East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair

East Dunbartonshire HSCP
Performance Audit & Risk Committee Meeting Agenda
Tuesday 20th June 2023 at 1:30pm
Meeting will be held virtually via MS Teams

Item.	Lead	Description	Update	For Noting/Approval
1.	Councillor Smith	Welcome and Introductions	Verbal	Noting
2.	Councillor Smith	Minutes of Last Meeting –Performance, Audit and Risk Committee Meeting of 21st March 2023	Paper	Approval
3.	Tom Reid	Mazars - Audit Strategy Memorandum for Year Ending 31st March 2023	Paper	Noting
4.	J Campbell	Unaudited Annual Accounts 2022-23	Paper	Approval
5.	G McConnachie	Mazars – Audit of East Dunbartonshire IJB's Financial Statements for the year ending 31 March 2023	Paper	Approval
6.	A Cairns / A Willacy	HSCP Annual Performance Report 2022/23	Paper	Noting
7.	G McConnachie	HSCP Annual Internal Audit Report to June 2022	Paper	Noting
8.	J Campbell	HSCP Delivery Plan 2022-23 Update	Paper	Noting
9.	J Campbell	HSCP Risk Management Policy and Corporate Risk Register Update	Paper	Approval
10.	J Campbell	HSCP Directions Log Update	Paper	Noting
11.	C Sinclair	Mental Welfare Commission's Findings in relation to Mental Health and Specialist Children's Services	Paper	Noting
12.	J Campbell	Accounts Commission Report – Integration Joint Boards Financial Analysis 2021/22	Paper	Noting
13.	C Carthy	Joint Inspection of Services for Children at Risk of Harm – Inspection Report and Action Plan	Paper	Noting
14.	C Smith	PAR Committee Agenda Planner	Paper	Noting
15.	Councillor Smith	A.O.C.B	Verbal	Noting
16.	Councillor Smith	Date of next meeting – 28th Sept 2023	Verbal	Noting

Minutes of
East Dunbartonshire HSCP Performance, Audit & Risk Committee Meeting
Date: Tuesday 21 March 2023 at 2pm
Location: Via MS Teams

Present:	Calum Smith (Chair)	**CSm**	Jacquie Forbes	**JF**
	Ian Ritchie	**IR**	Ketki Miles	**KM**
	Alan Moir	**AM**	Susan Murray	**SM**
	Jean Campbell	**JC**	Gillian McConnachie	**GMcC**
	Caroline Sinclair	**CS**	David Aitken	**DA**
	Derrick Pearce	**DP**	Claire Carthy	**CC**
	Alison Willacy	**AW**		
Minutes :	Siobhan McGinley	**SMcG**		

No.	Topic	Action by
1.	**Welcome and Apologies**	**CSm**
	Chair welcomed the Committee members to the meeting. Apologies submitted from:	
2.	**Minutes of Last Meeting – Extraordinary Performance, Audit and Risk Committee Meeting of 27th October 2022**	**All**
	The minutes of the meeting on the 27th October 2022 were accepted as accurate and approved.	
3.	**HSCP Internal Audit Update Feb 23**	**GMcC**
	GMcC gave an update on the audit work undertaken over the period since the last committee (September 2022 to February 2023). Four outputs were concluded during this period. In addition an update was provided on the interim review of outstanding audit actions which included 1 high risk action and 2 medium risk actions. A verbal update was provided on the Internal Audit Plan for 2023/24. It was anticipated that the plan would include a focus on the HSCP's approach to Social Care Payments, Workforce Planning and Hospital Discharges as key processes for the HSCP. JF queried the absence of a due date for conclusion of the high risk action related to HSCP contractual arrangements and the fact that this originated in 2014 and so had been outstanding for some time. GMcC highlighted that there had been improvement in the contractual position and work had been ongoing to progress this action which had stalled during Covid. Work had included the completion of a risk matrix in collaboration with Heads of Service to review services and categorise these in terms of risk, with a plan to move to a contractual underpinning. JC advised that the timescales to put everything into a contractual underpinning will be dependent on the outcome of the risk assessment and whether this requires a tender process, which can be lengthy, and a number of areas are subject to ongoing service reviews which will impact timescales. Following further discussion,	

	it was agreed that a further update would be brought back to the committee, at a future meeting, on the work underway and a timescale for conclusion.	
4.	**HSCP Delivery Plan 2022/23 Update**	**JC**
	JC gave an update on the status of projects within the 22/23 annual delivery plan. Committee members noted progress on the HSCP Delivery Plan. It was noted that resource constraints have limited the progress of a number of projects and that some projects would be carried forward to 2023/24 with revised plans for progress and that some projects, by their nature, would take a number of years to conclude.	
5.	**HSCP Performance Monitoring Report – Qtr3**	**AW**
	AW gave an update on the HSCP performance for Qtr 3. This report will now come to the PAR Committee ahead of the IJB to facilitate additional scrutiny and assurance to the IJB that performance is being managed. JF noted the performance in relation to delayed discharge, unscheduled bed days and given the national interest in this area are we confidant we are doing all we can to support this agenda. DP noted the number of A&E attendances is off target but noted that there is a high %age of people presenting at A&E who are then admitted suggesting that those attending are appropriately been referred to hospital. In addition we are seeing levels of complexity and frailty in those attending hospital which is contributing to the increase in bed days occupied and when individuals are assessed as fit for discharge there is an increase in the complexity of care packages required with an increase in the numbers requiring 2:1 support. CS advised that we have a number of local initiatives in place to support effective and timely discharge and there is daily scrutiny on cases. We are also linked into the national discussions and initiatives promoted are being adopted within East Dunbartonshire where appropriate.	
6.	**Mental Welfare Commission – "Ending the Exclusion"**	**DA**
	DA gave an update of the MWC report which focuses on the experience of people who have lived with mental ill health and problematic drug or alcohol use. The Commission made a number of recommendations for HSCPs to progress and work is underway in East Dunbartonshire to progress on these recommendations and build on the work to strengthen integrated work across the EDADRS and Community Mental Health teams as well as board wide processes and protocols.	
7.	**HSCP PAR Agenda Planner**	**JC**
	Committee members noted the updated agenda planner. It was requested that the Corporate Risk register should be considered at every PAR Committee to ensure members have effective oversight of the management of risks for the IJB.	
8.	**A.O.C.B**	**CSm**
	Nil of note.	
9.	**Date of next meeting**	**CSm**
	Date of next meeting – 20th June 2023 at 1.30pm via Ms Teams	

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 03.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20TH JUNE 2023**
REPORT REFERENCE:	**HSCP/200623/03**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER (07583902000)**
SUBJECT TITLE:	**MAZARS – AUDIT STRATEGY MEMORANDUM FOR YEAR ENDING 31ST MARCH 2023**

1.0 PURPOSE

1.1 The purpose of this report is to update the committee on Mazars Audit Strategy Memorandum for East Dunbartonshire IJB for the year ending 31 March 2023.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.1 Note and agree the content of the Annual Audit Plan for the IJB.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The Audit Strategy Memorandum sets out the scope of engagement, planned scope and audit approach with timelines, significant risks and key judgements, the wider audit scope and best value, proposed audit fee for the year, a commitment to independence and materiality and mis-statements.

