scotland.

	WDC	Scotland	Ranking 1 - lowest to 32 - highest FTE days lost per employee
2019/20	11.4	11.9	13
2020/21	8.38	9.58	8
2021/22	13.28	12.19	23

NHS HSCP staff is reported monthly. While absence dipped in May 2023 to 4.93%, it rose again in June 2023 to 7.27%, slightly higher than the position at the end of the previous quarter in March 2023.



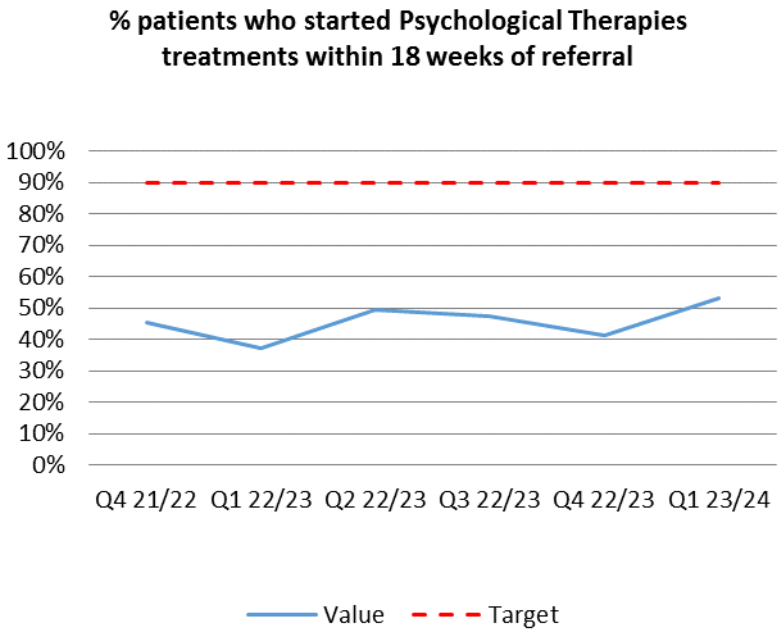
Nationally NHS Greater Glasgow and Clyde had the 2nd highest sickness absence rate out of the 14 Health Boards in Scotland in 2021/22 at 6.28%. The NHS Scotland figure was 5.69%.

West Dunbartonshire Health and Social Care Partnership
Exceptions Reporting: Quarter 1 April to June 2023

Performance Area: Psychological Therapies

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
12	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	53.2%	90%			41.4%	

Quarter	Value	Target
Q1 22/23	37.4%	90%
Q2 22/23	49.6%	90%
Q3 22/23	47.3%	90%
Q4 22/23	41.4%	90%
Q1 23/24	53.2%	90%



Key Points:
Recruitment and retention has impacted on waiting times for psychological therapies with some Band 6 vacancies being reconfigured to Band 7 posts to allow the PCMHT to recruit competitively with other services. Waiting times for older people within the Older People CMHT improved significantly when a vacant clinical psychology post was filled. However referral rates for OPCMHT have increased which is having an impact on the referral rates for psychological therapies.

There appears to be a change in the profile of referrals to OPCMHT, with more trauma, complex trauma and personality disorder presentations. The difficulties these patients have may require more sessions than were traditionally needed in Older People psychology treatments.

The Psychological Therapies budget includes Core HSCP Budget, NES funding contributions for trainee posts and Scottish Government Ring Fenced allocations including Action 15 and Mental Health Recovery and Renewal funding for access to Psychological Therapies. The latter being hosted centrally/Board wide with discussions ongoing on how to utilise this resource effectively to target local waiting times and increased demand.

In terms of the in scope local HSCP resource, Adult and Older People's Mental Health core budgets, including Psychological Therapies, are forecast to underspend by approximately £0.052m for financial year 2023/24. This includes underspend from current vacancies, skill mix of staffing profile to attract suitable candidates to vacancies and, where necessary, offset costs of bank and agency staff usage.

The projected underspend is in addition to the achievement of a non-recurring additional turnover savings target of £0.05m, (a non-recurring increased target of 1% in addition to recurring standard HSCP 3% Health turnover targets), set against 2023/24 Adult Mental Health budget to take into account current recruitment challenges and contribute towards an overall balanced budget position in year.

Improvement Actions:
There is an action plan for West Dunbartonshire PT which is reviewed monthly and reported to the NHSGG&C Board. It includes staff taking on additional sessions in PCMHT and weekly data cleansing. Discussions are underway with the centralised Digital Psychology service to identify what support they can give in addressing the longest waits.

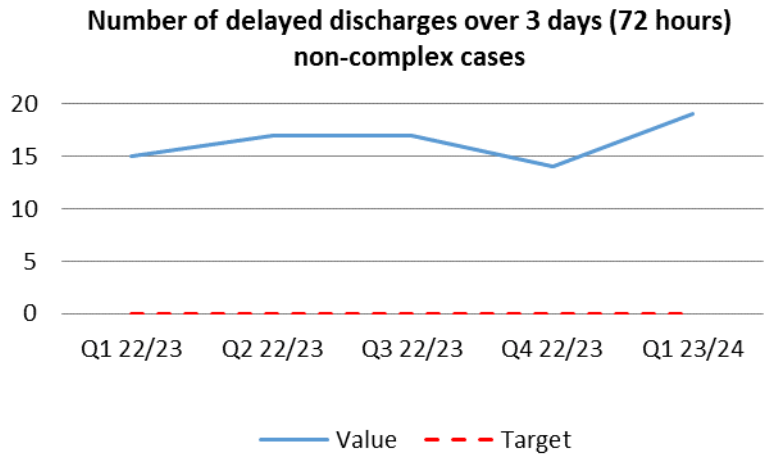
There has been an introduction of triage procedure underway for OPCMHT. This will ensure that only people who are suitable for psychological therapies are on the list to see the Cognitive Behavioural Therapist/ Clinical Psychologists. It will also identify people who are able to engage in remote delivery of therapy.

The Nurse Team Lead has set up Complex Case Discussion sessions. This encourages psychologically informed discussions, and has led to two members of staff requesting supervision/discussion with psychology to support the recommendations from the case discussions.

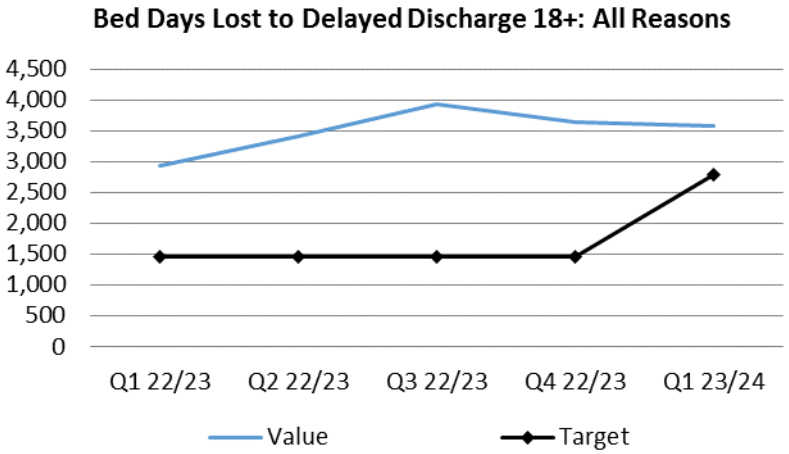
Performance Area: Delayed Discharges

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
21	Number of delayed discharges over 3 days (72 hours) non-complex cases	19	0			14	
22	Number of bed days lost to delayed discharge 18+ All reasons	3,581	2,781			3,631	
24	Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over	2,996	2,278			3,249	
25	Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	1,387	983			1,410	

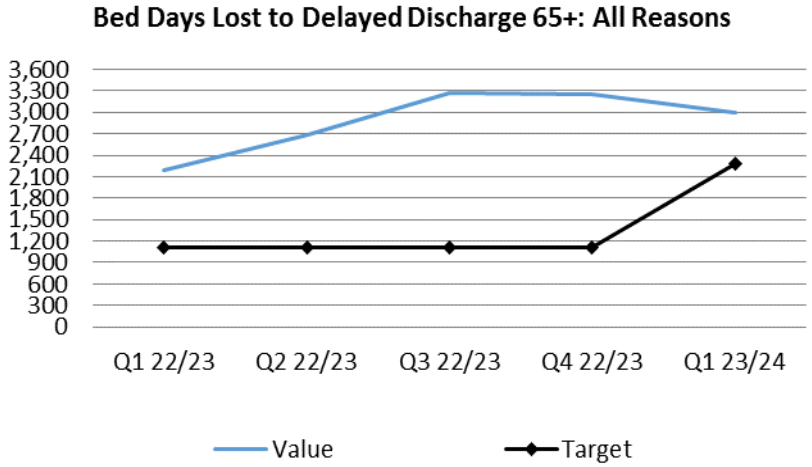
Quarter	Value	Target
Q1 22/23	15	0
Q2 22/23	17	0
Q3 22/23	17	0
Q4 22/23	14	0
Q1 23/24	19	0



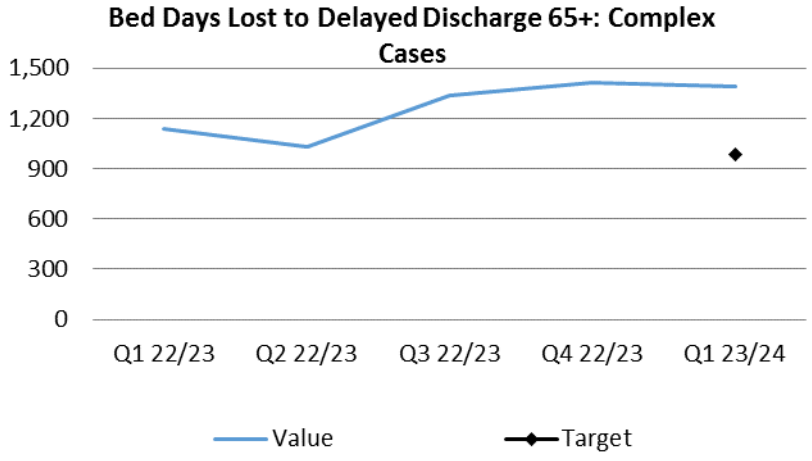
Quarter	Value	Target
Q1 22/23	2924	1460
Q2 22/23	3420	1460
Q3 22/23	3930	1460
Q4 22/23	3631	1460
Q1 23/24	3581	2781



Quarter	Value	Target
Q1 22/23	2195	1104
Q2 22/23	2676	1104
Q3 22/23	3270	1104
Q4 22/23	3249	1104
Q1 23/24	2996	2278



Quarter	Value	Target
Q1 22/23	1135	No target
Q2 22/23	1030	No target
Q3 22/23	1337	No target
Q4 22/23	1410	No target
Q1 23/24	1387	983



Key Points:
The range of improvement activities in place are beginning to demonstrate impact, with a steady decrease in total acute delays, monthly bed days lost and number of people delayed under Code 9 (Adults with Incapacity).

Recruiting Social Work staff remains a challenge within the team, and 2 agency Social Work staff are being utilised to ensure that assessments are completed timeously. This is being monitored closely and balanced against the turnover created by the existing vacancies.

There are also a number of Social Worker and Occupational Therapist vacancies across the Adult and Older People community teams, however these are being covered by agency staff and overtime where practicable. This has contributed to the improvements in the most recent Delayed Discharge figures, however they come at an additional cost on staffing budgets. This requires to be minimised by service managers and the current and projected financial impact is covered within regular financial performance reports to the HSCP Board.

Improvement Actions:
Community Hospital Discharge Team resource has been allocated to monitor the progression of Private and Local Authority Guardianship applications. This has ensured that key dates e.g. report submissions, applications to Court and granting of powers, are closely monitored. These improvement actions have demonstrated an impact and delays due to AWI (Code 9) have reduced from 21 at the end of March 2023 to 15 at the end of June 2023.

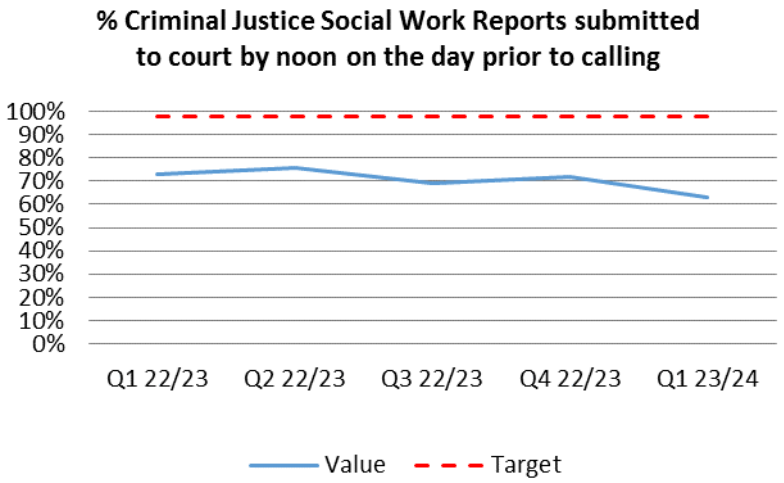
Earlier allocation to a Social Woker is also in progress, allowing assessments to commence ahead of the planned date of discharge, thereby reducing the risk of being coded a delay. The total number of Acute delayed discharges has shown a steady decline from 41 at the end of March 2023 to 34 at the end of June 2023. Monthly bed days lost for all delays has reduced from 1,319 in March 2023 to 1,214 in June 2023.

The Senior Social Worker is monitoring the time taken to complete My Life Assessments to reduce bed days lost and ensuring delay codes are updated on Trak timeously. Further improvement work continues, and the Community Hospital Discharge Team is currently targeting completion of My Life Assessments within a shorter time period, to further reduce the number of bed days lost.

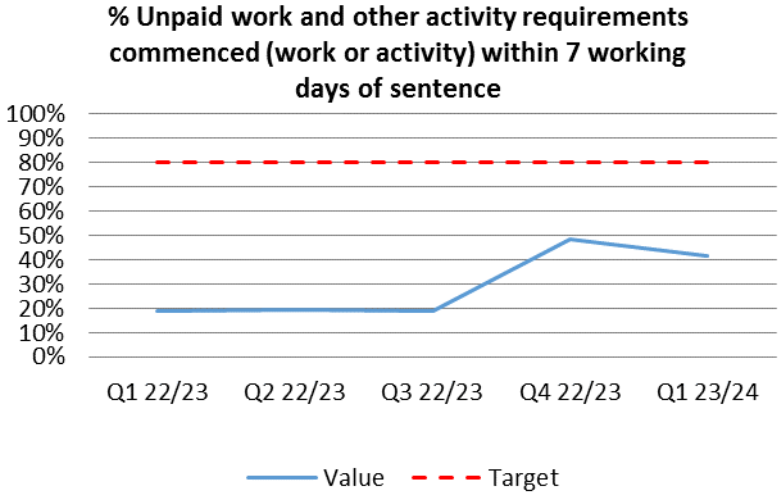
Performance Area: Criminal Justice Social Work

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
32	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	63.3%	98%			71.7%	
34	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	41.7%	80%			48.4%	

Quarter	Value	Target
Q1 22/23	73.0%	98%
Q2 22/23	75.9%	98%
Q3 22/23	69.2%	98%
Q4 22/23	71.7%	98%
Q1 23/24	63.3%	98%



Quarter	Value	Target
Q1 22/23	19.0%	80%
Q2 22/23	19.4%	80%
Q3 22/23	18.8%	80%
Q4 22/23	48.4%	80%
Q1 23/24	41.7%	80%



Please note Q1-3 2022/23 figures have been updated from those previously reported due to the availability of more complete data.

Key Points:
While there are vacant posts, some being covered by agency staff, the overall projection for Criminal Justice employee costs is an overspend of circa £0.196m. This is primarily due to the Scottish Government section 27 grant remaining at the same level for 3 years requiring the service to cover pay inflation by additional turnover and other management actions.

Quarter 1 figures reflect the high levels of long term sickness experienced by the Justice Social Work Service.

Additional Sheriff and Jury trials scheduled (9 trials every fortnight, to reduce Covid backlog) are adding to the demand placed on the team for Justice Social Work reports. There were requests for 228 Justice Social Work Reports to Courts between April and June 2023.

Figures indicate an average of 63.3% for Quarter 1 Justice Social Work Reports completed. For every report not completed a letter is sent to Court outlining the rationale for the requested report not having

been sent. Of the 36.7% of letters sent to Court, 90.3% of these were due to external factors, i.e. service user not making themselves available for interview.

The number of Community Payback Orders imposed in Quarter 1 was 90 with 72 of those having an unpaid work requirement. Of the 90 imposed orders, 92.2% of individuals attended an induction session within 5 working days of sentence. The delay in attending work placements within 7 days is due to staff sickness with existing squads at capacity. Every service user made subject to a statutory Community Payback Order at Dumbarton Sheriff Court is seen within 24 hours of the Court imposing the order.

Improvement Actions:
Recruitment is well underway to fill vacant posts. Recruitment has been challenging with some posts being re-advertised. Agency staff have been recruited on a short term basis to alleviate pressure on existing staff and support meeting national standards for Justice Social Work processes.

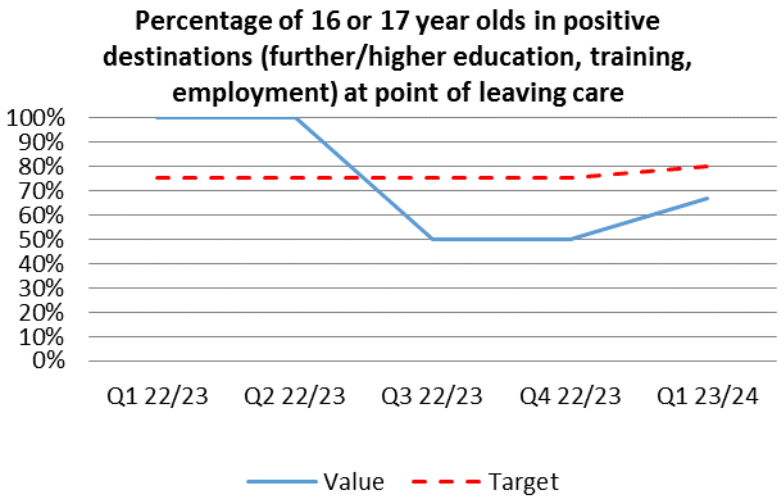
Procedures have been improved to capture service users made subject to statutory orders in outlying Courts.