3.2 A copy of the Audit Strategy Memorandum for 2022/23 is included as **(Appendix 1).**

4.0 IMPLICATIONS

The implications for the Committee are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022 – 2025 Priorities

1. Empowering People
2. Empowering Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery
7. Post-pandemic Renewal
8. Maximising Operational Integration

The audit strategy memorandum sets out the arrangements for review of areas related to financial governance, management, sustainability and assurance on value for money across the HSCP financial landscape. This ensures the partnership delivers on these key aspects which in turn supports the continued delivery of priorities set out within the strategic plan.

4.2 Frontline Service to Customers – None

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – None

4.5 Financial Implications – The Audit Strategy memorandum will review the financial performance of the IJB through a review and opinion on the annual accounts for the partnership and considers the wider audit dimensions that frame the scope of public sector audit requirements including financial management arrangements, financial sustainability, governance and transparency and value for money.

4.6 Procurement – None

4.7 ICT - None

4.8 Economic Impact – None

4.9 Sustainability – None

4.10 Equalities Implications – None

4.11 Other – None

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The report sets out the significant risks for the IJB.

6.0 IMPACT

6.1 **STATUTORY DUTY** - Mazars are the externally appointed auditors for the IJB. The scope of engagement is set out in the Code of Audit Practice, issued by the Auditor General and the Accounts Commission available from the Audit Scotland website: Code of audit practice | Audit Scotland (audit-scotland.gov.uk). The responsibilities are principally derived from the Local Government (Scotland) Act 1973 (the 1973 Act) and the Code of Audit Practice.

6.2 **EAST DUNBARTONSHIRE COUNCIL** - None

6.3 **NHS GREATER GLASGOW & CLYDE** - None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 Appendix 1 – Mazars Audit Strategy Memorandum for the year ending 31 March 2023.

Audit Strategy Memorandum

East Dunbartonshire Integration Joint Board

Year ending 31 March 2023

mazars

Contents

Performance, Audit and Risk Committee
East Dunbartonshire Integration Joint Board
10 Saramago Street
Kirkintilloch
G66 3BF

Mazars LLP
100 Queen Street
Glasgow
G1 3DN

13 April 2023

Dear Performance, Audit and Risk Committee Members

Audit Strategy Memorandum – Year ending 31 March 2023

We are pleased to present our Audit Strategy Memorandum for East Dunbartonshire Integration Joint Board for the year ending 31 March 2023. The purpose of this document is to summarise our audit approach, highlight significant audit risks and areas of key judgements and provide you with the details of our audit team. As it is a fundamental requirement that an auditor is, and is seen to be, independent of its clients, section 7 of this document also summarises our considerations and conclusions on our independence as auditors. We consider two-way communication with you to be key to a successful audit and important in:

- reaching a mutual understanding of the scope of the audit and the responsibilities of each of us;
- sharing information to assist each of us to fulfil our respective responsibilities;
- providing you with constructive observations arising from the audit process; and
- ensuring that we, as external auditors, gain an understanding of your attitude and views in respect of the internal and external operational, financial, compliance and other risks facing West Dunbartonshire IJB which may affect the audit, including the likelihood of those risks materialising and how they are monitored and managed.

With that in mind, we see this document, which has been prepared following our initial planning discussions with management, as being the basis for a discussion around our audit approach, any questions, concerns or input you may have on our approach or role as auditor. This document also contains an appendix that outlines our key communications with you during the course of the audit and explains the implications of the introduction of the new auditing standard for Identifying and assessing the risks of material misstatement: ISA (UK) 315 (Revised 2019).

Client service is extremely important to us and we strive to provide technical excellence with the highest level of service quality, together with continuous improvement to exceed your expectations so, if you have any concerns or comments about this document or audit approach, please contact me on 07816354994.

Yours faithfully

T. Reid

Tom Reid (Audit Director)

Mazars LLP

01

Section 01:

Engagement and responsibilities summary

1. Engagement and responsibilities summary

Overview of engagement

We are appointed to perform the external audit of East Dunbartonshire Integration Joint Board (the IJB) for the year to 31 March 2023. The scope of our engagement is set out in the Code of Audit Practice, issued by the Auditor General and the Accounts Commission available from the Audit Scotland website: Code of audit practice | Audit Scotland (audit-scotland.gov.uk). Our responsibilities are principally derived from the Local Government (Scotland) Act 1973 (the 1973 Act) and the Code of Audit Practice, as outlined below.

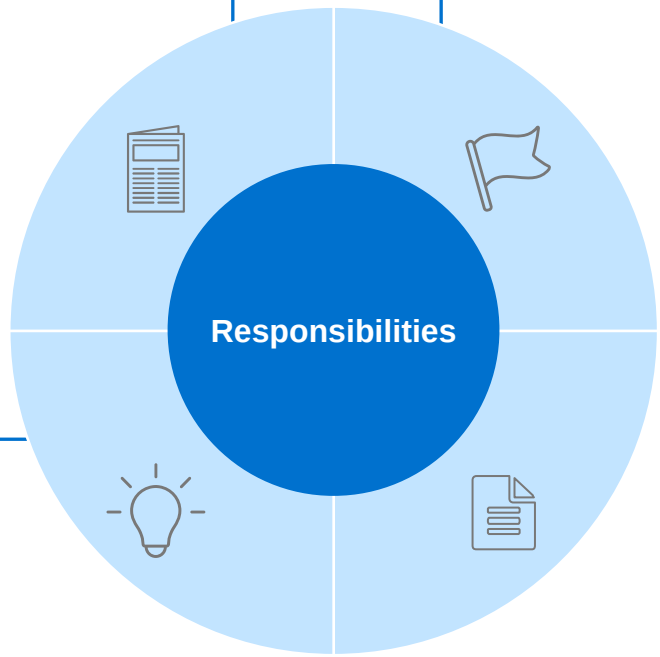
Audit opinion

We are responsible for forming and expressing an independent opinion on whether the financial statements are prepared, in all material respects, in accordance with all applicable statutory requirements. Our audit does not relieve management or the Performance, Audit and Risk Committee, as Those Charged With Governance, of their responsibilities.

The Chief Finance and Resources Officer is responsible for the assessment of whether it is appropriate for the IJB to prepare its accounts on a going concern basis. As auditors, we are required to obtain sufficient appropriate audit evidence regarding, and conclude on: a) whether a material uncertainty related to going concern exists; and b) consider the appropriateness of the Chief Finance and Resources Officer's use of the going concern basis of accounting in the preparation of the financial statements.

Wider scope and Best Value

We are also responsible for reviewing and reporting on the wider scope arrangements that the IJB has in place and its arrangements to secure Best Value. We discuss our approach to wider scope and Best Value work further in [section 5] of this report.



Fraud

The responsibility for safeguarding assets and for the prevention and detection of fraud, error and non-compliance with law or regulations rests with both Those Charged With Governance and management. This includes establishing and maintaining internal controls over reliability of financial reporting.

As part of our audit procedures in relation to fraud we are required to enquire of Those Charged With Governance, including key management and internal audit as to their knowledge of instances of fraud, the risk of fraud and their views on internal controls that mitigate the fraud risks. In accordance with International Standards on Auditing (UK), we plan and perform our audit so as to obtain reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. Our audit, however, should not be relied upon to identify all such misstatements.

02

Section 02:

Your audit engagement team

2. Your audit engagement team

Below is your audit engagement team and their contact details.

Tom Reid

Engagement Director

tom.reid@mazars.co.uk

07816 354 994

Ishana Singh

Engagement Manager

ishana.singh@mazars.co.uk

07814 060 369

03

Section 03:

Audit scope, approach and timeline

3. Audit scope, approach and timeline

Audit scope

Our audit approach is designed to provide an audit that complies with all professional requirements.

Our audit of the financial statements will be conducted in accordance with International Standards on Auditing (UK), relevant ethical and professional standards, our own audit approach and in accordance with the terms of our engagement. Our work is focused on those aspects of your activities which we consider to have a higher risk of material misstatement, such as those impacted by management judgement and estimation, application of new accounting standards, changes of accounting policy, changes to operations or areas which have been found to contain material errors in the past.

Audit approach

Our audit approach is risk-based and primarily driven by the issues that we consider lead to a higher risk of material misstatement of the accounts. Once we have completed our risk assessment, we develop our audit strategy and design audit procedures in response to the risks identified.

If we conclude that appropriately-designed controls are in place then we may plan to test and rely upon these controls. If we decide controls are not appropriately designed, or we decide it would be more efficient to do so, we may take a wholly substantive approach to our audit testing. Substantive procedures are audit procedures designed to detect material misstatements at the assertion level and comprise: tests of details (of classes of transactions, account balances, and disclosures); and substantive analytical procedures. Irrespective of the assessed risks of material misstatement, which take into account our evaluation of the operating effectiveness of controls, we are required to design and perform substantive procedures for each material class of transactions, account balance, and disclosure.

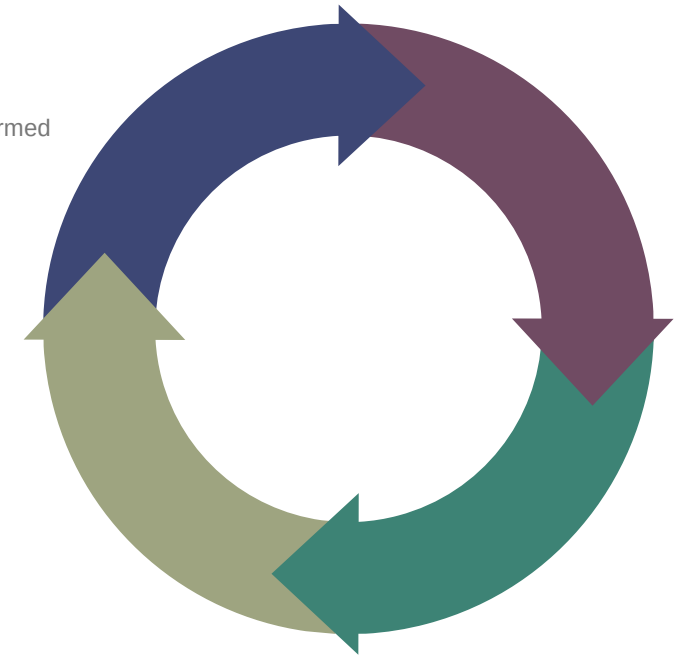
Our audit will be planned and performed so as to provide reasonable assurance that the financial statements are free from material misstatement and give a true and fair view. The concept of materiality and how we define a misstatement is explained in more detail in section 8.

The diagram on the next page outlines the procedures we perform at the different stages of the audit.

3. Audit scope, approach and timeline

Planning and Risk Assessment (January to April 2023)

- Planning visit and developing our understanding of the IJB
- Initial opinion and wider scope risk assessments
- Considering proposed accounting treatments and accounting policies
- Developing the audit strategy and planning the audit work to be performed
- Agreeing timetable and deadlines
- Risk assessment analytical procedures
- Determination of materiality



Interim (March to April 2023)

- Documenting systems and controls
- Performing walkthroughs
- Reassessment of audit plan and revision if necessary

Completion (September 2023)

- Final review and disclosure checklist of financial statements
- Final director review
- Agreeing content of letter of representation
- Reporting to the Audit and Performance Committee
- Reviewing subsequent events
- Signing the independent auditor's report

Fieldwork (July to August 2023)

- Receiving and reviewing draft financial statements
- Delivering our audit strategy starting with significant risks and high risk areas including detailed testing of transactions, account balances and disclosures
- Communicating progress and issues
- Clearance meeting

3. Audit scope, approach and timeline

Reliance on internal audit

Where possible we will seek to utilise the work performed by internal audit to modify the nature, extent and timing of our audit procedures. We will meet with internal audit to discuss the progress and findings of their work prior to the commencement of our controls evaluation procedures.

Where we intend to rely on the work on internal audit, we will evaluate the work performed by your internal audit team and perform our own audit procedures to determine its adequacy for our audit.

04

Section 04:

Significant risks and other key judgement areas

4. Significant risks and other key judgement areas

Following the risk assessment approach discussed in section 3 of this document, we have identified risks relevant to the audit of financial statements. The risks that we identify are categorised as significant, enhanced or standard. The definitions of the level of risk rating are given below:

Significant risk

Significant risks are those risks assessed as being close to the upper end of the spectrum of inherent risk, based on the combination of the likelihood of a misstatement occurring and the magnitude of any potential misstatement. Fraud risks are always assessed as significant risks as required by auditing standards, including management override of controls and revenue recognition.

Enhanced risk

An enhanced risk is an area of higher assessed risk of material misstatement at audit assertion level other than a significant risk. Enhanced risks require additional consideration but does not rise to the level of a significant risk, these include but may not be limited to:

- key areas of management judgement, including accounting estimates which are material but are not considered to give rise to a significant risk of material misstatement; and
- other audit assertion risks arising from significant events or transactions that occurred during the period.

Standard risk

This is related to relatively routine, non-complex transactions that tend to be subject to systematic processing and require little management judgement. Although it is considered that there is a risk of material misstatement (RMM), there are no elevated or special factors related to the nature, the likely magnitude of the potential misstatements or the likelihood of the risk occurring.

Summary risk assessment

The summary risk assessment, illustrated in the table below, highlights those risks which we deem to be significant and other enhanced risks in respect of the IJB. We have summarised our audit response to these risks on the next page.

1. Management override of controls

4. Significant risks and other key judgement areas

Specific identified audit risks and planned testing strategy

We have presented below in more detail the reasons for the risk assessment highlighted above, and also our testing approach with respect to significant risks. An audit is a dynamic process, should we change our view of risk or approach to address the identified risks during the course of our audit, we will report this to Performance, Audit and Risk Committee.

Significant risks

	Description	Fraud	Error	Judgement	Planned response
1	**Management override of controls** This is a mandatory significant risk on all audits due to the unpredictable way in which such override could occur. Management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur there is a risk of material misstatement due to fraud on all audits.	●	○	○	We plan to address the management override of controls risk by: • reviewing the key areas within the financial statements where management has used judgement and estimation techniques and consider whether there is evidence of unfair bias; • examining accounting policies; • testing the appropriateness of journal entries recorded in the general ledger and other adjustments made in preparing the financial statements; and • considering and testing any significant transactions outside the normal course of business or otherwise unusual.

4. Significant risks and other key judgement areas

Consideration of risks related to revenue and expenditure recognition

As set out in International Standard on Auditing (UK) 240: The auditor's responsibilities relating to fraud in an audit of financial statement, there is a presumed risk of fraud over the recognition of revenue. There is a risk that revenue may be misstated resulting in a material misstatement in the financial statements. We consider the risk of fraud to be low because the IJB is almost wholly funded by NHS Greater Glasgow and Clyde and East Dunbartonshire Council. Therefore, as Audit Scotland has in previous years, we have rebutted this risk.

Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom highlights that, as most public-sector bodies are net spending bodies, the risk of material misstatement due to fraud related to expenditure may in some cases be greater than the risk relating to revenue recognition. We have not recognised an increased risk in relation to expenditure on the basis that all the IJB's transactions are processed by the partner bodies, NHS Greater Glasgow and Clyde and East Dunbartonshire Council, rather than the IJB directly.

Therefore, at this stage, we are not proposing to include specific work in our audit plan in these areas over and above our standard audit procedures. We have presented below in more detail the reasons for the risk assessment highlighted above, and also our testing approach with respect to significant risks. An audit is a dynamic process, should we change our view of risk or approach to address the identified risks during the course of our audit, we will report this to the Performance, Audit and Risk Committee.

Protocol for Auditor Assurance 2022/23

The IJB depends on information for its financial reporting which is provided by systems hosted by NHS Greater Glasgow and Clyde and East Dunbartonshire Council (constituent authorities).

We will therefore need to obtain sufficient appropriate audit evidence which may not be held by the IJB. In line with Audit Scotland's *Protocol for Audit Assurance 2022/23* we will request assurances from the auditors of each constituent authority.

05

Section 05:

Wider scope and Best Value

5. Wider scope and Best Value

The framework for wider scope work

The Code of Audit Practice sets out the four areas that frame the wider scope of public sector audit. We are required to form a view on the adequacy of the IJB's arrangements in four areas:

1. **Financial management**
2. **Financial sustainability**
3. **Vision, leadership, and governance**
4. **Use of resources to improve outcomes.**

Our approach

Our planned audit work against the four wider scope areas is risk based and proportionate. We need to gather sufficient evidence to support our commentary on the IJB's arrangements and to identify and report on any significant weaknesses. We will carry out more detailed work where we identify significant risks. Where significant weaknesses are identified we will report these to the IJB and make recommendations for improvement. In addition to local risks, we consider challenges that are impacting the public sector as a whole.

Best Value

Under the Code of Audit Practice, annual Best Value audit work in Integration Joint Boards is integrated with wider scope annual audit work. We report on how the IJB demonstrates and reports that it has Best Value arrangements in place, to secure continuous improvement. We are not expected to carry out detailed or separate work on the Best Value themes. Instead, our audit findings in relation to financial management, financial sustainability and aspects of the governance arrangements provide assurance on key aspects of the Best Value themes on Governance and Accountability and The Use of Resources.

The changes to IJBs anticipated from Parliament's National Care Service plans mean that the Accounts Commission is no longer requiring the Controller of Audit to report to the Commission on each IJB at least once over the five-year audit appointment on the IJB's performance on its Best Value duty as per the Code of Audit Practice.

Financial management	Financial management means having sound budgetary processes. Audited bodies require the ability to understand the financial environment and whether internal controls are operating effectively. Auditors consider whether the body has effective arrangements to secure sound financial management.
Financial sustainability	Financial sustainability means being able to meet the needs of the present without compromising the ability of future generations to meet their own needs. Auditors consider the extent to which audited bodies have shown regard to financial sustainability. They look ahead to the medium term (two to five years) and longer term (over five years) to consider whether the body is planning effectively so that it can continue to deliver services.
Vision, leadership and governance	Audited bodies must have a clear vision and strategy, and set priorities for improvement within this vision and strategy. They work together with partners and communities to improve outcomes and foster a culture of innovation. Auditors consider the clarity of plans to implement the vision, strategy and priorities adopted by the leaders of the audited body. They also consider the effectiveness of governance arrangements for delivery.
Use of resources to improve outcomes	Audited bodies need to make best use of their resources to meet stated outcomes and improvement objectives, through effective planning and working with strategic partners and communities. Auditors consider the clarity of the arrangements in place to ensure that resources are deployed to improve strategic outcomes, meet the needs of service users taking account of equalities, and deliver continuous improvements in priority services.

5. Wider scope and Best Value

Wider scope risks

The Code of Audit Practice requires us to consider the significant audit risks in areas defined in the Code as the wider scope audit.

We have not fully completed our planning and risk assessment work in relation to our work on the wider scope audit. We can confirm, however that we will follow up progress on previous Audit Scotland recommendations and consider national risk areas under scope of audit in 2022/23 which are set out below.

We will report any further identified risks to the Performance, Audit and Risk Committee on completion of our planning and risk identification work.

National risk areas under scope of audit in 2022/23

Climate change

Tackling climate change is one of the greatest global challenges. The Scottish Parliament has set a legally binding target of becoming net zero by 2045, and has interim targets including a 75% reduction in greenhouse gas emissions by 2030. The public sector in Scotland has a key role to play in ensuring these targets are met and in adapting to the impacts of climate change. There are specific legal responsibilities placed on public bodies to contribute to reducing greenhouse gas emissions, to adapt to climate change, to act sustainably and to report on progress. A number of public bodies have declared a climate emergency and set their own net zero targets, some of which are earlier than Scotland's national targets.

All public bodies will need to reduce their direct and indirect emissions, and should have plans to do so. Many bodies will also have a role in reducing emissions in wider society, and in supporting activity to adapt to the current and potential future impact of climate change. For example, working with the private sector and communities to help drive forward the required changes in almost all aspects of public and private life, from transport and housing to business support.

Public audit has an important and clear role to play in helping drive change and improvement in this uncertain and evolving area of work; supporting public accountability and scrutinising performance; and helping identify and share good practice. The Auditor General and Accounts Commission are developing a programme of work on climate change. This involves a blend of climate change-specific outputs that focus on key issues and challenges as well as moving towards integrating climate change considerations into all aspects of audit work. For 2022/23 audits, we are required to gather basic information on the arrangements for responding to climate change in each body.

Cyber security

There continues to be a significant risk of cyber attacks to public bodies, and it is important that they have appropriate cyber security arrangements in place. A number of recent incidents have demonstrated the significant impact that a cyberattack can have on both the finances and operation of an organisation.

For 2022/23 audits, auditors are advised to consider risks related to cyber security at audited bodies. However, the revised ISA (UK) 315 includes enhanced requirements for auditors to understand a body's use of IT in its business, the related risks and the system of internal control addressing such risks. The Auditor General and Accounts Commission consider that meeting these additional requirements is likely to be sufficient consideration of cyber security in 2022/23.

06

Section 06:

Fees for audit and other services

6. Fees for audit and other services

Fees for work as the IJB's appointed auditor

At this stage of the audit we are not planning any divergence from the expected fees set by Audit Scotland. The breakdown of the fee is set out in the table below.

	2022/23 Proposed Fee	2021/22 Actual Fee
Auditor remuneration	£33,860	£19,250
Pooled costs	0	£2,010
Contribution to PABV costs	£6,440	£5,670
Audit support costs	£1,280	£1,030
Sectoral cap adjustment	(£10,110)	0
Total fee	**£31,470**	**£27,960**

We have taken account of the risk exposure of the IJB and the management assurances in place. We have assumed that the IJB has effective governance arrangements and will prepare comprehensive and accurate accounts and working papers for audit in line with the agreed timetable for the audit. We reserve the right to charge a supplementary fee where our audit cannot proceed as planned. An additional fee will be required for any other significant exercises not within our planned audit activity.

07

Section 07:

Our commitment to independence

7. Our commitment to independence

We are committed to independence and are required by the Financial Reporting Council to confirm to you at least annually in writing that we comply with the FRC's Ethical Standard. In addition, we communicate any matters or relationship which we believe may have a bearing on our independence or the objectivity of the audit team.