Justice Social Workers are being trained in the new abbreviated sentencing report as part of a national roll out.

Performance Area: Looked After Children

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
36	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	67%	80%			50%	

Quarter	Value	Target
Q1 22/23	100%	75%
Q2 22/23	100%	75%
Q3 22/23	50%	75%
Q4 22/23	50%	75%
Q1 23/24	67%	80%



Key Points:
This indicator is based on only those young people who were looked after away from home in residential, foster or other community placements. It does not include young people looked after at home with parents, with relatives or friends, or in kinship care. It therefore involves very small numbers which means that percentages will fluctuate more significantly. Publication of these numbers could make individuals potentially identifiable.

The Financial Performance Report presented to the August IJB provided details on the continuing increases in Looked After and Accommodated Children since 2016. The current projected overspend contained within the September IJB update is £1.970m for residential schools and external accommodation. The number of placements in residential schools has increased by 10 since the budget was set. The average costs of a placement is £274k per year: the split is 72% (£197k) HSCP and 28% Education (£77k).

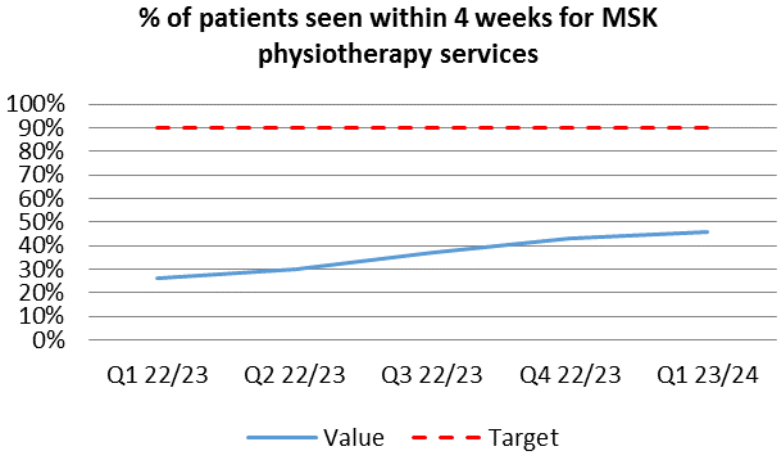
Community placement is forecasting an overspend of £431k. This is due to unachieved savings of £306k and the number of external foster placements increasing to 68. The average cost of an external foster placement is £50k compared to £20k for a WDC provided foster placement.

Improvement Actions:
The HSCP's Throughcare and Aftercare service continue to support care experienced young people to access education, employment and training alongside a range of supports in relation to housing, finances and developing confidence and lifeskills. Work is planned to compare the outcomes for all looked after children leaving each type of care setting.

Performance Area: MSK Physiotherapy

Ref	Performance Indicator	Q1 2023/24				Q4 2022/23	Trend over 8 Qtrs
		Value	Target	Status	Short Trend	Value	
44	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	46%	90%			43%	

Quarter	Value	Target
Q1 22/23	26%	90%
Q2 22/23	30%	90%
Q3 22/23	37%	90%
Q4 22/23	43%	90%
Q1 23/24	46%	90%



Key Points:
There has been an increase in the % seen within the 4 week target in Quarter 1. However this relates to the proportion of urgent referrals at any given time. There will be no significant change in the % seen within target until routine waiting times reduce to closer to the 4 weeks. Trajectory data indicates that this will be achieved by June 2024, assuming that staffing levels, capacity and demand remain static.

Routine waiting times have remained static at 12 weeks despite peak annual leave time at Easter. The service halved routine waiting times from 24 weeks to 12 weeks within 2022/23 and continues to address routine waiting times as part of a priority project (see below).

Demand/referrals to the service have continued to rise from March to June: over 6,300 referrals across Greater Glasgow and Clyde (GGC) in June 23.

There has been an ongoing reduction in the number of patients waiting over the 4 weeks target during Quarter 1, following on from the trend in Quarter 4 2022/23. Across GGC this figure reduced from 8,938 to 8,149 in Quarter 1.

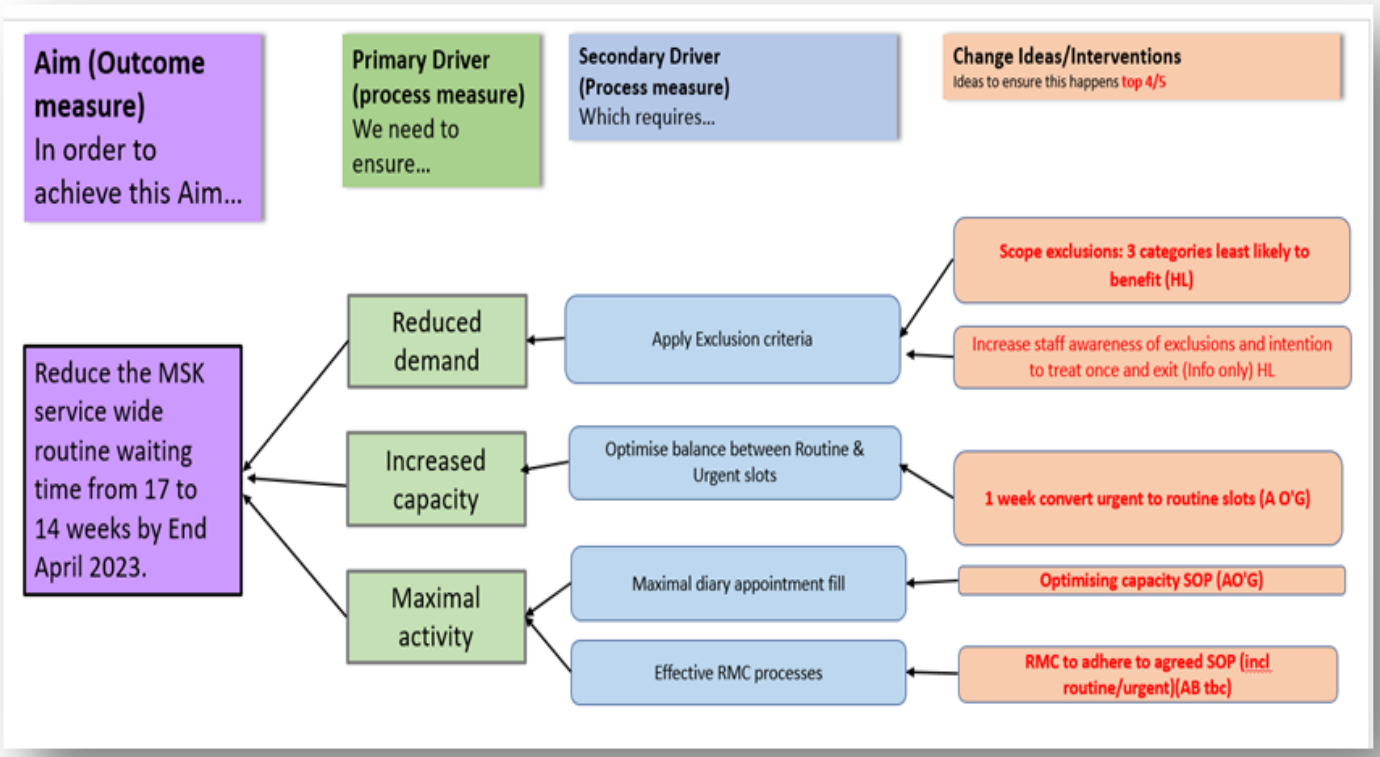
This quarter has seen an increase in New Patient (NP) capacity and return activity, primarily due to an ongoing recruitment drive to fill vacancies. Capacity has also been boosted by ongoing employment of agency staff to temporarily fill vacancies, address sickness absence and also address waiting times. NP activity peaked at 5,728 NP appointments in June and return activity at 15,492 across GGC. Remobilisation of class provision has increased return appointment activity.

Improvement Actions:
The service is not currently meeting AHP Scottish Government MSK waiting times target of 4 weeks, however there is a programme of ongoing improvement work supported by additional funding.

- Continued application of Earmarked Reserves funding to support ongoing improvement work and address routine waiting times, including employment of temporary agency staff, additional recruitment of 1.0 wte Band 5 and 2.0 wte Band 6 MSK Practitioners, and funding of overtime and extra hours where existing staff are willing to offer additional time, will result in a forecast drawdown from MSK Earmarked Reserve of circa £0.462m in 2023/24, inclusive of Digital Access and Training planned spend.

- The MSK service is currently on target to meet increased total turnover target of 9%, which includes a non- recurring increased target of 5%, (£0.362m), for 2023/24, reflective of the current recruitment challenges within the profession.

Quality Improvement methodology has been followed to address routine waiting times. Driver diagram is below.



Priority project work continues. The test of change, changing almost all urgent NP appointments to routine NP appointments, will be repeated in June. This has been successful in reducing the routine waiting times on the previous 2 occasions. The service will continue to monitor any breach on urgent referrals being seen within the 4 week target.

A Standard Operating Procedure has been produced and continues to be adopted to maximise efficiency: local administrative staff to merge any two unutilised return slots in clinicians' diaries and convert to NP slots. This created an additional 120 NP appointments across the Board area in April 23; 120 in May and 176 in June.

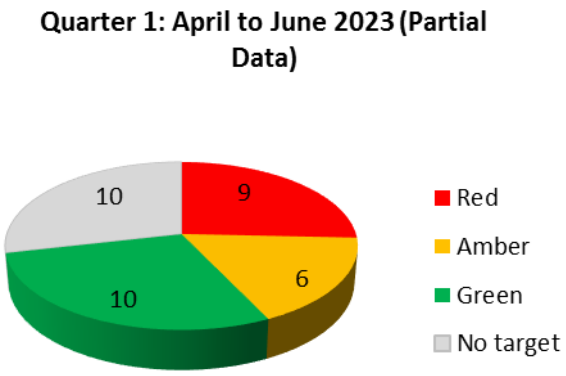
The MSK service is scoping out the number of referrals where the evidence base states that the patient is "less likely" to benefit from MSK. This relates to three categories of patients i.e. those patients who have been to MSK in the last year with the same condition; those patients who have been through the Pain Management Service with the same condition; and those patients with widespread body pain as will not truly be MSK pathology. This is with a view to focusing service provision on those who are most likely to benefit.

Recruitment challenges remain a national issue for the profession, however despite this, the service has been successful in filling the vacant Band 5 posts.

The service is continuing with planned drawdown from Earmarked Reserves to employ agency staff to reduce waiting times.

The priority project group will meet over the next month to plan next change ideas to be piloted.

Summary of Strategic Plan Key Performance Indicators



West Dunbartonshire Health and Social Care Partnership Complaints Reporting: Quarter 1 April to June 2023

Within the Model Complaints Handling Procedure developed by the Scottish Public Services Ombudsman (SPSO) is a requirement to report performance in relation to complaints internally on a quarterly basis and publicly on an annual basis in line with the SPSO's Model Complaints Handling Reporting Framework. As part of our commitment to best practice, openness and transparency we will include this framework within our Quarterly Performance Report going forward.

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

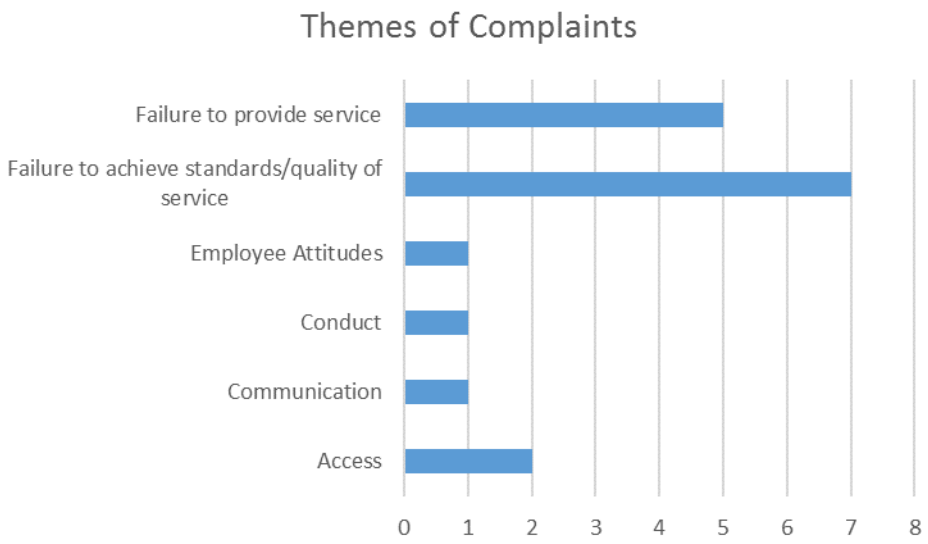
SPSO Indicator	Measure	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
2	Number of Stage 1 complaints (whether escalated to Stage 2 or not)	13	23	16	29	47
	Number of complaints direct to Stage 2	7	11	13	9	16
	Total number of complaints	20	34	29	38	63
3	% closed within timescale - Stage 1	Not available				
	% closed within timescale - direct to Stage 2	43%	36%	23%	33%	31%
	% closed within timescale - escalated to Stage 2	N/A	N/A	N/A	N/A	N/A
4	Average response time - Stage 1	Not available				
	Average response time - direct to Stage 2	29	22	25	25	24
	Average response time - escalated to Stage 2	N/A	N/A	N/A	N/A	N/A

Indicator 5: Outcomes of Complaints

Stage 2 – Quarter 1 2023/24

	Model Complaints Handling Procedure		
Outcome	NHSGGC	WDC*	% of total
Fully Upheld	0	0	0%
Partially Upheld	1	6	47%
Not Upheld	4	4	53%
Unsubstantiated	0	0	0%
Total	5	10	

*1 complaint is still ongoing


Themes of Complaints
Failure to provide service
Failure to achieve standards/quality of service
Employee Attitudes
Conduct
Communication
Access
0
1
2
3
4
5
6
7
8

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Andi Priestman, Chief Internal Auditor

Audit and Performance Committee - 19 September 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 June 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 2023/24.

3. Background

3.1 In June 2023, the Audit and Performance Committee approved the Internal Audit Annual Plan which detailed the activity to be undertaken during 2023/24.

3.2 This report provides a summary to the Audit and Performance Committee of recent Internal Audit activity against the annual audit plan for 2023/24. 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 2023/24 is now underway. The audit report relating to the 2022/23 audit plan has been finalised in relation to IJB Workforce Planning Arrangements.

IJB Workforce Planning Arrangements

4.2 Under the Public Bodies (Joint Working) (Scotland) Act 2014, the West Dunbartonshire Health & Social Care Partnership Board was formally

established on 1 July 2015, with the Health & Social Care Partnership (HSCP) becoming live on the same date. The West Dunbartonshire Health & Social Care Partnership is the joint delivery vehicle for a range of health and social care services delegated to it by NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council with those integrated services delegated to the West Dunbartonshire HSCP Board as set out within its integration scheme.

4.3 In relation to workforce planning, the Scottish Government's National Workforce Strategy (March 2022) requires HSCP's to submit Three Year Workforce Plans. The Plans are required to provide workforce planning information aligning local activity with the Strategy.

4.4 Workforce planning is a process which aims to align the HSCP Board's strategic objectives with the HSCP's current and future human resource levels whilst also being affordable. At its core workforce planning aims to ensure that the workforce employed through the HSCP have the required skills and qualifications so that they can deliver a diverse range of local services to West Dunbartonshire residents.

4.5 In order to recruit, retain and develop staff the HSCP must deploy an effective workforce planning framework and actively manage the actions which flow from that framework. To this end the HSCP Board approved the WD HSCP Integrated Workforce Plan 2022-25 (IWP) on 15 November 2022. The plan covers the three years to March 2025 and was the main focus of this review.

4.6 The objective of this audit is to provide the West Dunbartonshire HSCP 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 HSCP Board's Workforce Planning arrangements and concentrated on identified areas of perceived higher risk, such as not adequately translating the HSCP IWP into clearly defined tasks and timescales for officers to follow and not adequately reporting to the Partnership Board on the progress being made with implementing the plan.

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

<u>Adequacy of Succession Planning Arrangements</u>

Currently Succession Planning is restricted to overall HSCP Succession Planning at Heads of Service Level. Although there is some succession planning at service level, it is not current practice to undertake formally documented Succession Planning at this level.

Limited succession planning could result in the failure to satisfactorily identify and fill critical roles within acceptable timeframes which may impact on the delivery of the Strategic Plan.

Adequacy of Risk Management Arrangements

The review identified that risk management is currently limited to the strategic risks. Currently, there are no operational/service level risk registers and there is a lack of any specific arrangements to assess risks to the implementation of the IWP.

Where risk management arrangements are not embedded at an operational/ service level there is a risk that the risks to the implementation of the IWP at an operational level are adequately identified, assessed and managed.

Adequacy of Monitoring and Reporting Arrangements

Since the IWP 2022-25 along with its Action Plan was published in November 2022, there has been no formal monitoring and reporting on implementation of the IWP and its Action Plan to the WD HSCP Board or other stakeholders.

Lack of arrangements in place for formal regular monitoring and reporting of the IWP and its Action Plan to the WD HSCP Board or other stakeholders could result in delay in enactment of timely remedial action being taken to ensure its implementation.

4.8 The audit identified 3 issues and an action plan is in place to address all issues by 31 March 2024.

4.9 In relation to internal audit action plans, there were no actions due for completion by 31 August 2023. There are 5 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 31 August 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, there were no Internal Audit reports issued to the Council or NHSGGC which are relevant to the WD HSCP Board.

4.12 Internal Audit at West Dunbartonshire Council and NHSGGC undertake follow up work in accordance with agreed processes to confirm the implementation of agreed actions and report on progress to their respective Audit Committees. Any matters of concern will be highlighted to the 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 2023/24 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: **24 August 2023**

Person to Contact: Andi Priestman – Shared Service Manager – Audit & Fraud
West Dunbartonshire Council
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Appendices: Appendix 1 – Status of Internal Audit Action Plans at 31 August 2023
Appendix 2 – Status of External Audit Action Plans at 31 August 2023

Background Papers: Internal Audit Annual Audit Plan 2023-2024

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF INTERNAL AUDIT ACTION PLAN POINTS
AT 31 AUGUST 2023

Summary:

Section 1 **Summary of Management Actions due for completion by 31/08/2023**

There were no actions due for completion by 31 August 2023.

Section 2 **Summary of Current Management Actions Plans at 31/08/2023**

At 31 August 2023 there were no audit reports delayed due to management not finalising the action plan within agreed timescales.

Section 3 **Current Management Actions at 31/08/2023**

At 31 August 2023 there were 5 current audit action points.

Section 4 **Analysis of Missed Deadlines**

At 31 August 2023 there were no audit action points where the agreed deadline had been missed.

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

SUMMARY OF MANAGEMENT ACTION PLANS DUE FOR COMPLETION BY 31.08.2023

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 31.08.2023

SECTION 2

CURRENT ACTIONS

Month	No of actions
Due for completion September 2023	2
Due for completion 31 March 2024	3
Total Actions	**5**

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

CURRENT MANAGEMENT ACTIONS AS AT 31.08.2023

SECTION 3

Action	Owner	Expected Date
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**
IJB Workforce Planning Arrangements (August 2023)		
Adequacy of Succession Planning Arrangements (Amber) All Heads of Service will work with the Head of HR to embed succession planning through service planning structures and through annual performance reviews. Additionally, the Head of HR will consider any additional leadership resource requirements to enable visibility across services and create the conditions for engagement.	**Head of HR**	**31 March 2024**
Adequacy of Risk Management Arrangements (Amber) The Head of HR will consider any additional requirements to enable risk management reporting to be undertaken within workforce planning activities.	**Head of HR**	**31 March 2024**
Adequacy of Monitoring and Reporting Arrangements (Amber) The Head of HR will ensure a clear roll out of an action plan to support the delivery of the themes contained within the HSCP Integrated Workforce Plan 2022-25, reporting on the progress across the four pillars.	**Head of HR**	**31 March 2024**

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

SECTION 4

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

WEST DUNBARTONSHIRE HSCP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF EXTERNAL AUDIT ACTION PLAN POINTS
AT 31 AUGUST 2023

Summary:

Section 1 **Summary of Management Actions due for completion by 31/08/2023**

There were no actions due for completion by 31 August 2023.

Section 2 **Summary of Current Management Actions Plans at 31/08/2023**

At 31 August 2023 there were no audit reports delayed due to management not finalising the action plan within agreed timescales.

Section 3 **Current Management Actions at 31/08/2023**

At 31 August 2023 there were 2 current audit action points.

Section 4 **Analysis of Missed Deadlines**

At 31 August 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 31.08.2023

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

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

SUMMARY OF CURRENT MANAGEMENT ACTIONS AS AT 31.08.2023

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 31.08.2023

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. <u>Update</u> 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

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

Audit and Performance Committee - 19 September 2023

Subject: Governance of HSCP Commissioned Services

1 Purpose

1.1 The purpose of this report is to update the Audit and Performance Committee members on matters relating to West Dunbartonshire HSCP's (HSCP) current governance process and its plan for improving its governance of externally commissioned health and social care services.

1.2 In March 2023-26 the IJB approved their strategic plan, Improving Lives Together 2023-2026. In order to support the HSCP to deliver on the vision of this strategy we will undertake improvements in our governance (including contract monitoring) arrangements of our contracts for externally commissioned health and social care services.

1.3 By strengthening our governance arrangements of our externally commissioned health and social care services we will be gaining assurances around, quality of service (including service user feedback), compliant spend, outcomes for service users, effective referrals and admissions and best value.

2 Recommendations

2.1 The Contracts, Commissioning and Quality Assurance team continue to develop the way in which externally commissioned health and social care services are monitored. This shall be in the form of a Quality Assurance Framework, which will be brought to a future Audit and Performance Committee for consideration.

2.2 In order to develop a robust reporting tool for the Audit and Performance Committee, the Contracts, Commissioning and Quality Assurance team propose to work with members of the Audit and Performance Committee along with colleagues from Internal Audit, Finance, Procurement Teams and Legal Services. This partnership approach shall ensure that a fit for purpose report is delivered, which provides the Audit and Performance Committee with assurances around the HSCP's governance of externally commissioned health and social care services.

3 Background

3.1 Current governance arrangements that are in place within the HSCP include:

- Care Home Collaborative Assurance Visits.
- Clinical and Care Governance Committee oversight.
- Adult and Child Protection Committees oversight (when provider specific).
- Provider meetings regarding service delivery, commissioning planning and development and Care Inspectorate feedback and managing performance.
- Provider engagement sessions.
- Financial Regulations and Standing Order governance.
- Regular budget monitoring and financial performance reports to HSCP Board.
- Annually uplifting adult social care provider rates in line with the real Scottish Living Wage.
- Compliant spend including Contract and Supplier Management Scorecards (procurement governance)
- Procurement Request Form, which are pre contract governance procedures signed off by Head of Service and the Corporate Procurement Unit.
- Care Inspection reporting of registered services.
- Contract and Supplier Management scorecards.

3.2 With the formation of the Contracts, Commissioning and Quality Assurance Team in December 2022, the HSCP is able to develop its governance arrangements and focus on individual contract monitoring.

3.3 Contract monitoring arrangements, including bi-annual monitoring visits will form part of the Quality Assurance Framework which will be brought to a future Audit and Performance Committee for consideration.

4 Main Issues

4.1 In March 2023, colleagues from Internal Audit published the findings and recommendations of the audit into Supplier Management processes of West Dunbartonshire Council.

4.2 The objective of the audit was to provide management and the 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 Supplier Management. The audit was carried out between August and December 2022.

4.3 The report returned one Amber issue relating to the HSCP and highlighted a weakness in formal supplier management processes. This poses risks in relation to providers failing to deliver high quality services or delivering services which are not fit for purpose.

4.4 In order to meet the recommendations and comply with the findings of the Supplier Management Report the Contracts, Commissioning and Quality Assurance team will develop a contracts register specific to the HSCP in RAG format.

4.5 The development of the Quality Assurance Framework will include a revised contract monitoring procedure which will be fundamental to the RAG rating of external providers within the contracts register.

4.6 The definition of the RAG status will be developed in partnership with colleagues from Internal Audit, HSCP Heads of Service, Procurement and Finance. This would be included within the Quality Assurance Framework which will be submitted to a future Audit and Performance Committee for consideration.

4.7 In March 2023 the Integrated Joint Board approved their strategic plan, Improving Lives Together 2023 – 2026. In order to support the vision noted in the strategic plan, the Contracts, Commissioning and Quality Assurance Team, working with colleagues across the Council and HSCP have developed a commissioning process. The process is aligned to the strategic plan and supports the implementation of Ethical Commissioning Principles. The Audit and Performance Committee is asked to note that the Commissioning Process has been submitted as a separate paper to the September Integrated Joint Board for their consideration.

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 Paragraph 4.3 sets out the risk that has been identified and the development of a Quality Assurance Framework including a contract monitoring procedure will support the mitigation of this risk.

8 Equalities Impact Assessment

8.1 An Equalities Impact Assessment has not been carried out. This is because the report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

8.2 It is noted that this report gives advance notice of a change to an existing policy, however this report does not enact such change.

9 Environmental Impact Assessment

9.1 There are no issues.

10 Consultation

11.1 The report has been prepared by the Head of Strategy and Planning for West Dunbartonshire HSCP after due consideration with relevant senior officers in the HSCP.

12 Strategic Assessment

12.1 The establishment of a robust governance process is in line with the HSCP's Strategic Plan.

13 Directions

13.1 Directions are required and attached at Appendix 1.

Person to Contact: Neil McKechnie, Contracts, Commissioning and Quality Assurance Manager.
West Dunbartonshire HSCP
Email: neil.mckechnie@west-dunbarton.gov.uk

Appendices: Appendix 1 – Directions report

Background Papers: None

Item 8
Appendix 1

Appendix 1: Direction from Health and Social Care Partnership Board.

The Chief Officer will issue the following direction email directly after Integration Joint Board approval.

From: Chief Office HSCP
To: Chief Executive(s) WDC and/or NHSGCC
CC: HSCP Chief Finance Officer, HSCPB Chair and Vice-Chair
Subject: For Action: Direction(s) from HSCPB 19th September 2023
Attachment: Governance of HSCP Services

Following the recent Integration Joint Board meeting, the direction below have been issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014. Attached is a copy of the original HSCPB report for reference.

DIRECTION FROM WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD		
1	Reference number	HSCPB000049MJC19092023
2	Date direction issued by Integration Joint Board	Tuesday 19th September 2023
3	Report Author	Neil McKechnie Contracts, Commissioning & Quality Assurance Manager
4	Direction to:	West Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	All health and social care commissioned services.
7	Full text and detail of direction	The Contracts, Commissioning and Quality Assurance team shall continue to improve the way in which externally commissioned health and social care services are monitored, by developing a Quality Assurance Framework (QAF) with colleagues from Internal Audit, Finance, Procurement and Legal Services. The QAF, prior to being implemented will be brought to a future Audit and performance Committee for consideration.
8	Specification of those impacted by the change	HSCP and NHS GGC staff, service users and providers.

9	Budget allocated by Integration Joint Board to carry out direction	N/A	
10	Desired outcomes detail of what the direction is intended to achieve	This direction is to support the HSCP in delivering the vision detailed in the IJB's Strategic Plan – Improving Lives Together 2023-26. Improve the HSCP's monitoring of externally commissioned health and social care services. Address the Amber issue highlighted by audit into Supplier Management processes of West Dunbartonshire Council in March 2023.	
11	Strategic Milestones	Issue Audit and Performance Committee with Quality Assurance Framework for consideration	November Audit & Performance Committee
		Issue Quality Assurance Framework to IJB for approval.	Proceeding IJB following November's Audit and Performance Committee
		Providers forum on implementation of Quality Assurance Framework.	January 2024
12	Overall Delivery timescales	Quality Assurance Framework implementation role out from 1st February, concluding on the 31st of March.	
13	Performance monitoring arrangements	In line with the agreed Performance Management framework this direction will be monitored and progress reported twice per year.	
14	Date direction will be reviewed	April 2024.	

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

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

Audit and Performance Committee - 19 September 2023

Subject: Ministerial Strategic Group for Health and Community Care: Measuring Progress Under Integration

1. Purpose

1.1 The purpose of this report is to update the HSCP Audit and Performance Committee on the status of the "Progress with Integration of Health and Social Care, West Dunbartonshire Health and Social Care Partnership Action Plan" [the Action Plan] (Appendix 1).

2. Recommendations

It is recommended that the HSCP Audit and Performance Committee:

2.1 Note contents of the "Progress with Integration of Health and Social Care, West Dunbartonshire Health and Social Care Partnership Action Plan", September 2023 (Appendix I), and

2.2 Agree that given the advanced nature of this work that no further update reports are required.

3. Background

3.1 At the meeting of the Ministerial Strategic Group for Health and Community Care (MSG) on 29 May 2019, members considered how they would wish the existing MSG measures set to be extended and/or complemented with other information, to allow them to understand better the progress being made towards the health and wellbeing outcomes across the wider health and care system under integration.

3.2 MSG members agreed that they would like to better understand what information / evidence exists on outcomes and sought the support of HSCPs to collectively and iteratively improve awareness, understanding and evidence around the difference that integration is making to people.

3.3 In response to this request West Dunbartonshire HSCP undertook a mapping exercise in order to fully define the extent and types of activities that the partnership were already undertaking in respect of feedback/impact/outcome measures for people supported by, or working within, health and care services.

3.4 Leading on from this mapping work, in September 2019 the HSCP developed an Action Plan (Appendix 1).

4. Main Issues

4.1 There have been many areas of good integrated practice which have taken place in the period since the development of the Action Plan, with work areas impacted both positively and negatively by the global pandemic. Given there is greater stability across the HSCP, as we move further into the Covid-19 Recovery phase, this work has been enhanced by the publication of the HSCP Strategic Plan 2023 – 2026 “Improving Lives Together”.

4.2 The action plan is now in its fourth year, the majority of actions are complete or nearing completion. There are a number of actions which remain incomplete but are as advanced as they can be without further change at a national level, for example the desired move away from annual financial settlements in order to facilitate more effective long term strategic planning. Officers continue to proactively identify opportunities to positively influence change at within the Scottish Government but are not able to take some of these work streams forward independently.

5. Options Appraisal

5.1 Not required for this report.

6. People Implications

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

7. Financial and Procurement Implications

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

8. Risk Analysis

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

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

9. Equalities Impact Assessment (EIA)

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

10. Environmental Sustainability

10.1 Not required for this report.

11. Consultation

11.1 The HSCP Senior Management Team, Chief Financial Officer, Internal Auditor and Monitoring Officer within Regulatory Services have been consulted in the preparation of this report.

12. Strategic Assessment

12.1 Not required for this report.

13 Directions

13.1 The recommendations within this report do not require a Direction to be issued.

Name:	Margaret-Jane Cardno
Designation:	Head of Strategy and Transformation
Date:	11 August 2023

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

Appendices:	Appendix 1: Progress with Integration of Health and Social Care, West Dunbartonshire Health and Social Care Partnership Action Plan" [the Action Plan]

Collaborative Leadership And Building Relationships							
Shared and collaborative leadership must underpin and drive forward integration.							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	1. (i) All leadership development will be focused on shared and collaborative practice. An audit of existing national leadership programmes will be undertaken by the Scottish Government and COSLA to identify gaps and areas of synergy to support integration of health and social care. Further work will be delivered on cross-sectoral leadership development and support.	We will make further use of the range of leadership opportunities delivered across the NHS/HSCP/Council, focussing on learning about good practice and assessing opportunities for joint learning across the system.		Development opportunities are presented on a regular basis to appropriate staff.	Further work is required to strengthen this approach.	Gillian Gall	31-Mar-24

	Timescale: 6 months	We will look to expand the scope and membership of current groups in order to ensure we are getting the most out of these opportunities of joint working and will review the content and invitation list of any further events being developed to ensure they are offered across NHS/HSCP/Council where this is felt to be appropriate.		Over the last 18 months the Strategic Planning Group has been completely refreshed with development work supported by Healthcare Improvement Scotland. The HSCP Extended Management Team has undertaken a series of focused sessions on a monthly basis which have included external and internal partners who have shared best practice. The Carers Development Group has been refreshed and their ToR reviewed in order that it aligns more effectively with the Carers Strategy. The Recovery Orientated System of Care (ROSC) have also refreshed their ToR and now enjoy expanded membership refreshed TOR. The IJB has promoted inclusion by recruiting an additional carer representative in order that the voice of lived experience is strengthened at a strategic level.	This is an ongoing activity and is now business as usual as opposed to a standalone improvement action.	MJ Cardno	19-Sep-23
		We will have a continued commitment to informal and formal development sessions between the SMT and HSCP Partnership Board members.		15 August 2023 - IJB Paper "Future Meeting Dates". HSCP Board approval for 4 informal sessions per annum.	No further action required.	MJ Cardno	15-Aug-23

		We will, in the year ahead, be improving strategic commissioning, with partners, and the quality monitoring processes that accompany this.		Quality Assurance Strategy to be considered by the IJB on the 19 September 2023.	Further action required to implement the strategy.	MJ Cardno	Ongoing
		We will develop our new Integrated Workforce Development Plan over the next year to collectively share understanding and consider roles and responsibilities across the HSCP professional and leadership arrangements. The aim is to set out a collaborative approach, to find improved and joined up ways of working focussed on service user and patient care.		Link to IJB Papers 15 November 2022 - http://www.wdhscp.org.uk/about-us/health-and-social-partnership-board/health-and-social-care-partnership-board-meeting-papers/	Scottish Government Reporting arrangements have developed, further work will be required to align with their position.	Gillian Gall	15-Nov-22
		To date, organisational development support has been provided through the NHS, however we are going to commission additional resource from the Council; with the implicit objective of widening understanding		Good progress for example work related too hard to fill vacancies and social work career pathways.	Ongoing work required.	Gillian Gall	31-Mar-24

		of the HSCP across the Council.					
		We will continue to embrace integration in West Dunbartonshire which was originally progressed under a different leadership team, and we acknowledge the need to continue to embrace change and continue with collective practice across all partners.		Nationally the turnover in senior roles within HSCPs means that there needs to be a continual focus on the development of partnerships/relationships. Good examples at a local level include HSCP SMTs involvement in key partner forums such as NHS CMT; Council PMRG and Council Recovery and Renew.	No further action required.	Beth Culshaw	Complete
Relationships and collaborative working between partners must improve							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	1. (ii) Relationships and collaborative working between partners must improve. Statutory partners in particular must seek to ensure an improved understanding of	We have a continuing commitment to building understanding and trust; between partners as we focus on our shared objectives ensuring the Strategic Plan is implemented to ensure maximum impact from all our partners.		http://www.wdhscp.org.uk/media/2618/document-pack-bookmarked-and-agenda-hscp-board-15-march-2023.pdf	Strategic Plan agreed and implemented.	MJ Cardno	15-Mar-23

	pressures, cultures and drivers in different parts of the system in order to promote opportunities for more open, collaborative and partnership working, as required by integration.						
	Timescale: 12 months	We are continuing to build relationships with partners; ensuring all partners understand the extent of the work and pressures in the HSCP; for example the scope of the formal scrutiny and the priorities linked to implementing new policies and legislation. Through further collaboration, partners will begin to understand the range of responsibilities better and gain an insight into our shared areas of work.		Nationally the turnover in senior roles within HSCPs means that there needs to be a continual focus on the development of partnerships/relationships. Good examples at a local level include HSCP SMTs involvement in key partner forums such as NHS CMT; Council PMRG and Council Recovery and Renew.	No further action required.	Beth Culshaw	Complete