Based on the information provided by you and our own internal procedures to safeguard our independence as auditors, we confirm that in our professional judgement there are no relationships between us and any of our related or subsidiary entities, and you and your related entities creating any unacceptable threats to our independence within the regulatory or professional requirements governing us as your auditors.

We have policies and procedures in place which are designed to ensure that we carry out our work with integrity, objectivity and independence. These policies include:

- all partners and staff are required to complete an annual independence declaration;
- all new partners and staff are required to complete an independence confirmation and also complete computer based ethical training;
- rotation policies covering audit engagement partners and other key members of the audit team; and
- use by managers and partners of our client and engagement acceptance system which requires all non-audit services to be approved in advance by the audit engagement partner.

We confirm, as at the date of this document, that the engagement team and others in the firm as appropriate, Mazars LLP are independent and comply with relevant ethical requirements. However, if at any time you have concerns or questions about our integrity, objectivity or independence please discuss these with Tom Reid in the first instance.

Prior to the provision of any non-audit services Tom Reid will undertake appropriate procedures to consider and fully assess the impact that providing the service may have on our auditor independence.

Any emerging independence threats and associated identified safeguards will be communicated in our Annual Audit Report.

08

Section 08:

Materiality and misstatements

8. Materiality and misstatements

Summary of initial materiality thresholds

Threshold	Initial threshold £'000s
Overall materiality	4,000
Performance materiality	2,900
We assess the Remuneration Report as sensitive given users' interest in this specific area. We are proposing to set materiality in this area at £1,000.	1
Trivial threshold for errors to be reported to the Audit and Performance Committee	123

Materiality

Materiality is an expression of the relative significance or importance of a particular matter in the context of financial statements as a whole.

Information is considered to be material if omitting, misstating or obscuring it could reasonably be expected to influence the decisions that the primary users of general purpose financial statements make on the basis of those financial statements, which provide financial information about a specific reporting entity.

Judgements on materiality are made in light of surrounding circumstances and are affected by the size and nature of a misstatement, or a combination of both. Judgements about materiality are based on consideration of the common financial information needs of users as a group and not on specific individual users.

The assessment of what is material is a matter of professional judgement and is affected by our perception of the financial information needs of the users of the financial statements. In making our assessment we assume that users:

- have a reasonable knowledge of business, economic activities and accounts;
- have a willingness to study the information in the financial statements with reasonable diligence;
- understand that financial statements are prepared, presented and audited to levels of materiality;
- recognise the uncertainties inherent in the measurement of amounts based on the use of estimates, judgement and the consideration of future events; and
- will make reasonable economic decisions on the basis of the information in the financial statements.

8. Materiality and misstatements

Materiality (continued)

We consider materiality whilst planning and performing our audit based on quantitative and qualitative factors.

Whilst planning, we make judgements about the size of misstatements which we consider to be material and which provides a basis for determining the nature, timing and extent of risk assessment procedures, identifying and assessing the risk of material misstatement and determining the nature, timing and extent of further audit procedures.

The materiality determined at the planning stage does not necessarily establish an amount below which uncorrected misstatements, either individually or in aggregate, will be considered as immaterial.

We revise materiality for the financial statements as our audit progresses should we become aware of information that would have caused us to determine a different amount had we been aware of that information at the planning stage.

Our provisional materiality is set based on a benchmark of gross revenue expenditure at surplus/deficit level. We will identify a figure for materiality but identify separate levels for procedures designed to detect individual errors, and also a level above which all identified errors will be reported to the Performance, Audit and Risk Committee.

We consider that gross revenue expenditure at surplus/deficit level remains the key focus of users of the financial statements and, as such, we base our materiality levels around this benchmark.

We expect to set a materiality threshold at 2% gross revenue expenditure at surplus/deficit level. Based on the audited 2021/22 financial statements we anticipate the overall materiality for the year ending 31 March 2023 to be in the region of £4.0 million.

After setting initial materiality, we continue to monitor materiality throughout the audit to ensure that it is set at an appropriate level.

Performance Materiality

Performance materiality is the amount or amounts set by the auditor at less than materiality for the financial statements as a whole to reduce, to an appropriately low level, the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole. For a first-year audit, our initial assessment of performance materiality, based on low inherent risk, means that we have applied 70% of overall materiality as performance materiality.

Misstatements

We accumulate misstatements identified during the audit that are other than clearly trivial. We set a level of triviality for individual errors identified (a reporting threshold) for reporting to the Performance, Audit and Risk Committee that is consistent with the level of triviality that we consider would not need to be accumulated because we expect that the accumulation of such amounts would not have a material effect on the financial statements. Based on our preliminary assessment of overall materiality, our proposed triviality threshold is £123,000 based on 3% of overall materiality. If you have any queries about this please do not hesitate to raise these with Tom Reid.

Reporting to Performance, Audit and Risk Committee

The following three types of audit differences above the trivial threshold will be presented to the Audit and Performance Committee:

- summary of adjusted audit differences;
- summary of unadjusted audit differences; and
- summary of disclosure differences (adjusted and unadjusted).

A

Appendices

A: Key communication points

B: Revised auditing standard on Identifying and assessing the risks of material misstatement: ISA (UK) 315 (Revised 2019)

Appendix A: Key communication points

We value communication with Those Charged With Governance as a two way feedback process at the heart of our client service commitment. ISA 260 (UK) 'Communication with Those Charged with Governance' and ISA 265 (UK) 'Communicating Deficiencies In Internal Control To Those Charged With Governance And Management' specifically require us to communicate a number of points with you.

Relevant points that need to be communicated with you at each stage of the audit are outlined below.

Form, timing and content of our communications

We will present the following reports:

- Audit Strategy Memorandum;
- Annual Audit Report.

These documents will be discussed with management prior to being presented to yourselves and their comments will be incorporated as appropriate.

Key communication points at the planning stage as included in this Audit Strategy Memorandum

- Our responsibilities in relation to the audit of the financial statements.
- The planned scope and timing of the audit.
- Significant audit risks and areas of management judgement.
- Our commitment to independence.
- Responsibilities for preventing and detecting errors;
- Materiality and misstatements; and
- Fees for audit and other services.

Key communication points at the completion stage to be included in our Annual Audit Report

- Significant deficiencies in internal control.
- Significant findings from the audit.
- Significant matters discussed with management.
- Significant difficulties, if any, encountered during the audit.
- Qualitative aspects of the entity's accounting practices, including accounting policies, accounting estimates and financial statement disclosures.
- Our conclusions on the significant audit risks and areas of management judgement.
- Summary of misstatements.
- Management representation letter.
- Our proposed draft audit report.
- Independence.