		Through service plans we will achieve early visibility on key strategic and/or operational priorities. We will be better able to identify early, through a focus on performance and data analysis, where joint planning or working would support best delivery our collective outcomes.		http://www.wdhscp.org.uk/media/2618/document-pack-bookmarked-and-agenda-hscp-board-15-march-2023.pdf	Strategic Plan agreed and implemented.	MJ Cardno	15-Mar-23
Relationships and partnership working with the third and independent sectors must improve							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	1. (iii) Relationships and partnership working with the third and independent sectors must improve. Each partnership will critically evaluate the effectiveness of their working arrangements and relationships with colleagues in the third and	We will work to further develop our Provider Forums, across all care groups, to establish joint attendance from HSCP and third/independent sector providers for shared dialogue and development.		The HSCP are in the process of establishing a range of strategic frameworks which will provide a platform for provider forums to exist. These will go live on the 1 April 2024.	This is an ongoing piece of work. BAU in line with work plans.	MJ Cardno	01-Apr-24

	independent sectors, and take action to address any issues.						
	Timescale: 12 months	We will conclude our work on developing and publishing a Commissioning Strategy, informed by close working with our Care Inspectorate Link Inspector		Commissioning Strategy to be considered by IJB on the 19 September 2023.	Work will be required to effectively implement the strategy.	MJ Cardno	31-Mar-24
		We will review the process for service reviews to ensure early engagement with key stakeholders in the redesign of service delivery models		Quality Improvement and Service Redesign Strategies to be considered by IJB on the 19 September 2023.	Work will be required to effectively implement these strategies.	MJ Cardno	31-Mar-24

		We will involve third sector partners as they provide a valuable contribution to our way forward; there is scope to have partners more involved in some pieces of work including the work developing through the ADP and the procurement Pipeline work already underway		The above evidence contributes to the delivery of this action.	Via the Strategic Delivery Plan, work is required to the Partnership agreement between the HSCP and the TSI. This work will be monitored as part of standard reporting in relation to the delivery of the Strategic Plan.	MJ Cardno	31-Mar-24

Integrated finances and financial planning							
Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**

	2. (i) Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration. In each partnership area the Chief Executive of the Health Board and the Local Authority, and the Chief Officer of the IJB, while considering the service impact of decisions, should together request consolidated advice on the financial position as it applies to their shared interests under integration from, respectively, the NHS Director of Finance, the Local Authority S95 Officer and the IJB S95 Officer.	We are committed to developing medium/longer term financial planning.		Published and reviewed twice. Reported to IJB March 2020 and March 2022.	Will be reviewed again in March 2024	Julie Slavin	31-Mar-24
	Timescale: By 1st April 2019 and thereafter each year by end March.	We are continuing to work towards whole system financial planning which is at its very early stages.		The board, finance colleagues and the 6 HSCP CFOs have agreed a mechanism for costing the activity aligned to set aside budgets. These are reflected within our annual accounts. However, work continues to move towards release of elements of the set aside budget into community based budgets.	Continuing to work with the Board and 6 HSCPs	Julie Slavin	Ongoing

		We will work to ensure we further develop shared narratives to support financial information not only in relation to financial planning but also in the monthly financial monitoring arrangements, in conjunction with the senior managers in the HSCP.		All managers receive monthly financial monitoring information. Financial performance reported to the IJB is also reflected within partner organisations management meetings (eg NHS CMT and PMRG). Quarterly reporting to the Health and Sport Committee.	No further action required.	Julie Slavin	Complete
Delegated budgets for IJBs must be agreed timeously							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	2. (ii) Delegated budgets for IJBs must be agreed timeously. The recently published financial framework for health and social care sets out an expectation of moving away from annual budget planning processes towards more medium term arrangements. To support this requirement for planning ahead by Integration Authorities, a requirement should be placed upon statutory partners that all delegated budgets should be agreed by the Health	We will continue to undertake further work to effectively transition towards medium term financial and scenario planning, in line with Audit Scotland Report recommendations.		Medium term financial plan in place however due to the Covid pandemic the Scottish Government have not published a refreshed financial plan. The move away from single	No further action can be taken at a local level.	Julie Slavin	Ongoing/Nationally

	Board, Local Authority and IJB by the end of March each year.			year settlements has therefore not progressed at a national level.			
	Timescale: By end of March 2019 and thereafter each year by end March	We will work through the Integrated Joint Boards Chief Finance Officers' network and through our ongoing local partnership working to learn from best practice elsewhere, and offer our learning into the developing national picture to continue to strengthen our local practice.		CFO section meet at least 10 times per year. The group is supported by CIPFA and has worked collaboratively to develop best practice. Scottish Govt and Cosla are also members of the group.	No further action required.	Julie Slavin	Complete
		We will continue to work with the health board in respect of indicative and formal budget settlements to be made earlier (in time for March IJB meetings) including		Although we work closely with NHS finance colleagues, the NHS budget remains indicative in March each year. This is a systemic issue which can only	No further action can be taken at a local level.	Julie Slavin	Ongoing/Nationally

		all aspects of delegated budgets.		be addressed by Scottish Government.			
		We support the move towards medium to long term financial planning across the NHS and the Council which will positively impact on the HSCP financial planning arrangements. We note that as part of the parliamentary review process there is an aspiration for next year's budget process to set out multiyear settlements and the recent change in arrangements for NHS Boards to allow medium term planning and increased flexibility. We welcome these developments.		Medium term financial plan in place however due to the Covid pandemic the Scottish Government have not published a refreshed financial plan. The move away from single year settlements has therefore not progressed at a national level.	No further action can be taken at a local level.	Julie Slavin	Ongoing/Nationally

Delegated hospital budgets and set aside budget requirements must be fully implemented							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	2. (iii) Delegated hospital budgets and set aside requirements must be fully implemented. Each Health Board, in partnership with the Local Authority and IJB, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. These arrangements must be in place in time for Integration Authorities to plan their use of their budgets in 2019/20. The Scottish Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. The set aside arrangements are key to delivering this commitment.	We will continue to work with NHSGGC on the process for the management of set aside budgets with a view to establishing a clear position for 2020 – 2021 budget setting.		The board, finance colleagues and the 6 HSCP CFOs have agreed a mechanism for costing the activity aligned to set aside budgets. These are reflected within our annual accounts. The process of the management of set aside budgets is complete.	No further action required.	Julie Slavin	Complete
	Timescale: 6 months	We will develop a Commissioning Plan which will more clearly align finance and planning work streams across all areas including unscheduled hospital bed usage.		Commissioning Strategy to be considered by the IJB on the 19 September 2023.	Further work is required in order to effectively embed this strategy and also to develop market facilitation plans across a number	MJ Cardno	31-Mar-25

					of operational delivery areas.		
		We will deliver a due diligence exercise, required as part of the overall process of agreeing set aside budgets, which addresses the significant financial gap identified in acute budgets based on figures provided by the health board to date.		The board, finance colleagues and the 6 HSCP CFOs have agreed a mechanism for costing the activity aligned to set aside budgets. These are reflected within our annual accounts. However, work continues to move towards release of elements of the set aside budget into community based budgets.	Continuing to work with the Board and 6 HSCPs	Julie Slavin	Ongoing
		We will aim to ensure a common understanding as to set aside; we will continue to host sessions with HSCP Board members to support joint understanding of set		Formal reporting to IJB is enhanced with informal finance sessions with the Board.	No further action required.	Julie Slavin	Complete

		aside budgets prior to beginning of financial year 2020 – 2021.					
Each IJB must develop a transparent and prudent reserves policy							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	2. (iv) Each IJB must develop a transparent and prudent reserves policy. This policy will ensure that reserves are identified for a purpose and held against planned expenditure, with timescales identified for their use, or held as a general reserve as a contingency to cushion the impact of unexpected events or emergencies. Reserves must not be built up unnecessarily.	We will continue to monitor and review spend against reserves and focus spend on areas identified as requiring additional investment		Every financial performance report to the IJB provides an update on reserves.	No further action required.	Julie Slavin	Complete
Statutory partners must ensure appropriate support is provided to IJB S95 Officers							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**

	2. (v) Statutory partners must ensure appropriate support is provided to IJB S95 Officers. This will include Health Boards and Local Authorities providing staff and resources to provide such support. Measures must be in place to ensure conflicts of interest for IJB S95 Officers are avoided – their role is to provide high quality financial support to the IJB. To ensure a consistent approach across the country, the existing statutory guidance should be amended by removing the last line in paragraph 4.3 recommendation 2, leaving the requirement for such support as follows: It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole. It is also recommended that each partnership area moves to a model where both the strategic and operational finance functions are undertaken by the IJB S95 officer: and that these functions are sufficiently resourced to provide effective financial support to the Chief Officer and the IJB	We are investing in additional senior finance officer support to the CFO. The recruitment process has just completed and this new manager level post will work on consolidating the financial information hosted by both the local authority and health board to allow financial resources to lose their identity, where appropriate.		HSCP Finance Manager in place.	No further action required.	Julie Slavin	Aug-19
	Timescale: 6 months	We will continue with HSCP Partnership sessions for learning and		Formal reporting to IJB is enhanced with informal finance	No further action required.	Julie Slavin	Complete

		development focused on financial position, set aside, reserves and pressures in the system.		sessions with the Board.			
IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	2. (vi) IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations. Local audits of the Health Board and Local Authority must take account of the expectation that money will be spent differently. We should be focused on outcomes, not which public body put in which pound to the pot. It is key that the resources held by IJBs lose their original identity and become a single budget on an ongoing basis. This does not take away from the need for the IJB to be accountable for these resources and their use.	We will work to review the Scheme of Integration to support HSCP officers to manage and deploy the resources in their remit directly and effectively.		This work is well advanced with an initial report due to be considered by West Dunbartonshire Council and NHS GGC Board in October 2023.	Further work required to complete task. This included seeking permission to consult, a period of consultation, approval by NHS Board and WDC and final approval by Ministers.	MJ Cardno	31-Mar-24

	Timescale: from 31st March 2019 onwards	We would welcome further national consultation on future funding mechanisms for HSCPs, including pros and cons of direct funding or more medium term funding settlements to health boards and local authorities to allow better medium to longer term financial planning.		The HSCP have contributed positively to work related to the development of a National Care Service for Scotland. The importance of receiving recurring allocations is also highlighted via the national CFO group.	No further action is required at a local level.	Julie Slavin	Ongoing/Nationally

Effective strategic planning for improvement							
Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**

	3. (i) Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB. This will include Health Boards and Local Authorities providing staff and resources to provide such support. The dual role of the Chief Officer makes it both challenging and complex, with competing demands between statutory delivery partners and the business of the IJB. Chief Officers must be recognised as pivotal in providing the leadership needed to make a success of integration and should be recruited, valued and accorded due status by statutory partners in order that they are able to properly fulfil this "mission critical" role. Consideration must be made of the capacity and capability of Chief Officers and their senior teams to support the partnership's range of responsibilities.	We will review the scheme of integration with a view to ensuring the HSCP Chief Officer and HSCP Senior Management Team can act within their appropriate areas of authority.		This work is well advanced with an initial report due to be considered by West Dunbartonshire Council and NHS GGC Board in October 2023.	Further work required to complete task. This included seeking permission to consult, a period of consultation, approval by NHS Board and WDC and final approval by Ministers. A further work stream is required in relation to the Scheme of Officer Delegation	MJ Cardno	31-Mar-24
	Timescale: 12 months	We will review our approach to planning to ensure we are able to identify early the likely support requirements associated with planned changes and the service delivery agenda.		Quality Improvement and Service Redesign Strategies to be considered by IJB on the 19 September 2023.	Work will be required to effectively implement these strategies.	MJ Cardno	31-Mar-24

		We will refresh the operational approaches across the partnership area relating to transformational change support so we can collectively streamline and align arrangements, operationally and in relation to Strategic Planning and performance.		Quality Improvement and Service Redesign Strategies to be considered by IJB on the 19 September 2023.	Work will be required to effectively implement these strategies.	MJ Cardno	31-Mar-24
		We will be focusing on delivery of key policies and procedures within operational services areas including Self Directed Support and carers; this aligns to our refreshed approach to commissioning and procurement.		The development of a Policy Register is well advanced.	Further work is required to develop a rolling programme of policy review and development. This will be supported by appropriate reporting to the IJB.	MJ Cardno	Ongoing
Improved strategic planning and commissioning arrangements must be put in place							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**

	3. (iv) Improved strategic planning and commissioning arrangements must be put in place. Partnerships should critically analyse and evaluate the effectiveness of their strategic planning and commissioning arrangements, including establishing capacity and capability for this. Local Authorities and Health Boards will ensure support is provided for strategic planning and commissioning, including staffing and resourcing for the partnership, recognising this as a key responsibility of Integration Authorities.	We will be developing dedicated procurement and commissioning support which needs to be developed further to support the HSCP going forward.		Contracts, Commissioning & Quality Assurance Manager appointed 12 December 2022. In June 2021 IJB approved additional hours for a full time Contract & Commissioning Officer, recruitment to this post is now at an advanced stage.	No further action required.	MJ Cardno	12-Dec-22
	Timescale: 12 months	We will continue to embed understanding, awareness and understanding to the HSCP Extended Management Team.		Presentations on Strategic Plan provided to Extended Management Team. A mid-term planning session is scheduled for October 2023.	No further action required.	Gillian Gall	31-Oct-23
Improved capacity for strategic commissioning of delegated hospital services must be in place							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**

	3. (v) Improved capacity for strategic commissioning of delegated hospital services must be in place. As implementation of proposal 2 (iii) takes place, a necessary step in achieving full delegation of the delegated hospital budget and set aside arrangements will be the development of strategic commissioning for this purpose. This will focus on planning delegated hospital capacity requirements and will require close working with the acute sector and other partnership areas using the same hospitals. This should evolve from existing capacity and plans for those services.	We will continue to work with NHSGGC on the process and treatment of set aside budgets with a view to establishing a clear position for 2020 – 2021 budget setting.		The board, finance colleagues and the 6 HSCP CFOs have agreed a mechanism for costing the activity aligned to set aside budgets. These are reflected within our annual accounts. The process of the management of set aside budgets is complete.	No further action required.	Julie Slavin	Complete
	Timescale: 12 months	We will continue to host HSCP Board sessions devoted to continuing to support understanding of set aside budgets prior to beginning of financial year 2020 – 2021.		Formal reporting to IJB is enhanced with informal finance sessions with the Board.	No further action required.	Julie Slavin	Complete
		We will review the Terms of Reference for our HSCP Audit Committee to incorporate a more explicit role in relation to performance.		http://www.wdhscp.org.uk/media/2607/hscp-audit-and-performance-14-02-23.pdf	No further action required. ToR agreed by Audit and Performance Committee 14 February 2023.	Julie Slavin	14-Feb-23

Effective strategic planning for improvement							
The understanding of accountabilities and responsibilities between statutory partners must improve							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	4. (i) The understanding of accountabilities and responsibilities between statutory partners must improve. The responsibility for decisions about the planning and strategic commissioning of all health and social care functions that have been delegated to the IJB sits wholly with the IJB as a statutory public body. Such decisions do not require ratification by the Health Board or the Local Authority, both of which are represented on the IJB. Statutory partners should ensure duplication is avoided and arrangements previously in place for making decisions are reviewed to ensure there is clarity about the decision making responsibilities of the IJB and that decisions are made where responsibility resides. Existing committees and groups should be refocused to share information and support the IJB.	We will further work on our clinical and care governance supported by a new Clinical Director and Chief Nurse Advisor which will help us progress to being exemplary		Significant process has been made for example: a clinical and care governance action plan has been developed and implemented with annual reporting to IJB. Improved collaboration between CSWO, Chief Nurse Advisor, and commissioning teams means that we're more confident in our scrutiny and assurance of the quality of services delivered both by the HSCP and commissioned	All improvement actions are now business and usual and will be delivered and monitored via the clinical and care governance action plan.	Val Tierney	15-Aug-23

				services. Annual report and action plan presented to IJB 15 August 2023.			
	Timescale: 6 months	We will review this to check for clarity of responsibility and accountability as part of the review of the Integration Scheme		This work is well advanced with an initial report due to be considered by West Dunbartonshire Council and NHS GGC Board in October 2023.	Further work required to complete task. This included seeking permission to consult, a period of consultation, approval by NHS Board and WDC and final approval by Ministers. A further work	MJ Cardno	31-Mar-24

					stream is required in relation to the Scheme of Officer Delegation		
Accountability processes across statutory partners will be streamlined							
	4. (ii) Accountability processes across statutory partners will be streamlined. Current arrangements for each statutory partner should be scoped and opportunities identified for better alignment, with a focus on better supporting integration and transparent public reporting. This will also ensure that different rules are not being applied to different parts of the system particularly in circumstances of shared accountability.	We are committed to creating an environment where data and information is reviewed and interpreted by all partners in a similar way		The HSCP developed a Strategic Needs Assessment which served as the basis for the 2023 - 2026 Strategic Plan Improving Lives Together. Six workshops with multiple partners were delivered in order to ensure that the data was understood in a consistent way. The HSCP have established a Programme Management Office as part of	Work ongoing to standardise reports so services receive data in a consistent way. Work ongoing with adult protection data set, data scrutiny group has been established to consider improvement actions.	MJ Cardno	31-Mar-23

				the governance framework for all major change projects, this provides further assurance that decisions are data informed. A Multi agency data set has been developed and is used by PPCOG.			

	Timescale: 12 months	We are committed to ensuring we link data to intelligence to inform evidence based approaches to change and redesign services		In line with best practice the HSCP published a strategic needs assessment which was a foundational piece of work in respect of the development and implementation of the 2023 - 2026 Strategic Plan "Improving Lives Together". Major change projects are managed through a Programme Management Office and all projects are data informed as evidenced via the Project Initiation Documents (PIDs) and subsequent business plans. The IJB will consider the Quality Improvement and Service Redesign strategies on 19 September 2023.	No further action required.	MJ Cardno	19-Sep-23

IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	4. (iii) IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis. There are well-functioning IJBs that have adopted an open and inclusive approach to decision making and which have gone beyond statutory requirements in terms of memberships to include representatives of key partners in integration, including the independent and housing sectors. This will assist in improving the effectiveness and inclusivity of decision making and establish IJBs as discrete and distinctive statutory bodies acting decisively to improve outcomes for their populations.	We are developing our HSCP Board programme to reflect member led issues and areas of shared development.		15 August 2023 - IJB Paper "Future Meeting Dates". HSCP Board approval for 4 informal sessions per annum.	No further action required.	MJ Cardno	15-Aug-23
	Timescale: 12 months	We are reviewing the structure of planning and transformational change across the HSCP including the HSCP Partnership Board.		In line with best practice the HSCP published a SNA which was the foundation to the approved Strategic Plan Improving Lives Together.		MJ Cardno	

				The Strategic Delivery Plan informs the IJB of progress in delivering the plan and major change projects are monitored by the Programme Management Office.			
Clear directions must be provided by IJB to Health Boards and Local Authorities							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	4. (iv) Clear directions must be provided by IJBs to Health Boards and Local Authorities. Revised statutory guidance will be developed on the use of directions in relation to strategic commissioning, emphasising that directions are issued at the end of a process of decision making that has involved partners. Directions must be recognised as a key means of clarifying responsibilities and accountabilities between statutory partners, and for ensuring delivery in line with decisions.	We will work with Scottish Government to ensure the level of detail in "Directions" is clearer and not only referred to in the financial performance reports.		http://www.wdhscp.org.uk/media/2361/hscp-board-agenda-230920.pdf	Directions Policy Approved and Implemented 23 September 2020. The implementation of this policy and the monitoring of directions is reported to the IJB on a six monthly basis.	MJ Cardno	23-Sep-20

	Timescale: 6 months	We will be hosting a dedicated session with national integration colleagues to support local understanding for HSCP Board members and partners.		Powerpoint presentation - Member Induction. Email to Michael Ross, Integration Governance & Evidence, Directorate for Social Care and NCS Development 27 March 2023.	A dedicated session with national colleagues did not take place due to the onset of the Covid 19 pandemic. However, formal evidence submitted by email to Scottish Govt 27/3/23. HSCP Board members are advised on directions as part of their induction process.	MJ Cardno	27-Mar-23
		We will consider the recently issued draft Scottish Government Guidance on Directions and this will inform our revision of our Directions processes locally.		http://www.wdhscp.org.uk/media/2361/hscp-board-agenda-230920.pdf	Directions Policy Approved and Implemented 23 September 2020. The implementation of this policy and the monitoring of directions is reported to the IJB on a six monthly basis.	MJ Cardno	23-Sep-20

		We aim to have a clear process for the development of and issuing of directions which sees directions as the final stage in a collaborative process.		http://www.wdhscp.org.uk/media/2361/hscp-board-agenda-230920.pdf	Directions Policy Approved and Implemented 23 September 2020. The implementation of this policy and the monitoring of directions is reported to the IJB on a six monthly basis.	MJ Cardno	23-Sep-20
		We will link the directions issuing processes with the outcomes of the governance/accountability scoping work in order to improve overall Partnership understanding of purpose, process and respective obligations.		http://www.wdhscp.org.uk/media/2361/hscp-board-agenda-230920.pdf	Directions Policy Approved and Implemented 23 September 2020. The implementation of this policy and the monitoring of directions is reported to the IJB on a six monthly basis.	MJ Cardno	23-Sep-20
Effective, coherent and joined up clinical and care governance arrangements must be in place							

	4. (v) Effective, coherent and joined up clinical and care governance arrangements must be in place. Revised statutory guidance will be developed based on wide ranging consultations with local partnerships, identifying good practice and involving all sectors. The key role of clinical and professional leadership in supporting the IJB to make decisions that are safe and in accordance with required standards and law must be understood, co-ordinated and utilised fully.	We are further developing our quality assurance processes and structures will further develop our quality improvement framework and transformational change approach.		Quality Improvement and Quality Assurance Frameworks will all be considered by the IJB on 19 September 2023.	Further work will be required to implement these strategies.	MJ Cardno	31-Mar-24
	Timescale: 6 months	We will further work on our clinical and care governance supported by a new Clinical Director and Chief Nurse Advisor which will help us progress following a period of change.		Significant process has been made for example: a clinical and care governance action plan has been developed and implemented with annual reporting to IJB. Improved collaboration between CSWO, Chief Nurse Advisor, and commissioning teams means that we're more confident in our scrutiny and	All improvement actions are now business and usual and will be delivered and monitored via the clinical and care governance action plan.	Val Tierney	15-Aug-23

				assurance of the quality of services delivered both by the HSCP and commissioned services. Annual report and action plan presented to IJB 15 August 2023.			

Ability and willingness to share information							
IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**

	5. (i) IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data. Chief Officers will work together to consider, individually and as a group, whether their IJBs' annual reports can be further developed to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure that, as a minimum, all statutorily required information is reported upon.	The national Chief Officers Group have agreed to work collectively to agree a common framework and benchmarking processes.				B Culshaw	
	Timescale: By publication of next round of annual reports in July 2019	We will continue to work to the challenging timescales of July 2019 round of reports, and will be seeking to work with Scottish Government to address these pressures.		Discussions with Scottish Government via Healthcare Improvement Scotland have reached their conclusion. No improvements which	No further action can be taken at this stage.	MJ Cardno	Incomplete and unlikely to progress in the short term.

				require legislative change will be progressed out with the work related to the National Care Service.			
Identifying and implementing good practice will be systematically undertaken by all partnerships							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**
	5. (ii) Identifying and implementing good practice will be systematically undertaken by all partnerships. Chief Officers will develop IJBs' annual reports to enable partnerships to identify, share and use examples of good practice, and lessons learned from things that have not worked. Inspection findings and reports from strategic inspections and service inspections should also	We will be extending the sharing of the outcomes of inspection processes to support staff and managers to learn and be involved in changes to process that may be required to enhance and improve services.		Report on all inspection activity under development and will be reported to the HSCP Audit and Performance committee on 19 September 2023.	No further action required.	MJ Cardno	19-Sep-23

	provide a clear means of identifying and sharing good practice, based on implementation of the framework outlined below at 5 (iii) and the national health and social care standards.						
	Timescale: 6 - 12 months	We are committed to working with the national Chief Officers Group to work collectively to agree a common framework and benchmarking processes.				B Culshaw	
		We are committed to working with the national Chief Financial Officers Section in partnership with Scottish Government finance representatives on future funding directions for HSCP Board.		CFO section meet at least 10 times per year. The group is supported by CIPFA and has worked collaboratively to develop best practice.	No further action required.	Julie Slavin	Complete

				Scottish Govt and Cosla are also members of the group.				
		We are committed to working with the national Chief Officers Group and Scottish Government to identify mechanisms to share good practice and benchmarking information routinely and systematically.				B Culshaw		

Meaningful and sustained engagement							
Effective approaches for community engagement and participation must be put in place for integration							
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Improvement Action**	**Responsible Officer**	**Completion Date**

	6. (i) Effective approaches for community engagement and participation must be put in place for integration. This is critically important to our shared responsibility for ensuring services are fit for purpose, fit for the future, and support better outcomes for people using services, carers and local communities. Revised statutory guidance will be developed by the Scottish Government and COSLA on local community engagement and participation based on existing good practice, to apply across health and social care bodies. Meaningful engagement is central to achieving the scale of change and reform required, and is an ongoing process that is	We will continue to work to identify opportunities for integrated participation and engagement across whole system, with all partners.		The Strategic Planning process exemplifies our approach to this action. An SNA was developed and multiple stakeholder meeting held to validate the data and set it in a local context. The Strategic Plan and associated delivery plan was developed, consulted upon and feedback provided using the "you said we did" model.	Ongoing. Established as business as usual.	MJ Cardno	31-Mar-23

	not undertaken only when service change is proposed.						
	Timescale: 6 months	We will continue to review and revisit our approach to participation and engagement with partners and our citizens and measure against national good practice and standards for community engagement.		The Strategic Plan and associated delivery plan were approved in March 2023. This includes an action to review and update the participation and engagement strategy.	This work will commence on the appointment of a Participation Officer. Progress will be monitored via the strategic delivery plan.	MJ Cardno	31-Mar-24

Improved understanding of effective working relationships with carers, people using services and local communities is required							
	6. (ii) Improved understanding of effective working relationships with carers, people using services and local communities is required. Each partnership should critically evaluate the effectiveness of their working arrangements and relationships with people using services, carers and local communities. A focus on continuously improving and learning from best practice will be adopted in order to maximise meaningful and sustained engagement.	We will be seeking to host an annual carers event involving staff from across West Dunbartonshire to help support staff and partners to further embed the new legislation and support delivery of the assessment tools, respite, SDS and access.		SDS Engagement events have been undertaken across the HSCP with providers, carers and third sector organisations, tech providers, and staff. Carers of West Dunbartonshire hold an annual carers event. The IJB have also approved and successfully implemented a new short break pilot.	Business as usual via CDG.	MJ Cardno	31-Jul-23

	Timescale: 12 months	We will continue to work with partners to ensure all carers understand their rights and have access to advice, support and information to help them maintain their caring role.		Evidence can be found via the implementation of the Carers Development Group action plan. The HSCPs commitment to this work is also exemplified through the appointment of an unpaid carer's lead, who also have a clear work plan. This work has seen the development and implementation of eligibility criteria, a new carer's assessment and a clear pathway for accessing services for carers.	Business as usual	MJ Cardno	31-Mar-23
We will support carers and representatives of people using services better to enable their full involvement in integration							

	MSG Recommendation	Agreed Actions September 2019	Position August 2023	Evidence August 2023	Improvement Action	Responsible Officer	Completion Date
	6. (iii) We will support carers and representatives of people using services better to enable their full involvement in integration. Carers and representatives of people using health and social care services will be supported by partnerships to enable meaningful engagement with their constituencies. This will support their input to Integration Joint Boards, strategic planning groups and locality arrangements for integration. This would include, for example, receipt of IJB papers with enough time to engage other carers and people using services in responding to issues raised. It would also include paying reasonable	As above an ongoing commitment to carers and their representatives to ensure carers are supported and involved in all areas of engagement and participation.		As above.	Business as usual via CDG.	MJ Cardno	31-Mar-23

	expenses for attending meetings.						
	Timescale: 6 -12 months						

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Report by Fiona Taylor, Head of Health and Community Care

Audit and Performance Committee - 19 September 2023

Subject: Care Inspection of West Dunbartonshire Health and Social Care Partnership (HSCP) Sheltered Housing: Summary of the Inspection Report

1. Purpose

1.1 The purpose of this report is to summarise the Care Inspectorate report following an unannounced inspection of West Dunbartonshire HSCP Sheltered Housing Service between the 17th and 21st April 2023.

2 Recommendations

2.1 The Committee is asked to note that the Care Inspectorate graded West Dunbartonshire Sheltered Housing with an overall grade three – adequate.

2.2 The Committee is asked to note that an action plan is in place to monitor completion of the actions required to address the Requirements and Areas for Improvement identified by the Care Inspectorate.

3 Background

3.1 On the 17th April 2023 the Care Inspectorate commenced an unannounced inspection of West Dunbartonshire Sheltered Housing Service. They spoke with 21 people using the service and 11 of their family representatives. They also spoke with 12 staff, conducted direct observation of practice and reviewed relevant documentation. 3 multi disciplinary team (MDT) professionals were also interviewed as part of the inspection.

3.2 The visit was concluded on the 21st April 2023 and on the 25th April 2023 the inspectors met with key members of the Care at Home and Sheltered Housing Management Team to provide feedback ahead of the formal report.

3.3 The last Sheltered Housing Inspection was an unannounced inspection on 11th Dec 2019 and the report was published on the 4th Feb 2020. At this time the Care Inspectorate used a different quality framework and the headings for the areas inspected have subsequently changed, however the grading system remains the same.

The grades for the 2019 Inspection were as follows:

Quality of care and support	5 – Very good
Quality of staffing	Not assessed
Quality of management and leadership	5 – Very good

There were no requirements and one recommendation.

3.3 The recommendation was that all staff should receive Dementia training at 'Skilled' level.

4 Main Issues

4.1 The Inspection in April 2023 resulted in the following grades:

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate
How well is our care and support planned?	4 - Good

4.2 There were six key messages identified in the report.

- Warm and compassionate interactions were observed between people and staff who knew them well.
- Supported people and their relatives were very happy with the support provided. People felt safe and secure.
- Health and wellbeing were being well supported by the service.
- Some gaps in staff training and supervision were noted, though new management had plans in place with a focus on improvement.
- The service were not submitting the required notifications to the Care Inspectorate. This meant scrutiny monitoring was not always well-informed.
- People had care plans in place which were reviewed at regular intervals.

4.3 The Care Inspectorate identified 3 requirements. A requirement is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Act, its regulations, or orders made under the Act, or a condition of registration.

4.4 The three requirements were as follows:

4.4.1 By 31st August 2023 the service must comply with the Care Inspectorate guidance 'Records that all Registered Care Services must keep and guidance on notification reporting'. The provider must notify the Care Inspectorate of all relevant incidents under the correct notification heading and within the required time frame.

4.4.2 By 31st August 2023 the service must reintroduce supervision for staff to support their learning and development

4.4.3 By 31st August 2023 the service must have completed, or have scheduled, training for Sheltered Housing Supervisors. This should include, but not limited to, completion of induction, IPC and dementia training to skilled level. This requirement incorporated the previous AfI noted at section 3.3.

4.4 The Care Inspectorate identified 2 areas for improvement (AfI). An area for improvement is a statement that sets out an area or areas of care indicating where a care service provider should make changes, because outcomes or potential outcomes for people experiencing care need to be better than they currently are.

4.5 The two AfI's are as follows:

4.5.1 The service should undertake regular spot checks on staff competencies in key areas. This should include, but not limited to, IPC standards.

4.5.2. Dementia training at skilled level should be completed by all staff.

4.6 There have been no upheld complaints since the last Inspection.

5 Next steps

5.1 The Head of Health and Community Care and the Interim Integrated Operations Manager (IOM) for Care at Home have developed an action plan to demonstrate progression towards meeting the requirements and AfI. Regular meetings with the IOM, Sheltered Housing Service Manager and Coordinator are in place in order to ensure the appropriate level of operational scrutiny and accountability to ensure effective implementation of the action plan.

5.2 A report will be brought to the Audit and Performance Committee meeting on the 14 November 2023 to provide the Committee with assurance that all actions within the plan have been implemented.

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 Requirement 3 requires the implementation of a significant suite of training for frontline staff. The method of delivering the required staff training has been considered to ensure that it can be rostered within each staff member's contracted hours. There may however be specific circumstances where staff will need to be paid enhanced hours to enable them to achieve this. This will be minimised as there are already significant financial efficiencies required of the service for 23/24.

8. Risk Analysis

8.1 Grades awarded to a service after a Care Inspectorate inspection are an important performance indicator for registered services. Any failure to meet requirements within time-scales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to The Sheltered Housing service would be of concern to the Audit and Performance Committee and be an Organisational Risk.

9. Equalities Impact Assessment (EIA)

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

10. Environmental Sustainability

10.1 Not required for this request.

11. Consultation

11.1 None required for this report.

12. Strategic Assessment

12.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan 2023 – 2026 recognises the need to ensure that services align with strategic outcomes and priorities, and work with people to safely maintain

their independence at home and in their local community, building on strengths and supporting unmet need.

13. Directions

13.1 There are no directions required for this report.

Name: Fiona Taylor
Designation: Head of Community Health and Care
Date: 3 September 2023

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fiona.taylor2@ggc.scot.nhs.uk

Appendices: **Appendix 1 –** Sheltered Housing Improvement Action Plan
Appendix 2- Care Inspection Report

West Dunbartonshire Council Sheltered Housing
Housing Support Service

Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Telephone: 01419 516 188

Type of inspection:
Unannounced

Completed on:
25 April 2023

Service provided by:
West Dunbartonshire Council

Service provider number:
SP2003003383

Service no:
CS2004077072

About the service

At the time of inspection, West Dunbartonshire Council Sheltered Housing supported 219 people living in 9 complexes within the local authority area. The service utilises sheltered housing supervisors to provide support on a 24 hour basis, 7 days a week. There is a designated sheltered housing supervisor at each complex on day and back shifts. Night shift is covered by a team responding to people across the complexes as required. The service aims to provide appropriate support for promotion of independence within a safe, secure environment. There were opportunities to access common rooms for social activities and events.

About the inspection

This was an unannounced inspection which took place on 17, 19, 20, and 21 April 2023. The inspection was carried out by 2 inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, any complaints, information submitted by the service and intelligence gathered since the last inspection. In making our evaluations of the service we:

- spoke with 21 people using the service and 11 of their family representatives
- spoke with 12 staff and management
- observed practice and daily life
- reviewed documents
- spoke with 3 external professionals

Key messages

- Warm and compassionate interactions were observed between people and staff who knew them well.
- Supported people and their relatives were very happy with the support provided. People felt safe and secure.
- Health and wellbeing were being well supported by the service.
- Some gaps in staff training and supervision were noted, though new management had plans in place with a focus on improvement.
- The service were not submitting the required notifications to the Care Inspectorate. This meant our scrutiny monitoring was not always well-informed.
- People had care plans in place which were reviewed at regular intervals.