Appendix A: Key communication points

ISA (UK) 260 ‘Communication with Those Charged with Governance’, ISA (UK) 265 ‘Communicating Deficiencies In Internal Control To Those Charged With Governance And Management’ and other ISAs (UK) specifically require us to communicate the following:

Required communication	Where addressed
Our responsibilities in relation to the financial statement audit and those of management and those charged with governance.	Audit Strategy Memorandum
The planned scope and timing of the audit including any limitations, specifically including with respect to significant risks.	Audit Strategy Memorandum
With respect to misstatements: • uncorrected misstatements and their effect on our audit opinion; • the effect of uncorrected misstatements related to prior periods; • a request that any uncorrected misstatement is corrected; and • in writing, corrected misstatements that are significant.	Annual Audit Report
With respect to fraud communications: • enquiries of the Performance, Audit and Risk Committee to determine whether they have a knowledge of any actual, suspected or alleged fraud affecting the entity; • any fraud that we have identified or information we have obtained that indicates that fraud may exist; and • a discussion of any other matters related to fraud.	Annual Audit Report and discussion at the Performance, Audit and Risk Committee, audit planning and clearance meetings

Appendix A: Key communication points

Required communication	Where addressed
Significant matters arising during the audit in connection with the entity's related parties including, when applicable: • non-disclosure by management; • inappropriate authorisation and approval of transactions; • disagreement over disclosures; • non-compliance with laws and regulations; and • difficulty in identifying the party that ultimately controls the entity.	Annual Audit Report
Significant findings from the audit including: • our view about the significant qualitative aspects of accounting practices including accounting policies, accounting estimates and financial statement disclosures; • significant difficulties, if any, encountered during the audit; • significant matters, if any, arising from the audit that were discussed with management or were the subject of correspondence with management; • written representations that we are seeking; • expected modifications to the audit report; and • other matters, if any, significant to the oversight of the financial reporting process or otherwise identified in the course of the audit that we believe will be relevant to the Audit and Performance Committee in the context of fulfilling their responsibilities.	Annual Audit Report
Significant deficiencies in internal controls identified during the audit.	Annual Audit Report
Where relevant, any issues identified with respect to authority to obtain external confirmations or inability to obtain relevant and reliable audit evidence from other procedures.	Annual Audit Report

Appendix A: Key communication points

Required communication	Where addressed
Audit findings regarding non-compliance with laws and regulations where the non-compliance is material and believed to be intentional (subject to compliance with legislation on tipping off) and enquiry of the Performance, Audit and Risk Committee into possible instances of non-compliance with laws and regulations that may have a material effect on the financial statements and that the Performance, Audit and Risk Committee may be aware of.	Annual Audit Report and Performance, Audit and Risk Committee meetings
With respect to going concern, events or conditions identified that may cast significant doubt on the entity's ability to continue as a going concern, including: • whether the events or conditions constitute a material uncertainty; • whether the use of the going concern assumption is appropriate in the preparation and presentation of the financial statements; and • the adequacy of related disclosures in the financial statements.	Annual Audit Report
Reporting on the valuation methods applied to the various items in the annual financial statements including any impact of changes of such methods	Annual Audit Report
Indication of whether all requested explanations and documents were provided by the entity	Annual Audit Report

Appendix B: Revised auditing standard on Identifying and assessing the risks of material misstatement: ISA (UK) 315 (Revised 2019)

Background

ISA (UK) 315 (Revised 2019) introduces major changes to the auditor's risk identification and assessment approach, which are intended to drive a more focused response from auditors undertaking work to obtain sufficient appropriate audit evidence to address the risks of material misstatement. The new standard is effective for periods commencing on or after 15 December 2021 and therefore applies in full for the IJB's 2022/23 audit.

The most significant changes relevant to the IJB's audit are outlined below.

Enhanced risk identification and assessment

The standard has enhanced the requirements for the auditor to understand the audited entity, its environment and the applicable financial reporting framework in order to identify and assess risk based on inherent risk factors which include:

- subjectivity;
- complexity;
- uncertainty and change; and
- susceptibility to misstatement due to management bias or fraud.

Using these inherent risk factors, we assess inherent risk on a spectrum, at which the higher end of which lies significant risks, to drive an audit that is more focused on identified risks. Auditors are now also required to obtain sufficient, appropriate evidence from these risk identification and assessment procedures which means documentation and evidence requirements are also enhanced.

Greater emphasis on understanding IT

In response to constantly evolving business environments, the standard places an increased emphasis on the requirements for the auditor to gain an understanding of the entity's IT environment to better understand the possible risks within an entity's information systems. As a result, we are required to gain a greater understanding of the IT environment, including IT general controls (ITGCs).

Increased focus on controls

Building on the need for auditors to gain a greater understanding of the IT environment, the standard also widens the scope of controls that are deemed relevant to the audit. We are now required to broaden our understanding of controls implemented by management, including ITGCs, as well as assess the design and implementation of those controls.

Tom Reid (Audit Director)

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Mazars is an internationally integrated partnership, specialising in audit, accountancy, advisory, tax and legal services*. Operating in over 90 countries and territories around the world, we draw on the expertise of 40,400 professionals – 24,400 in Mazars' integrated partnership and 16,000 via the Mazars North America Alliance – to assist clients of all sizes at every stage in their development.

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East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 04.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20th JUNE 2023**
REPORT REFERENCE:	**PERF/200623/04**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER, TELEPHONE NUMBER, 0141 232 8216**
SUBJECT TITLE:	**UNAUDITED ANNUAL ACCOUNTS 2022-2023**

1.0 PURPOSE

1.1 The purpose of this report is to update the Committee on the financial out turn for 2022/23 and present the Unaudited Annual Accounts for the year ended 31st March 2023.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit and Risk Committee:

2.1 Note and approve the Unaudited Accounts for 2022/23 included as **Appendix 1.**
2.2 Approve the Annual Governance Statement included within the Unaudited Accounts at **page 41.**
2.3 Approve the local code of governance against which the IJB will measure itself in the Annual Governance Statement for 2022/23 set out in **Appendix 2.**
2.4 Note and approve the self-assessment against the Scottish Government's best value framework set out in **Appendix 3.**
2.5 Note and approve the assessment of compliance for the IJB against the requirements of the CIPFA Financial Management code set out in **Appendix 4.**

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3 BACKGROUND/MAIN ISSUES

3.1 The IJB is specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Local Authority Accounts (Scotland) Regulations 2014.

3.2 This will be the eighth set of Annual Report and Accounts produced for the HSCP Board.

3.3 LASAAC [The Local Authority (Scotland) Accounts Advisory Committee] has produced additional guidance on accounting for the integration of health and social care. The 2022/23 annual accounts for the IJB will be prepared in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom (ACOP) and requirement of the International Financial Reporting Standards (IFRS). The ACOP seeks to achieve comparability of financial performance across all IJB's and therefore prescribes the format to be used in presenting income and expenditure information.

3.4 Audit Scotland have also produced a good practice note on improving IJB Accounts and this has been reviewed in preparing the annual report and accounts.

3.5 The regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately following the financial year to which they relate. The IJB or committee whose remit includes audit and governance must meet to consider the unaudited annual accounts as submitted to the external auditor no later than the 31st August immediately following the financial year to which the annual accounts relate.

3.6 Scottish Government guidance states that best practice would reflect that the IJB or committee whose remit includes audit and governance should consider the unaudited accounts prior to submission to the external auditor.

3.7 Regulation 9 of the Local Authority (Scotland) Regulations 2014 provides the right to inspect and object to the accounts. The inspection period will commence no later than the 1st July in the year the notice is published.

3.8 The IJB is responsible for ensuring that its business is conducted in accordance with the law appropriate to standing, safeguarding public funds and assets and making arrangements to ensure best value. In order to demonstrate this, an annual governance statement is produced each year and included with the Annual Accounts. The IJB is required to review the effectiveness of the control environment annually and these feature in the annual governance statement.

3.9 Approval of Audited Accounts

- The regulations require that the audited annual accounts should be considered and approved by the IJB or a committee of the IJB whose remit includes audit and governance having regard to any report made on the audited annual accounts by the proper officer or external auditor by the 30 September immediately following the financial year to which the accounts relate. In addition, any further report by the external auditor on the audited annual accounts should also be considered by the IJB or committee of the IJB whose remit includes audit and governance.