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?	4 - Good
How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate
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? 4 - Good

We evaluated this key question as good, where several strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

People were very happy with the support provided by the service. Relatives also gave us positive feedback. Staff knew people well and were able to provide appropriate support in people's homes, via the intercom system or in the communal areas. Warm, compassionate interactions were observed and people told us about the supports they received. Through our observations and speaking to people, we could see that people were treated with dignity and respect. Safety equipment was in use and was routinely checked. We could see that feedback from people had influenced the service delivery.

Supported people told us:

'I'm happy with the sense of community here'

'I'd advocate for anyone to come and live here'

'I wouldn't be anywhere else'

People were being supported with their health and wellbeing. This included using the common room to socialise and keep active. One complex had a well-established gardening club and the sense of community was evident. Another complex did have some environmental issues and a tenant forum was in place to raise concerns with the landlord. At time of inspection one common room was out of use, but refurbishment plans were in place. Some activity sessions were less well attended than before the pandemic. People received handbooks with the aims of the service and felt that their expectations were met. People felt safe and secure and were satisfied regarding emergency responses when they were needed. Support plans were in place and health needs were recorded and acted upon.

The service did regularly review care plans and health needs, but could consider anticipatory care planning for future needs. The service were considering which assessed level of need they could safely support and were working with those commissioning the service. The service had links with external health professionals and care plans reflected people's current support needs. This meant that care and support could be effectively delivered.

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses.

We observed that team meetings had been taking place, but that many lacked meaningful action plans. This meant we were not easily able to track any progress that the service had made. The service had commenced an improvement plan, but this also missed key stages. This meant that we could not be sure that required actions were followed through, and that the planned timescales weren't detailed. An adult protection overview was in place and a complaints log had been recently implemented, but some other management overviews had not been considered. The service had completed staff surveys and had collated the results, however, there had been no recent attempt to extend this to people using the service. The management team gave assurances that these suggestions would be added to their processes.

There had been recent changes in management, and staff had reported that this had led to improvements in how the service was running. Staff also told us that managers were accessible and responsive. The coordinator of the service was well respected by staff and was enthusiastic to continue improving the service.

The service has not been making all of the required notifications to the Care Inspectorate. This meant our scrutiny monitoring was not always well-informed. This had been mentioned at the previous inspection, but has remained an ongoing issue. The service had started the progress of resolving access to our notification system.

Requirements

1.
By 31 August the service must comply with the Care Inspectorate guidance 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'. The provider must notify the Care Inspectorate of all relevant incidents under the correct notification heading and within the required timeframe.

This is 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)

This is to comply with Regulation 4(1)(a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210)

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses.

Staff were knowledgeable about the people using the service, and felt well supported in their roles by management, but had not been receiving regular supervision sessions. This meant that their own learning and development needs may have not been given the required attention.

Not all staff had completed their induction training, and there were some gaps with regards to training in IPC (Infection Prevention and Control) and Adult Support and Protection. An Area For Improvement from 2017, and repeated twice 2018 and again 2019, with regards to dementia training to skilled level, had not been met. The service had not completed regular spot checks on staff competencies and practice. This meant that the service could not evidence that staff had the right knowledge, competence and development.

The service improvement plan had recognised that sheltered housing supervisor job profiles were a high priority for review. We suggested that supervision sessions could be the way to engage staff in this process. Staff did report that management were responsive to issues and were always contactable by phone or email.

Requirements

1. By 31 August the service must reintroduce supervision for staff to support their learning and development.

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 is to comply with Regulation 15 (a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210)

2. By 31 August the service must have completed, or have scheduled, training for sheltered housing supervisors. This should include, but not limited to, completion of induction, IPC and dementia training to skilled level (incorporating previous AFI from 2017, 2018 and repeated 2019).

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 is to comply with Regulation 15 (b) (i) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210)

Areas for improvement

1. The service should undertake regular spot checks on staff competencies in key areas. This should include, but not limited to, IPC standards.

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).

How well is our care and support planned? 4 - Good

We evaluated this key question as good, where several strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

We could see that there was assessment and planning in place for outcomes and wishes of people using the service. Care plans were in place and reviews were happening on a regular basis. People and their relatives felt involved in the review process. We could see that there was input from relevant health professionals.

We saw evidence of a forum for tenants and social activity planners were in place. The service agreed to seek feedback from people on how they used the communal areas, and ask for their suggestions on activities when reviewing care plans. This could help support people's mental health and wellbeing and minimise social isolation.

The shift pattern at time of inspection worked well for people, and there had been lessening of sheltered housing supervisors being called away for community supports. People told us they felt reassured by the safety alerts in place and the responsiveness of the sheltered housing supervisors.

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

Dementia training at skilled level should be completed by all 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 20 December 2019.

Action taken since then

Of 45 listed sheltered housing supervisors, only 3 have completed dementia training at skilled level and 8 have received no dementia training.

This was initially recommended in 2017 inspection, repeated twice in 2018 and again in 2019 inspection.

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?	4 - Good
1.1 People experience compassion, dignity and respect	5 - Very Good
1.2 People get the most out of life	4 - Good
1.3 People's health and wellbeing benefits from their care and support	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
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate

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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Na życzenie niniejsza publikacja dostępna jest także w innych formatach oraz językach.

Next steps: developing your improvement plan

The manager retains overall responsibility for completing and reviewing the improvement plan. This should be in a format you can share. Aim to review this plan regularly and make the information accessible so you can share it with the people who use your service, their families, staff, and others involved with your service. It is essential that they can be part of the review process.

Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?
Personalised care plans	Review of care plan documentation	31st May 2023	Annemarie Lennox/Lee Bell/Michelle McDonald/Linda Ryan	Meeting with lee Identifying working group. Group identified and 1st subgroup meeting planned for Friday 25th August 11-12.30pm
Personalised review process	Review of review documentation	31st May 2023	Annemarie Lennox/Lee Bell/Linda Ryan/Michelle McDonald	Meeting with Lee identifying working group. Group identified and 1st subgroup meeting planned for Friday 11-12.30pm.

Reportable notifications to be completed within Care Inspectorate guidelines	Change of registered manager on Care Inspectorate notifications Additional users added to eforms to enable time sensitive notifications to be reported appropriately	Immediate	Annemarie Lennox/Jane Gray	Completed
Easily accessible information recording tool developed for all accidents/ Incidents, Complaints and ASP	Excel spreadsheet developed and all accident/incidents recorded going forward	In place by 31st May 2023	Annemarie Lennox/Linda Ryan	Complete and in used. Next actions Monitored process to be developed Lee Bell/Annemarie Lennox.14th Aug – **Complete**.
Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?
Care Inspectorate reporting stage to be incorporated into concerns pathway	Adding care inspectorate reporting stage to concerns pathway	Immediately	Laura Evans/Annemarie Lennox/ Lee Bell/ Annemarie Lennox	Complete Emailed out to all complexes
Staff training Update Moving and assisting training	Contact Tell training provider for regular training sessions for all staff	Ongoing/ Review progress monthly	Annemarie Lennox	Scheduled training now in place weekly for staff as of 31st May 23,100% of staff have now attended

				refresh moving and assisting - Complete
Staff Training Infection Control and staff competencies	Contact District nurse team for training	Ongoing/ review monthly	District Nurse Team	Training and obs being delivered to staff. Currently underway 75% attended as of 17th July 23
Staff training Adult Support and Protection	Support staff to access i-learn within WDC intranet	Ongoing/ review monthly	Linda Ryan	Step by step log in instruction to be emailed to all staff (Completed) I-Learn training to be completed sessions monthly (Various topics) This is now underway and awaiting staff progress reports from OD and Change. Updated info: Now receiving reports of staff completion from OD and Change
Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?

Staff to have knowledge and skills at the appropriate level to support people living with dementia	Staff training for Improving practice in Dementia Skilled Staff to register for Tarus account within NHS e-learning	Ongoing All Staff to be registered by 30th July 2023 Review monthly	Annemarie Lennox/Lee Bell/ Linda Ryan	Registration training sessions now been scheduled for week beginning 15th May. and will continue till all staff have log ins for planned date of June 2023. Update 80% of staff have registered and completed Module 1+
Ensuring all staff are meeting their responsibilities in terms of SSSC registration	Through communication to all staff With admin staff completing status review on SSSC register	Reports to be pulled monthly and status of all staff registrations checked Review monthly	Suzann Alexander (Admin Manager) Linda Ryan	In place by May 2023 and will be ongoing to ensure all staff registrations are compliant. All staff registered appropriately monthly reports being sent for auditing purposes to AML from admin
Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?

Sheltered Housing new staff Induction to enable new staff to have the knowledge and skills for their role	Development of staff induction	Planning meeting scheduled for 19th June 23	Annemarie Lennox/Lee Bell	Scheduled initial planning meeting for development plan for 19th June 23 UPDATE Developed and being implemented in next Induction of new staff planned for Aug 23
Staff to receive regular supervision, which will provide support and guidance and identify development needs and enables staff to reflect on practice	Lee Bell/Annemarie Lennox to attend group supervision and supervision training July 23	Initial supervision agreement meetings to be held with staff throughout the months of Aug/Sept/Oct	Annemarie Lennox/Lee Bell	Annemarie Lennox has attended training session. Lee Bell is scheduled to attend training July. UPDATE Supervision now scheduled for initial one to one supervision agreement meeting, will be carried out Aug Sept Oct

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Report by Fiona Taylor, Head of Health and Community Care

Audit and Performance Committee - 19 September 2023

Subject: Care Inspection of West Dunbartonshire Health and Social Care Partnership (HSCP) Care at Home Service: Summary of the Inspection Report

1. Purpose

1.1 The purpose of this report is to summarise the Care Inspectorate report following an unannounced inspection of West Dunbartonshire HSCP Care at Home Services between the 15th and 24th March 2023.

1.2 This paper will also provide assurance to the Committee that there is an action plan in place to address the three requirements and eight areas for Improvement (AFI) which must be complete by 30th September 2023.

2 Recommendations

2.1 The Committee is asked to note that the Care Inspectorate graded the West Dunbartonshire Care at Home Service an overall grade 3 – adequate.

2.2 The Committee is also asked to note that an action plan is underway to demonstrate the activities in place to address the requirements and the Afl's identified by the Care Inspectorate.

3 Background

3.1 On the 15th March 2023 the Care Inspectorate commenced an unannounced inspection of West Dunbartonshire Care at Home Service. They spoke with 92 service users and 18 relatives to seek their views of the service. They also spoke with 13 staff and management, observed practice and reviewed documentation. Finally, they spoke with 5 visiting professionals.

3.2 They concluded their visit on the 24th March 2023 and on the 27th May 2023 met with key members of the Care at Home service and Senior Management Team to provide feedback ahead of the formal report.

3.3 The last Care at Home Inspection was an announced inspection in Autumn 2019 and the report was published on the 29th September 2019. At this time the Care Inspectorate used a different quality framework and the headings for the areas inspected have subsequently changed, however the grading

system remains the same.

The grades were as follows:

Quality of care and support	Grade 4 - Good
Quality of staffing	Grade 4 - Good
Quality of management and leadership	Grade 4 - Good

There were no requirements and 5 recommendations (now termed areas for improvement).

3.3 The 5 recommendations in September 2019 were as follows:

3.3.1. The service must ensure that people are provided with care plans that provide full information on their assessed needs and the supports that will be provided.

2. The service should ensure that it reviews the care provided to people no less than every six months. People supported should be actively involved in reviewing their care and support.

3. The service needs to ensure that gaps in core training are promptly addressed.

4. The service should implement a system for properly evaluating and recording the quality of staff practice at all staff levels.

5. The service must ensure that staff are provided with supervision on a regular basis, in keeping with the service's supervision policy.

4 Main Issues

4.1 The March 2023 Inspection awarded the following grades:

How well do we support people's wellbeing	Grade 3 - Adequate
How good is our leadership	Grade 3 - Adequate
How good is our staff team	Grade 3 - Adequate
How well is our care and support planned	Grade 3 - Adequate

4.2 There were seven key messages identified in the report:

- People are happy with the way staff engage with them
- Care plans were out of date
- People were not always aware that a review of their care had been performed
- Staff training needs to be more robust
- Supervision is inconsistent
- The redesign is in process to deliver service improvement
- The service worked well with others to improve outcomes for people

4.3 The Care Inspectorate identified 3 requirements. A requirement is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Act, its regulations, or orders made under the Act, or a condition of registration.

By 30th September 2023, the provider must ensure that people's care plans are reflective of care and support that is right for them and reviewed on a 6 monthly basis as a minimum, in line with current legislation.

By 30th September 2023, the provider must review and improve communication systems when people are returning home following a hospital admission.

By 30th September 2023, the provider must ensure people and staff are kept safe by ensuring the workforce is appropriately trained

4.4 The Care Inspectorate identified 7 areas for improvement (AfI). An area for improvement is a statement that sets out an area or areas of care indicating where a care service provider should make changes, because outcomes or potential outcomes for people experiencing care need to be better than they currently are.

4.5 The following areas for improvement were identified:

- To meet people's needs, the provider should ensure that they communicate effectively with people about their service when changes need to happen. This should include, but not limited to, updating people's preferred modes and timing of communication.

- The provider should ensure that medication risk assessment processes are reviewed to include the time required between medication doses. People's care visits should be scheduled to allow them to take their medication safely and in accordance with prescribing instructions.

- To support people's health and wellbeing, the provider should ensure that staff are competent with promoting good infection prevention and control practices. This should include, but not limited to, observing staff

in training and in practice.

- To ensure complaints are managed effectively and in accordance with their own policy and procedure, the care service should ensure that all who raise complaints or concerns are treated with courtesy. Any information requests, concerns and complaints are recorded accurately and responded to promptly, ensuring that follow up actions are met in line with the policy or in an agreed manner.

- To improve outcomes for people, the provider should ensure that they continually monitor, evaluate and complete all actions that they have identified within their improvement plan.

- To protect people from potential risks of financial harm, the provider should implement a cash handling policy and procedure.

- To support people's health and wellbeing the provider needs to implement and evidence regular staff team meetings across the services.

- To support people's health and wellbeing, the provider should implement a system to ensure that all staff are supervised on a regular basis. This includes, but is not limited to, supervising staff on an individual, group and on-the-job basis.

4.6 The Inspection team also investigated actions the service had taken to meet the recommendations identified at the last inspection. As noted at 3.3, at the last inspection there were 5 recommendations (now termed AFI).

4.7 As none of these AFI's were evidenced to have been met these are now requirements and subsumed within requirement 1 and requirement 3.

4.8 There have been 3 upheld complaints since the last Inspection. When a complaint is upheld the Care Inspectorate determine the seriousness of what they found during the investigation and the impact on people using the service. Subsequently they make recommendations as to how a service might improve and can also make requirements to deliver the necessary improvements.

4.9 There have been 3 upheld complaints between 2019 and 2023 and The Care Inspectorate issued an additional 10 AFI's.

4.10 The Inspectors decided that 1 of these AFI's had been met and have subsumed the remaining 9 within requirement 2 and 3 and also within the AFI's.

4.11 Appendix 2 shows a collation of recommendations from September 2019 to 2023, and the requirements and AFI's from the 2023 Inspection.

5 Next steps

5.1 The Head of Health and Community Care and the Interim Integrated Operations Manager (IOM) for Care at Home developed an action plan to demonstrate progression towards meeting the requirements and AfI. Regular meetings with the Head of Service and the Care at Home management team are in place in order to ensure operational scrutiny and accountability to ensure effective implementation of the action plan.

5.2 There are scheduled meetings with the lead Inspector to assure her of progression and to act as a line of communication if there are any issues which arise that may impede progress towards the conclusion date of 30th September 2023.

5.3 There was recognition by the Inspection team that Care at Home is currently in the process of a redesign and that the 'future state' service will reflect the learning from this report.

5.4 A report will be brought to the Audit and Performance Committee meeting on the 14 November 2023 to provide the Committee with assurance that all actions within the plan have been implemented.

6 Options Appraisal

6.1 Not required for this report.

7. People Implications

7.1 There are no personnel issues associated with this report.

8. Financial and Procurement Implications

8.1 Requirement 1 requires a review of all care packages. This should happen on a 6 monthly basis, and the financial implication is that these reviews may result in an increase or decrease in allocated hours per week. The number of completed care package reviews are reported on a weekly basis to demonstrate the weekly overall increase or decrease in hours of care packages.

8.2 Requirement 3 requires the implementation of a significant suite of training for frontline staff. The method of delivering training has been considered to ensure that it can be rostered within each staff member's contracted hours. There may however be specific circumstances where staff will need to be paid enhanced hours to enable them to achieve this. This will be minimised as

there are already significant financial efficiencies required of the service for 23/24.

9. Risk Analysis

9.1 Grades awarded to a service after a Care Inspectorate inspection are an important performance indicator for registered services. Any failure to meet requirements within time-scales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to The Care at Home Service would be of concern to the Audit and Performance Committee and be an Organisational Risk.

10. Equalities Impact Assessment (EIA)

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

11. Environmental Sustainability

11.1 Not required for this report.

12. Consultation

12.1 None required for this report.

13. Strategic Assessment

13.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan 2023 – 2026 recognises the need to ensure that services align with strategic outcomes and priorities, and work with people to safely maintain their independence at home and in their local community, building on strengths and supporting unmet need.

14. Directions

14.1 There are no directions required for this report.

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Date: 21/08/2023

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Appendices: Appendix 1 – Care Inspectorate Report

Appendix 2 – Summary of requirements

Background Papers: None

Housing Support Service

Clydebank Health & Care Centre
Queens Quay Main Avenue
Clydebank
G81 1BS

Telephone: 01412322317

Type of inspection:
Unannounced

Completed on:
27 March 2023

Service provided by:
West Dunbartonshire Council

Service provider number:
SP2003003383

Service no:
CS2004077075

About the service

West Dunbartonshire Council Home Care Services provide support to clients of all ages and ethnic groups, assisting them to live as independently as possible in their own home whilst respecting their right to dignity, privacy, choice, safety, realising potential, equality and diversity.

The service operates throughout the West Dunbartonshire area from two office bases, in Clydebank and Dumbarton.

At the time of our inspection, the service was supporting around 1450 people.

About the inspection

This was an unannounced inspection which took place on 15th March 2023 - 24th March 2023.

The inspection was carried out by five inspectors from the Care Inspectorate and two inspection volunteers. 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 92 people using the service and 18 relatives
- spoke with 13 staff and management
- observed practice and daily life
- reviewed documents
- spoke with five visiting professionals.

Key messages

- People had been happy with how staff had engaged with them.
- People's care plans were outdated and not reflective of their current health and wellbeing needs.
- People were not always aware that reviews of their care had been held. This meant that the review processes in place were not working to benefit the people supported.
- Staff training needed to improve.
- Supervision for staff and team meetings were inconsistently and infrequently held. This meant staff did not receive the support they should.
- The service had been working through improvements which were related to a redesign of their current home delivery structure. The aim was to improve how support is provided to people.

- The service worked well with other agencies to improve outcomes for people.

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
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

We evaluated this key question as adequate. While the strengths had a positive impact, key areas need to improve.

Most people told us that they had been happy with how staff supported them and they knew their regular staff. People told us, "All very nice", "they cheer you up so they do", "No complaints", "yes, I'm happy". We concluded relationships between people and staff were positive and stable.

Relatives spoke positively about staff teams and told us;"They're smashing people", "Carers are lovely people", "Happy with the service", "Carers are wonderful but far too rushed". Some relatives told us there had been issues with office communication which had impacted on people's care particularly around answering queries and updating people's information. This is an area that the service had identified and had been working on to improve.

People had a copy of their care plans and a care diary which staff had wrote in on each visit. The service also had digital care plans which held the information that guided staff. However, the care plans that people had were outdated and did not reflect current needs or next of kin. People and their guardians need to have the correct information about their support and who to contact, especially if they have concerns. It is important that people are included within the care planning process (see requirement 1).

People also told us they were not informed of changes to their support. This included not always knowing who would be supporting them and when. Some people told us that staff did disclose information about why they were running late which included information about other clients. This means that confidential information had been shared unnecessarily with people which could impact on their health and wellbeing (links to requirement 1 in KQ 3). People should receive and understand information if changes need to happen with their service (see area for improvement 1).

The service had been flexible for some people whose health appointments had conflicted with their visits. Other people told us they felt their visits had been too late or too early. Most people had felt grateful for their service and did not want to complain as they knew staff were under pressure. This means that some people had not received a service that suited them (links to requirement 1)

People's health and care needs were being met by different teams of staff. People who needed assistance with clinical health needs were supported by care staff (known as augmented). All other aspects of care were supported by home carers. Some people would receive multiple visits a day by different teams depending on what their health and care needs were. Some people did make comment about the staffing numbers and how this could be reduced to help with staffing challenges. The service were in the midst of a redesign in efforts to improve how they currently deliver services to meet people's needs.

To ensure people's health and wellbeing needs continued to be met, the service worked closely with other colleagues in health and social care. There was evidence of fortnightly meetings with the adult community services group. This group consisted of district nurses, dietician, physiotherapist, social workers and hospital discharge. Discussions and actions would be agreed where people's health and wellbeing had deteriorated. This assured us that the service had been responsive where changes had occurred with people's health and wellbeing needs.

People we visited had drinks left for them by staff. Feedback from people was that staff always made sure that they had a snack or drink before they left. There was some evidence about what support people required with their food and drink. Although, this was not consistent across all care plans. This was highlighted to the management team as an area of people's care plans that required attention (links to requirement 1).

People had been supported with medication needs. Staff would mainly prompt people to take their medication however, there was minimal evidence where staff assistance with medication had been required. People's care diaries had only noted when medication was taken, left out or declined. There was also no evidence within the risk assessment process surrounding medication, particularly where people required set times between medication doses. This means that people may not always receive the right medication at the right time, with the potential to affect their physical and emotional wellbeing. This was discussed at feedback and the management team assured us that improvements would be made with current medication procedures as they had developed a new policy (due to be implemented in April 23) with input from colleagues in health. We have carried forward an area for improvement from the previous inspection (see area for improvement 2).

Infection prevention and control (IPC) was evident when visiting people. People told us that staff would wash their hands, use gel or wear gloves. Some people had IPC information within their care plan due to their health needs. There was also evidence of IPC training for staff. However, there was no evidence of IPC competency checks of staff practice. To keep people safe, the provider needs to implement IPC competency checks. These steps will help to prevent the spread of infections and contribute to keeping people safe (see area for improvement 3).

Requirements

1. By 30th September 2023, the provider must ensure that people's care plans are reflective of care and support that is right for them.

To do this the provider must, at a minimum, ensure:

a) people have access to current detailed information about their service which details their support needsincluding any highlighted risks and how the provider will meet these

b) information about how to complain is updated

b) information within care plans is person centred including how to promote people's independence wherepossible with personal care

c) person centred strategies that describe how people living with dementia like their support to be provided.This should include information about their likes, dislikes and how staff should introduce care tasks and what they should do if the person declines support

d) oral care is highlighted within care plans where appropriate

e) records and reports are included within care plans about people's wellbeing

f) managers are involved in the monitoring and the audit of people's needs and records

g) update the improvement work that has happened on care plans with lead inspector bi-monthly.

This is to comply with Regulation 4(1) (a) and (d) (welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state 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' (HSCS 1.15).

Areas for improvement

1. To meet people's needs, the provider should ensure that they communicate effectively with people abouttheir service when changes need to happen. This should include but not limited to updating people's preferred modes and timing of communication.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am recognised as an expert in my own experiences, needs and wishes' (HSCS 1.9).

2. The provider should ensure that medication risk assessment processes are reviewed to include the time required between medication doses. People's care visits should be scheduled to allow them to take their medication safely and in accordance with prescribing instructions.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'If I need help with medication, I am able to have as much control as possible' (HSCS 2.23).

3. To support people's health and wellbeing, the provider should ensure that staff are competent with promoting good infection prevention and control practices. This should include but not limited to observing staff in training and in practice.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: '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).

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate. While the strengths had a positive impact, key areas need to improve.

There had been evidence of detailed discussions about people with the hospital discharge team fortnightly. There were care notes on the digital system about people transferring from the hospital. However, there were no hospital discharge letters within people's care plans. People's health and wellbeing could be impacted if important information is not passed on about their needs (see requirement 1).

People had information within their care plans about how to complain. However, this information was outdated and not reflective of current legislation. This means that people did not have the correct information about how to raise a complaint (this links to KQ 1 requirement 1). The service did have an accident, incident and complaints tracker.

There were clear actions attached to all entries although it did not show, particularly with complaints, if they were now closed and that all parties involved had been satisfied with outcomes. This was fedback to the management team who have assured us that this information will be included within their complaints process. We have carried forward an area for improvement which was from an upheld complaint (see area for improvement 1).

Continual improvement enhances the care experience for people. The service had undertaken self-evaluation to see how well they were doing. They also had an improvement plan which linked to the services redesign project which had been in phase 1 and 2. A few of the items quoted within self-evaluation plan were still in the pilot phase and incomplete, such as pen pictures within digital care plans. Many of the themes identified within the improvement plan were not complete and would not be complete until later on this year in alignment with the service redesign project. There was minimal

evidence of quality assurance. To ensure outcomes for people improve, the service should improve scrutiny and quality assurance. This was discussed with the management team who have recognised and had begun to work on improvements (see area for improvement 2).

Some people required support with shopping. People would give staff cash to purchase items which would then be recorded in care diaries. Each person's care diary had a cash handling recording sheet at the back. However, these had not been completed which means there was a potential risk for financial harm. We did not see evidence of staff training regarding cash-handling. This was feedback to the management team who have agreed to review and update their cash handling protocols including training for staff (see area for improvement 3).

There had been changes to the registered managers of the service. During the inspection, they told us there had been 10 staff absent due to contracting Covid-19 which we would expect to be notified of. This was discussed during feedback. The management team explained that they were experiencing difficulties accessing the e-form system and assured us they would resolve.

Requirements

1. By 30th September 2023, the provider must review and improve communication systems when people are returning home following a hospital admission. To do this the provider must:

a) Ensure the hospital discharge letter is opened, read and understood by all staff involved in the person's care

b) Ensure discharge letter is accessible to all involved in the person's care

c) Implement any support changes necessary to the person's care plan

d) Managers monitor and audit this task

e) Update the improvement work that has happened on care plans with lead inspector bi-monthly.

This is to comply with Regulation 4(1) (a) and (d) (welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'If I am supported and cared for by a team or more than one organisation, this is well coordinated so that I experience consistency and continuity' (HSCS 4.17).

Areas for improvement

1. To ensure complaints are managed effectively and in accordance with their own policy and procedure, the care service should ensure that all who raise complaints or concerns are treated with

courtesy, any information requests, concerns and complaints are recorded accurately and responded to promptly, ensuring that follow up actions are met in line with the policy or in an agreed manner.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I know how, and can be helped, to make a complaint or raise a concern about my care and support' (HSCS 4.20).

2. To improve outcomes for people, the provider should ensure that they continually monitor, evaluate and complete all actions that they have identified within their improvement plan.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support because people have the necessary information and resources' (HSCS 4.27).

3. To protect people from potential risks of financial harm, the provider should implement a cash handling policy and procedure. This should include but not limited to training in cash handling procedures and service spot checks.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities' (HSCS 3.20).

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate. While the strengths had a positive impact, key areas need to improve.

Although there had been changes to the management team, there was an established staff team within the service. The majority of staff told us that the management team had been supportive, good at listening and had actioned concerns that they had raised. However, team meetings had not been consistent or often. Team meeting records did not show who attended or an action plan. It was difficult to see if previous actions had been resolved or if the team meeting had achieved its purpose. Limited opportunities for staff to get together as a team to plan and develop could lead to inconsistencies with meeting people's needs (see area for improvement 1).

Staff supervisions had not taken place often. The service had been piloting a new supervision template which had not been fully rolled out. This means that staff had limited opportunities to reflect on their skills, knowledge and development. Staff learning needs left unidentified may result in knowledge gaps that could impact on people's health and wellbeing (see area for improvement 2).

The service development plan had identified the expansion of training framework to enable the development pathway for all staff which was due for completion later in the year. Staff training had happened face to face and on-line. If staff had been unable to attend face to face training, they could access videos on the subject. However, the service was unable to identify which staff had viewed videos.

The service also had an intranet space with resources that staff had access to. Attendance numbers for courses had shown that a number of staff had not received up to date training. Not all staff had completed their core training. There was also little evidence that staff had regular opportunities to reflect on and evaluate their practice and professional development. This was feedback to management who have assured us that training for all staff will recommence. A trained and competent workforce will better support the outcomes of people using the service (see requirement 1).

Staff had completed dementia awareness training. The service had not yet rolled out dementia skilled training. We expect staff working daily with people to be trained to the level as defined within the "promoting excellence 2021" framework. This would give them the additional skills and knowledge to support people who live with dementia. This was discussed at feedback and the provider has assured us that they will roll out this training (links to requirement 1).

The service had a staff intranet page for home carers where they could access resources to support health and wellbeing. The service also used this page to update the staff team on the service redesign project which was still within phase 1 and 2 of completion. There had been no recent updates. There had been a home carer survey completed with 13% home carer participation. This stated that staff felt they had no influence over the service design. There was no action plan attached to this survey and no link to the improvement plan. This was feedback to the management team who have assured us they will revisit this matter.

We acknowledged there were challenges with recruitment and retention of health and social care staffing nationwide. The service had staffing vacancies and had been outsourcing support agency staff on occasion. This meant that at times, people did not know who would be supporting them. This was discussed at feedback and the management team informed us that as part of their service redesign, service delivery will be more efficient to ensure people receive the right support for their needs (links to KQ.1 area for improvement 1).

Requirements

1. By 30th September 2023, the provider must ensure people and staff are kept safe by ensuring the workforce is appropriately trained.

To do this, the provider must, at a minimum, ensure:

a) all staff have completed core mandatory training particularly adult support and protection training

b) all staff have the appropriate levels of training for their role including dementia skilled, skin integrity, record keeping and confidentiality training.

c) all staff have clear and SMART (specific, measurable, achievable, realistic, time specific) learning objectives to evaluate their practice and professional development.

d) all staff are aware of their responsibility in maintaining accurate records and retaining records

e) managers are involved in the monitoring and the audit of staff training.

f) Update the improvement work that has happened on care plans with lead inspector bi-monthly.

This is to comply with Regulation 15(b)(i) (Staffing) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) 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 organisations codes' (HSCS 3.14).

Areas for improvement

1. To support people's health and wellbeing the provider needs to implement and evidence regular staff team meetings across the services.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My care and support is consistent and stable because people work well together' (HSCS 3.19).

2. To support people's health and wellbeing, the provider should implement a system to ensure that all staff are supervised on a regular basis. This includes but is not limited to supervising staff on an individual, group and on-the-job basis.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

How well is our care and support planned? 3 - Adequate

We evaluated this key question as adequate. While the strengths had a positive impact, key areas need to improve.

Most people told us they had not yet had a review. The service did have evidence that reviews had taken place however, there was no information about this within people's care plans. As part of the service redesign, the service had identified and planned the implementation of a systematic review process. They had also piloted a new review template which did not include information about the person's wellbeing or if people had been happy with this record of their review. From this evidence, we were not assured that people had been fully involved in the professional assessment of their health and wellbeing needs. To ensure people are happy and receiving the service they need, the service must review people's care plans on a six-monthly basis (see requirement 1).

The service had piloted revised online care plans within the Clydebank area which included a pen picture, health and care needs assessment, service review and risk assessments. This had not yet been

rolled out to everyone. There was a lack of consistency as some care plans contained more information than others. For instance, some had no information about the type of support the person required or how medical conditions affected the support required. There was also no information about people's wellbeing. This was concerning as this meant people may not be experiencing care and support that is right for them.

This was discussed with the management team who assured us that this would be improved upon in alignment with service redesign (links to KQ 1 requirement 1).

There was evidence that environmental risk assessments the service had carried out, considered areas and aspects of the people's home that may be of risk. However, the risk assessments provided very limited information as to the risks identified. Many risk assessments were not dated and it was unclear when they were written or due for review. There was evidence that faults had been reported and logged however, the information available to people was outdated. People's health and wellbeing could be affected if any health and safety risks have not been mitigated (links to KQ 1, 3 and 5 requirements).

Requirements

1. By 30th September 2023, the provider must ensure that care plans are reviewed on a six-monthly basis as a minimum, in line with current legislation.

To do this, the provider must, at a minimum, ensure:

a) people are supported to understand and be included within their care review

b) they collaborate with people and others involved with their care to gather their views on what is working well with their care and support. This includes but is not limited to reviewing health and safety risk assessments and needs assessments

c) ensure that any agreed actions are completed and reviewed regularly to ensure they remain effective.
Completed actions to be carried forward to the next agreed review date

d) people and their representatives (where appropriate) have read over and are happy with the record of their review

e) managers are involved in the monitoring and the audit of people’s reviews

f) Update the improvement work that has happened on care plans with lead inspector bi-monthly.

This is to comply with Regulation 4(1) (a) and (d) (welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state: "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 areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The service must ensure that people are provided with care plans that provide full information on their assessed needs and the supports that will be provided.

This ensures care and support is consistent with the Health and Social Care Standards which state, 'My personal 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) and
'I am fully involved in developing and reviewing my personal plan, which is always available to me.' (HSCS 2.17).

This area for improvement was made on 26 September 2019.

Action taken since then

People had a copy of their care plans and a care diary which staff would complete on each visit. The service also had digital care plans which held the information that guided staff. The care plans that people had were outdated and did not reflect their current needs or next of kin. People also needed to have the correct information about who to contact especially if they were not happy or need support. It is important that people are included within their care planning process.

This area for improvement has not been met and will now become a requirement within KQ 1.

Previous area for improvement 2

The service should ensure that it reviews the care provided to people no less than every six months. People supported should be actively involved in reviewing their care and support. Copies of reviews should be available to people in their own homes. Where risk assessments are in place, these should be reviewed at least every six months or when changes to people's care and support take place.

This ensures care and support is consistent with the Health and Social Care Standards which state, 'My care and support meets my needs and is right for me.' (HSCS 1.19),
'Any treatment or intervention that I experience is safe and effective.' (HSCS 1.23) and
'I am fully involved in developing and reviewing my personal plan, which is always available to me.' (HSCS 2.17).

This area for improvement was made on 26 September 2019.

Action taken since then

Reviews had not happened regularly and there was no information about reviews within the care plans that people had. There was evidence of reviews, however, people told us they had not had a review. The service is going through a redesign and has identified that they need to improve and implement a systematic review process.

This area for improvement has not been met and will now become a requirement within KQ 5.

Previous area for improvement 3

The service needs to ensure that gaps in core training are promptly addressed. Staff should have clear and SMART, (Specific, Measurable, Achievable, Realistic and Timely), learning objectives that could be used to evaluate their practice and professional development.

This ensures that the quality of staffing 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) and "I experience high quality care and support based on relevant evidence, guidance and best practice." (HSCS 4.11).

This area for improvement was made on 26 September 2019.

Action taken since then

Staff training had happened face to face and on-line. If staff had been unable to attend face to face training, they could access videos on the subject. However, the service was unable to identify which staff had viewed videos. The service also had an intranet space with resources that staff had access to. Attendance numbers for courses had shown that a number of staff had not received up to date training. Not all staff had completed their core training. There was also little evidence that staff had regular opportunities to reflect on and evaluate their practice and professional development.