- The Performance, Audit & Risk Committee would normally consider the external auditors report and proposed audit certificate (ISA 260 report) prior to inclusion in the audited annual accounts.

- In order to comply with the regulations, the ISA260 and a copy of the audited annual accounts, would be considered by the Performance, Audit & Risk Committee prior to the 30 September in the year immediately following the financial year to which they relate.

3.10 The regulations require a number of key documents (within the annual accounts) to be signed by the Chair of the IJB, the Chief Officer and the Chief Financial Officer, namely:

Management Commentary / Foreword	Chair of the IJB Chief Officer
Statement of Responsibilities	Chair of the IJB Chief Financial & Resources Officer
Annual Governance Statement	Chair of the IJB Chief Officer
Remuneration Report	Chair of the IJB Chief Officer
Balance Sheet	Chief Financial & Resources Officer

3.11 Publication of Audited Accounts

- The regulations require that the annual accounts of the IJB be available in both hard copy and on the website for at least five years together with any further reports provided by the external auditor that relate to the audited accounts.

- The annual accounts of the IJB must be published by 31st October.

3.12 Year End Financial Performance

The Annual Accounts provide an overview of the financial performance of the IJB in 2022/23. The main messages from the Annual Accounts in relation to the financial performance of the HSCP during 2022/23 are:

- The Comprehensive Income and Expenditure Statement (CIES) (see page 47 of the Unaudited Accounts 2022/23) describes expenditure and income by care group across the IJB and shows an over spend of £6.928m against the partnership funding available for 2022/23. Adjusting this position for in year movements in reserves provides an underlying positive variance on budget of £4.387m for 2022/23 which represents operational service delivery for the year

and has been reported throughout the year to the IJB through regular revenue monitoring updates.

- The financial performance on the partnership budget against the allocation from each partnership agency is set out below:

Partner Agency	Annual Budget 2022/23 £000	Actual Expenditure 2022/23 £000	Year End Variance 22/23 £000	Reserves Adjustment £000	Underlying Variance - Mth 12 (£000)
East Dunbartonshire Council	71,437	77,737	(6,301)	9,480	3,179
NHS GG&C	137,042	137,670	(628)	1,836	1,208
TOTAL	208,479	215,407	(6,928)	11,316	4,387

- This has reduced the overall reserves position for the HSCP from a balance of £26.990m at the year ending 31 March 2022 to that of a balance of £20.062m as at year ending 31 March 2023 (as detailed in the reserves statement on page 48 of the Unaudited Accounts 2022/23.)

- The CIES includes £2.930m of expenditure related to the impact from Covid-19. Costs were covered through HSCP earmarked reserves, held for this specific purpose. The balance of reserves of £7.034m was returned to SG in the financial year to be redistributed across the sector to meet current Covid-19 priorities. The mechanism by which the funds were returned resulted in the contribution from NHSGG&C being reduced by this amount.

The main reasons for the variances to budget for the HSCP during the year are set out below:

- **Mental Health, Learning Disability, Addiction Services, Health Improvement (£0.255m under spend) -** the overall variance relates to pressures in relation to increased taxi provision (as opposed to use of fleet transport) to support SW service users to access services, loss of income from charging due to numbers attending day services and in receipt of non-residential services not resuming to pre covid levels. This is offset by the numbers of care packages not resuming to pre covid levels anticipated at the time of setting the Budget for 2022/23, vacancies, ongoing recruitment and retention issues across nursing and psychology posts within MH and LD health services.

- **Community Health and Care Services – Older People / Physical Disability (underspend of £3.616m) –** there continued to be reduced levels of care home placements, supported living packages and care at home services purchased from the external market from that assumed at the time of setting the budget, due to the continuing impacts of Covid-19. Numbers are continuing to recover to more normalised levels. This mitigates pressures within the in-house care at home service and pressures in relation to equipment to support people to remain at home along with additional adult winter planning funding to increase capacity in this area. SG funding was made available in year for Adult winter planning which was not fully spent in year due to ongoing recruitment challenges in filling posts. This will be taken to earmarked reserves.

This also includes the refund of monies of £1.1m related to charges for continuing care beds within Fourhills Care Home dating back to 1st April 2019 (£0.3m related to 19/20, £0.4m related to 20/21 and £0.4m related to 21/22).

- **Children and Criminal Justice Services (underspend of £0.663m) –** there continued to be recruitment and retention challenges across Children's services for the year. There was also reductions in external fostering and residential childcare placements as children move onto positive destinations. There continue to be pressures in relation to Unaccompanied Asylum Seeking Children (USAC) where placements within in house provision is at capacity and will require the purchase of externally purchased placements to accommodate these children.

- **Housing Aids and Adaptations and Care of Gardens (underspend of £0.308m) -** there are a number of other budgets delegated to the HSCP related to private sector housing grants, care of gardens and fleet provision. These services are .delivered within the Council through the Place, Neighbourhood and Corporate Assets Directorate – there has been a continuing underspend in relation to fleet recharges related to a downturn in transport provision needed as a consequence of Covid and a reduction in services requiring this type of transport. This is compounded by underspends across the care and repair service and private sector housing grants.

- **Prescribing (overspend of £0.932m) -** pressures in relation to price and volume increases across a range of medicines have been reported throughout the financial year which has resulted in an adverse variance in this area. A number of initiatives are in development to target the volume and types of prescriptions dispensed such as script-switch, review of use of formulary vs non formulary, waste reduction, repeat prescription practices. Prices across the market will continue due to global factors outwith the control of the HSCP, however use of alternative medicines will form part of the programme of initiatives being rolled out across East Dunbartonshire and more widely across GG&C.

- **Oral Health (overspend of £1.025m) -** the overspend relates to expenditure incurred in year on temporary staffing to address winter pressures and ventilation and equipment purchases in support of recovery of services following the pandemic to be funded from earmarked reserves set aside for this purpose. This was offset by some delays in filling vacancies during the year.

- **Covid Expenditure (overspend of £9.964m)** – there was expenditure related to Covid-19 during the year of £2.930m and the return of un-used reserves to SG of £7.034m. This expenditure will be met entirely from HSCP earmarked reserves held for this purpose.

3.13 HSCP Reserves

- As at the 1 April 2022, the HSCP had a general (contingency) reserves balance of £3.1m. The surplus on operational service delivery generated during 2022/23 (£4.387m) will allow the HSCP to further that reserve in line with the HSCP Reserves Policy. This will provide the HSCP with some financial sustainability into future years and an ability to manage in year unplanned events and afford a contingency to manage budget pressures without the need to resort to additional partner contributions as a means of delivering a balanced budget.

- The performance of the budget during 2022/23 supports the HSCP in the enhancement of a reserve to support the redesign of accommodation by a further £1m. This will increase the reserve already available to £3m to support the HSCP in delivery of its strategic priorities, primarily related to the delivery of the primary care improvement programme, moving services currently delivered within acute settings to local communities, such as Phlebotomy, and additional space to accommodate increased staffing capacity in response to Adult Winter Planning monies, adult social work capacity funding. In addition it will facilitate the creation of a digital redesign programme of £0.5m in response to the outcome of a national digital maturity assessment and the work already underway as a result of the Covid-19 pandemic where resort to digital platforms moved forward significantly and needs ongoing investment to maintain and develop further. At its meeting in March 2023, the IJB approved the use of an element of contingency reserves to create a smoothing reserve to underwrite the delivery of the savings programme for 2023/24 of £0.594m and also to enhance the prescribing reserve by £1m to mitigate anticipated pressures related to increased price and volume demands during 2023/24. This provides a remaining balance on general reserves of £4.371m.