This area for improvement has not been met and will now become a requirement within KQ 3.

Previous area for improvement 4

The service should implement a system for properly evaluating and recording the quality of staff practice at all staff levels. The findings should link with the service's staff supervision and appraisal procedures as well as the staff training needs analysis.

This ensures that the quality of management and leadership 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) and "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.1).

This area for improvement was made on 26 September 2019.

Action taken since then

There was no evidence that this had been happening. The service had recognised that this is an area they needed to improve upon and had identified this as part of their service redesign and had included within improvement plan.

This area for improvement has not been met and will be amalgamated with AFI 5 and AFI 8. This will be reworded and repeated.

Previous area for improvement 5

The service must ensure that staff are provided with supervision on a regular basis, in keeping with the service's supervision policy. This should be scheduled in advance with discussions and decisions being clearly recorded.

This ensures 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 26 September 2019.

Action taken since then

Supervisions had happened but were not consistent across the service. The service had recognised that this is an area they needed to improve upon and had identified this as part of redesign and within their improvement plan.

This area for improvement has not been met and will be amalgamated with AFI 4 and AFI 8. This will be reworded and repeated.

Previous area for improvement 6

As an outcome of a complaint dated 21/6/21, we made the following area for improvement:

The provider should ensure that support plans include person centred strategies that describe how people living with dementia like their support to be provided. Strategies should include their likes and dislikes, how staff should introduce care tasks and what they should do if the person declines support.

This area for improvement was made on 21 June 2021.

Action taken since then

People’s care plans were outdated and did not include person centred strategies. There was some good but limited examples within digital care plans of where consideration had been made to supporting people living with dementia in a way that is person centred. However, this did not include how to introduce care tasks and what do if care is refused. Dementia skilled training for staff had not fully been rolled out. This means that people living with dementia may not be receiving the support they require.

This area for improvement has not been met and will become part of a requirement within KQ 3.

Previous area for improvement 7

As an outcome of a complaint dated 21/6/21, we made the following area for improvement:

The provider should ensure that medication risk assessment processes are reviewed to include the time required between medication doses. People's care visits should be scheduled to allow them to take their medication safely and in accordance with prescribing instructions.

This area for improvement was made on 21 June 2021.

Action taken since then

There was no evidence within the risk assessment review process surrounding medication, that times had been included between medication doses. People's care diaries only have records if medication is taken, left out or declined. The service had developed a new policy with input from colleagues in health to improve medication procedures across the service. The new policy is due to be implemented in April 2023.

This area for improvement will be repeated under KQ 1.

Previous area for improvement 8

As an outcome of a complaint dated 21/6/21, we made the following area for improvement:

To ensure safe outcomes for people, the provider should ensure that they have effective processes in place to quality assure the support provided by care agency employees. This should include, but is not limited to, providing comprehensive induction, supervision arrangements and assessments of competence.

This area for improvement was made on 21 June 2021.

Action taken since then

We found no evidence of quality assurance happening with agency staff. This had not happened with service staff and is an area for improvement that the service had recognised and had included within their improvement plan.

This area for improvement has not been met and will be amalgamated with AFI 4 and AFI 5. This will be reworded and repeated.

Previous area for improvement 9

As an outcome of a complaint dated 4/4/22, we made the following area for improvement:

To ensure complaints are managed effectively and in accordance with their own policy and procedure, the care service should ensure that all who raise complaints or concerns are treated with courtesy, any information requests, concerns and complaints are recorded accurately and responded to promptly, ensuring that follow up actions are met in line with the policy or in an agreed manner.

This area for improvement was made on 4 April 2022.

Action taken since then

People had information within their care plans about how to complain. However, this information was outdated and not reflective of current legislation. This means that people did not have the correct information about how to raise a complaint.
The service did have a complaint tracker however, it did not show if complaints had now been closed and all parties involved had been satisfied with outcomes.

This area for improvement will be repeated under KQ 2.

Previous area for improvement 10

As an outcome of a complaint dated 4/4/22, we made the following area for improvement:

To ensure the health, safety and welfare needs of people experiencing care are met, the provider should ensure:

a) there is an up to date and accurate assessment of each person's health care needs which includes a plan for managing any assessed risks in relation to nutritional care and oral care
b) support plans are implemented and evaluated and care delivered in accordance with the assessment of people's individual needs
c) ongoing monitoring, review and clinical oversight of the care provided to each person
d) improvement to record keeping is needed to ensure accuracy in the documentation and to ensure information relating to people's wellbeing is recorded and changes in presentation are escalated and acted upon without delay.

This area for improvement was made on 4 April 2022.

Action taken since then

People had information within their digital plan regarding their nutritional needs. This included an accurate assessment particularly if the person had a choking risk. Nutrition was also a topic that was discussed within the new review template. However, there was no information about oral care.

People's care plans had been outdated however staff had been guided by the digital care plans which contained current information about their needs.
There was evidence that some people who had declining health needs were being monitored through fortnightly meetings with district nurses. This meant the service was responsive to people's changing needs.

Staff would log their visits within people's care diary. Most information that had been recorded by staff was task focused and did not contain information about people's wellbeing. To ensure people are in receipt of the right support, all health and wellbeing needs should be monitored and recorded.

This area for improvement has not been met. Elements of this area for improvement will become a requirement within KQ 5.

Previous area for improvement 11

As an outcome of a complaint dated 4/4/22, we made the following area for improvement:

To ensure the health, safety and welfare needs of people experiencing care are met, the provider should ensure:

a) that all staff have up to date and relevant training in the importance of appropriate washing and assisting people with their skin integrity
b) staff need to be aware of the importance of accurate and daily recording when administering any topical treatment
c) the service manager should ensure that any person being supported with their skin integrity has had referrals made for pressure relieving equipment
d) that a clear and robust care and support plan is in place that instructs staff on how to support people with washing and with their skin integrity.

This should be reviewed regularly to ensure it remains effective for the person experiencing care.

This area for improvement was made on 4 April 2022.

Action taken since then

The service had linked in with the areas district nurses to deliver skin integrity training. However, it was not evident which staff had completed this training. The service had worked closely with health colleagues to ensure that people received the right support regarding skin care. Staff had been guided to support people with their skin integrity by health colleagues. This assured us that there was an integrated approach to ensuring that people's health and wellbeing needs continued to be meet.

This area for improvement has not been met. Elements of this area for improvement will be amalgamated into a requirement under KQ 3.

Previous area for improvement 12

As an outcome of a complaint dated 4/4/22, we made the following area for improvement:

To ensure the health and welfare needs of people experiencing care are met, the provider should ensure:

a) that if there is district nurse or general practitioner input in someone's care package this is referenced to in their care and support plan
b) that all staff are aware of any treatments being administered by the district nursing team and are able to assist people in the correct way as to support this.

This area for improvement was made on 4 April 2022.

Action taken since then

There was good evidence of the service using an integrated approach with health colleagues to meet people's health and wellbeing needs. Feedback from external professionals was positive about the services working well together and following instructions.

This area for improvement has been met.

Previous area for improvement 13

As an outcome of a complaint dated 4/4/22, we made the following area for improvement: To

ensure the health, safety and welfare needs of people experiencing care are met, the provider

should:

a) update their home risk assessment to include any potential risks within a person's own home to staff and the individual
b) ensure that any agreed actions are completed and reviewed regularly to ensure they remain effective
c) the manager should ensure that all staff understand their responsibilities in reporting faults and the importance of supporting someone safely in their own home
d) the management should arrange for risk assessments to be completed by other relevant bodies if required
e) ensure that risk assessments include removing any hazards preventing someone's rights to freedom of movement when staff are not present in the person's home.

This should be in discussion with the person or their chosen advocates.

This area for improvement was made on 4 April 2022.

Action taken since then

There was evidence that environmental risk assessments considered areas and aspects of the people's home that may be of risk. However, the risk assessments provided very limited information as to the risks identified. Many risk assessments were not dated and it was unclear when they were written or due for review. There was evidence that faults had been reported and logged however, information for people was outdated. People's health and wellbeing could be affected if any health and safety risks have not been mitigated.

This area for improvement has not been met and will be incorporated into all three new requirements.

Previous area for improvement 14

As an outcome of a complaint dated 4/4/22, we made the following area for improvement:

The provider must ensure personal plans record all risk, health, welfare and safety needs in a coherent manner which identifies how needs including personal care need are met. In order to do this the provider must ensure staff have the information required to support the person and ensure that:

a) documentation and records are accurate, sufficiently detailed and reflect the care planned or provided
b) ensure that all relevant assessments are carried out, with any adaptations required to people's houses requested and put in place. This is to ensure staff can meet all needs of people living in their own houses inclusive of personal care in a safe and respectful manner

c) provide training so that staff are aware of their responsibility in maintaining accurate records and retaining records
d) demonstrate that managers are involved in monitoring and the audit of people's needs and records
e) demonstrate proactive strategies to encourage people to participate in their personal care.

This area for improvement was made on 4 April 2022.

Action taken since then

Digital care plans and assessments were variable in content which meant that some information was not accurate. There was evidence that adaptations had been made for people. This included occupational therapist input which shows that the service had worked closely with health colleagues to meet people's needs.

There is training available for accurate record keeping however, this appeared to be for newer staff, not the existing wider team.

People's reviews had not all been in date and some care plans did not contain strategies to encourage people to participate with their personal care. This means that people might be at risk of not receiving the support they need.

This area for improvement has not been met and will be incorporated into all three new requirements.

Previous area for improvement 15

As an outcome of a complaint dated 15/6/22, we made the following area for improvement:

The manager should review and improve communication systems when people are returning home following a hospital admission. This should include ensuring the hospital discharge letter is opened, read and understood with any changes detailed acted upon without delay.

This area for improvement was made on 15 June 2022.

Action taken since then

There had been detailed discussions about people under the hospital discharge team as part of the fortnightly group meetings. There was evidence of planned actions taken however, we did not see any hospital discharge letters within care plans. There was evidence of care notes on the digital system about people transferring from the hospital discharge organiser to mainstream organiser and requests for new care diaries.

This area for improvement has not been met and will become a requirement within KQ 2.

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
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate
1.4 People are getting the right service for them	3 - Adequate
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	3 - Adequate

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

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 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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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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2023 Inspection Areas for Improvement

1 To meet people's needs, the provider should ensure that they communicate effectively with people about their service when changes need to happen. This should include, but not limited to, updating people's preferred modes and timing of communication
2 The provider should ensure that medication risk assessment processes are reviewed to include the time required between medication doses. People's care visits should be scheduled to allow them to take their medication safely and in accordance with prescribing instructions
3 To support people's health and wellbeing, the provider should ensure that staff are competent with promoting good infection prevention and control practices. This should include, but not limited to, observing staff in training and in practice.
4 To ensure complaints are managed effectively and in accordance with their own policy and procedure, the care service should ensure that all who raise complaints or concerns are treated with courtesy. Any information requests, concerns and complaints are recorded accurately and responded to promptly, ensuring that follow up actions are met in line with the policy or in an agreed manner
5 To improve outcomes for people, the provider should ensure that they continually monitor, evaluate and complete all actions that they have identified within their improvement plan
6 To protect people from potential risks of financial harm, the provider should implement a cash handling policy and procedure. This should include but not limited to training in cash handling procedures and service spot checks.
7 To support people's health and wellbeing the provider needs to implement and evidence regular staff team meetings across the services.
8 To support people's health and wellbeing, the provider should implement a system to ensure that all staff are supervised on a regular basis. This includes, but is not limited to, supervising staff on an individual, group and on-the-job basis.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

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

Audit and Performance Committee - 19 September 2023

Subject: Care Inspectorate Report – Clyde Court Care Home

1. Purpose

1.1 To provide the Audit and Performance Committee with an up-date on Care Inspectorate reporting for Clyde Court Care Home which is an independent, private sector residential older peoples' Care Home 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 Clyde Court Care Home is owned by Maven Healthcare Limited. Maven Healthcare Limited have owned Clyde Court Care Home since October 2022 when they took over from previous owners Four Seasons Healthcare. Clyde Court Care Home is registered with the Care Inspectorate to provide a care service to a maximum of 70 older people.

4. Main Issues

4.1 An unannounced inspection took place on the 18th, 19th and 20th April and again on the 2nd and 9th May 2023. The inspection was carried out by 3 inspectors and focussed on Key Questions 1 – 4. Feedback on the full inspection was provided on the 25th May 2023 with the final report published in early July 2023.

4.2 The inspection resulted in the following grades:

KQ 1	**How well do we support people's wellbeing**	**2 - Weak**
KQ2	**How good is our Leadership**	**2 - Weak**
KQ3	**How good is our staff team**	**3 - Adequate**
KQ4	**How good is our setting**	**2 - Weak**

During the inspection, Inspectors raised immediate concern which resulted in 4 requirements with immediate timescales – 1 with a timescale of 1st May 2023 and 3 with a timescale of 8th May 2023.

Inspectors confirmed that these 4 requirements were met within the allocated timescales.

Inspectors made a further 8 requirements with the following timescales:

- 3 requirements with a timescale of 28th June 2023; and
- 5 requirements with a timescale of 23rd August 2023.

4.3 Full details of all 8 Requirements and corresponding dates can be found in Appendix 1 - Clyde Court Care Home Inspection Requirements.

4.4 Following publication of the final report from the full inspection, HSCP staff met with Clyde Court Care Home to discuss their action plan and to offer support from the HSCP.

4.5 Due to the grades awarded and the nature of the requirements it was jointly agreed that a Voluntarily Moratorium would be put on all placements to Clyde Court Care Home with immediate effect.

4.5 The initial moratorium was put in place from 8th June 2023 with a review date of 30th June 2023, which was in line with the Care Inspectorate follow up visit on the 28th June 2023.

Inspectors confirmed that the 3 requirements with the timescale of 28th June 2023 had been fully met. A discussion took place with HSCP staff and Clyde Court Care Home where it was agreed to extend the moratorium until at least the 23rd August to ensure that the remaining requirements were met within allocated timescales. This would also demonstrate a period of continuous and sustained improvement, which would provide the HSCP additional assurance when considering lifting the moratorium.

4.6 The Care Inspectorate visited Clyde Court on 24th August 2023 and it was confirmed that the remaining requirements had been met within the timescale.

Inspectors also confirmed that as a result of this, that grades will increase and will no longer be graded as 2 – Weak. The final report, confirming this will not be published until after the September Audit and Performance Committee.

4.7 Following the feedback from the Care Inspectorate on 25 August 2023 it was agreed by the HSCP Senior Management Team that the moratorium on placements to Clyde Court would be removed with immediate effect.

4.8 Staff from the Quality Assurance team are in regular contact with the Management Team at Clyde Court to offer support and further meetings are planned to ensure the service is supported to continually improve.

4.9 The Care Home Collaborative conducted assurance visits during the period that the moratorium was in place to provide the HSCP with further assurance that improvements were being made. The Care Home Collaborative will continue to work closely with Clyde Court Care Home.

5 People Implications

5.1 There are no personnel issues associated with this report.

6 Financial and Procurement Implications

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

7 Risk Analysis

7.1 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.

8 Equalities Impact Assessment (EIA)

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

9 Environmental Sustainability

9.1 Not required for this request.

10 Consultation

10.1 None required for this report.

11 Directions

11.1 Not required for this report.

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Appendices: Appendix 1 – Clyde Court Care Home Inspection Requirements.

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

Appendix 1 – Clyde Court Care Home Inspection Requirements.

	Requirement	Timescale	Met / Not Met
1.	The provider must ensure people's dignity, wellbeing and physical health is promoted and protected. People must be supported according to their care plan and in line with best practice. Personal care must be carried out daily to ensure and support people to be clean, free of malodour and look presentable	28/06/23	MET
2	The provider, must ensure people are supported with their medication management, the service should ensure that people receive their medications as prescribed, and that all medications, including topical creams and ointments, are stored correctly.	28/06/23	MET
3	The provider, must provide a varied programme of meaningful activities. To do this, you, 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; and c) opportunities for people to be out in the community.	23/08/23	MET
4	The provider, must ensure that care and support is provided in an outcome focused way, linked to individual choices, preferences and needs and in line with their care plan. This must be reflected in people's daily lives.	23/08/23	MET
5	The provider, must ensure that the quality assurance system is used effectively to capture and demonstrate continuous improvement. Where areas for improvement have been identified following consultation, or within the auditing system, there must be sufficient information to show actions taken and progress made until fully resolved.	23/08/23	MET

	Requirement	Timescale	Met / Not Met
6	The provider, must ensure that people's health and wellbeing needs are met by the right number of people and that their care and support is right for them to support good outcomes for people. In order to achieve this, the provider must as a minimum: a) Continue to recruit staff to fill the current vacancies and develop a robust contingency plan to cover any periods of vacancy, annual leave or sickness. b) Continue to ensure sufficient staff are consistently rostered to keep people safe and meet their health and care needs. c) Ensure staff are deployed appropriately to ensure responsive care to people. d) Ensure that effective reviews are regularly undertaken to take account of: - the layout of the building; - direct care hours required to meet the needs of each person; - the appropriate mix of staff skills required to meet the needs of people using the service; and - staff hours are adjusted to meet people's changing needs.	23/08/23	MET
7	The provider, must ensure that to keep people safe, all fire exit doors and associated alarms are fully functional at all times. To do this, the provider must, at a minimum: a) Devise a system to ensure that this is maintained 24-hours a day. b) Provide guidance for staff on how to achieve this. c) Maintain records of daily checks.	28/06/23	MET
8	The provider, must ensure that the premises and environment people are living in is clean, well maintained and free from malodour. The provider must: (a) Ensure that there is a robust environmental auditing process in place. (b) Implement a cleaning system that ensures the cleanliness of the environment. (c) Resolve any identified concerns relating to environmental hazards	23/08/23	MET