- IJB's are empowered under the Public Bodies (Joint Working) Scotland Act 2014 (section 13) to hold reserves and recommends the development of a reserves policy and reserves strategy. A Reserves policy was approved by the IJB on the 11 August 2016. This provides for a prudent reserve of 2% of net expenditure (less Set Aside) which equates to approximately £3.8m for the partnership. The level of general reserves is in line with this prudent level and provides the partnership with a contingency to manage any unexpected in year pressures moving into future years of financial uncertainty.

- While contingency reserves have increased during 2022/23, there has been a net reduction in the level of earmarked reserves from £23.912m to £15.691m with the application of reserves in year to deliver on specific strategic priorities. During 2022/23, the HSCP used £12.891m of its earmarked reserves. In the main this related to the application of £2.930m towards Covid-19 expenditure incurred in year, the return of £7.034m to SG of the balance of Covid reserves as well as the use of reserves to support expenditure related to the delivery of PCIP, Action 15 and Oral Health priorities. There were some additions to earmarked reserves in year of £1.576m (related primarily to ADP, Adult Winter Support Funding and Community Link workers) along with the creation / enhancement of earmarked reserves as set out above totalling ££3.094m provides for an overall net reduction in earmarked reserves for the year of £8.221m. This will leave a balance on earmarked reserves of £15.691m.

- A breakdown of the HSCP earmarked reserves is set out in note 10, page 56 of the Unaudited Accounts 2022/23.

- The total level of partnership reserves is now £20.062m as set out in the table on page 48 of the Unaudited Accounts 2022/23.

3.14 A copy of the Draft Annual Accounts 2022/23 including the Annual Governance Statement is attached as **Appendix 1.**

3.15 Delivering Good Governance Framework

In April 2016, CIPFA / SOLACE published a report entitled 'Delivering Good Governance in Local Government: Framework'. The objective of this framework is to help local government in taking responsibility for developing and shaping an informed approach to governance, aimed at achieving the highest standards in a measured and proportionate way. This document is written in a local authority context, however most of the principles are applicable to the IJB, particularly as the legislation recognises the partnership (IJB) body as a local government body under Part V11 of the Local Government (Scotland) Act 1973.

3.16 A review has been undertaken and a compliance rating attributed to each principle. A summary of this is set out below with the detailed assessment included as **Appendix 2**. Many of the assurances are reliant on documents which belong to NHS GG&C and East Dunbartonshire Council which is appropriate given decisions taken by the IJB require being taken in collaboration with partner organisations.

Governance Principle	Level of Compliance
Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of the law.	Fully Compliant
Ensuring openness and comprehensive stakeholder engagement.	Fully Compliant
Defining outcomes in terms of sustainable economic, social and environmental benefits	Fully Compliant
Determining the interventions necessary to optimise the achievement of intended outcomes.	Fully Compliant
Developing the entity's capacity, including the capability of its leadership and individuals within it.	Fully Compliant
Managing risk and performance through robust internal control and strong public financial management	Fully Compliant
Implementing good practices in transparency, reporting and audit to deliver effective accountability	Fully Compliant

3.17 Best Value Framework

In terms of best value, it is the duty of the IJB to secure best value as prescribed in Part 1 of the Local Government in Scotland Act 2003. The Scottish Government have developed a best value framework to support public bodies in considering their responsibilities to secure best value, the partnership has assessed itself against this framework and this is reviewed and updated annually. This is set out in **Appendix 3.**

3.18 CIPFA Financial Management Code

CIPFA has published a new Financial Management Code which is designed to support good practice in financial management and to assist local authorities in demonstrating their financial sustainability.

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

The underlying principles which inform the code are outlined below:-

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

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

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

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

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

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

The IJB is compliant with the Financial Management Code and this is set out in detail in **Appendix 4**. This highlights some areas for development which will be progressed in the coming months.

4 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022 - 2025;-

1. Empowering People
2. Empowering Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery
7. Post-pandemic Renewal
8. Maximising Operational Integration

10 (Key Enabler) Medium Term Financial and Strategic Planning. The Unaudited Annual Accounts reflect the partnership performance for the year passed and detail the reserves position to contribute to the strategic priorities for the partnership. The assessment against the CIPFA Financial Management Code determines the IJB compliance across a range of measures in support of financial sustainability.

4.2 Frontline Service to Customers – None.

4.3 Workforce (including any significant resource implications) – None.

4.4 Legal Implications – The Unaudited Annual Accounts form part of the Local Authority Accounts (Scotland) Regulations 2014. The Financial Management Code is a series of financial management standards which set out the professional standards needed if an IJB is to meet the minimal standards of financial management acceptable to meet fiduciary duties to taxpayers and customers. Since these are minimum standards CIPFA's judgement is that compliance with them is obligatory if an IJB is to meet its statutory responsibility for sound financial administration. Beyond that, CIPFA members must comply with it as one of their professional obligations.

4.5 Financial Implications – The annual accounts set out the financial performance of the IJB for the year 2022/23. The financial implications and performance are set out within this report. The financial performance reflects an underlying under spend on budget of £4.387m for the financial year 2022/23. This will further the general reserve balances in line with the HSCP Reserves Policy to provide a contingency to manage in year pressures and support ongoing financial sustainability. It will also facilitate the creation of reserves to support progression of HSCP strategic priorities and mitigate specific anticipated future year pressure in relation to the delivery of the savings programme for 23/24 and prescribing pressures. In addition the HSCP holds earmarked reserves of £15.7m to deliver on specific strategic priorities set out within the Strategic Plan 2022-2025 in the years ahead.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Economic Impact – None

4.9 Sustainability – The sustainability of the partnership in the context of the current financial position and potential to create general reserves will support ongoing financial sustainability. In order to maintain this position the HSCP will require to continue to focus on transformational change and service redesign going forward in order to meet the financial challenges and deliver within the financial framework available to the partnership on a recurring basis. There remain constraints on future financial settlements in the context of increasing costs to deliver services and the increasing demand on health and social care services. The Financial Management Code has been developed to support organisations to maintain financial management standards which will assist with an organisation remaining financial sustainable.

4.10 Equalities Implications – None

4.11 Other – None.

5 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 There are a number of financial risks moving into future years given the rising demand and cost pressures in the context of reducing budgets which will require effective financial planning and service redesign to ensure financial balance as we move forward.

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

6 IMPACT

6.1 **STATUTORY DUTY** – The IJB is specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Local Authority Accounts (Scotland) Regulations 2014.

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The reliance on identification of service redesign and transformation activity to deliver a balanced budget will require strong collaborative working to achieve a year on year balanced budget for the HSCP.

6.3 **NHS GREATER GLASGOW & CLYDE** - The reliance on identification of service redesign and transformation activity to deliver a balanced budget will require strong collaborative working to achieve a year on year balanced budget for the HSCP.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction required.

7 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8 APPENDICES

8.1 **Appendix 1** – HSCP Unaudited Accounts 2022/23
8.2 **Appendix 2** – Delivering Good Governance Framework
8.3 **Appendix 3** – Best Value Framework
8.4 **Appendix 4** – CIPFA Financial Management Code – Self Assessment and Action Plan

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Integration Joint Board

Unaudited Annual Accounts 2022/23

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

MANAGEMENT COMMENTARY

Introduction

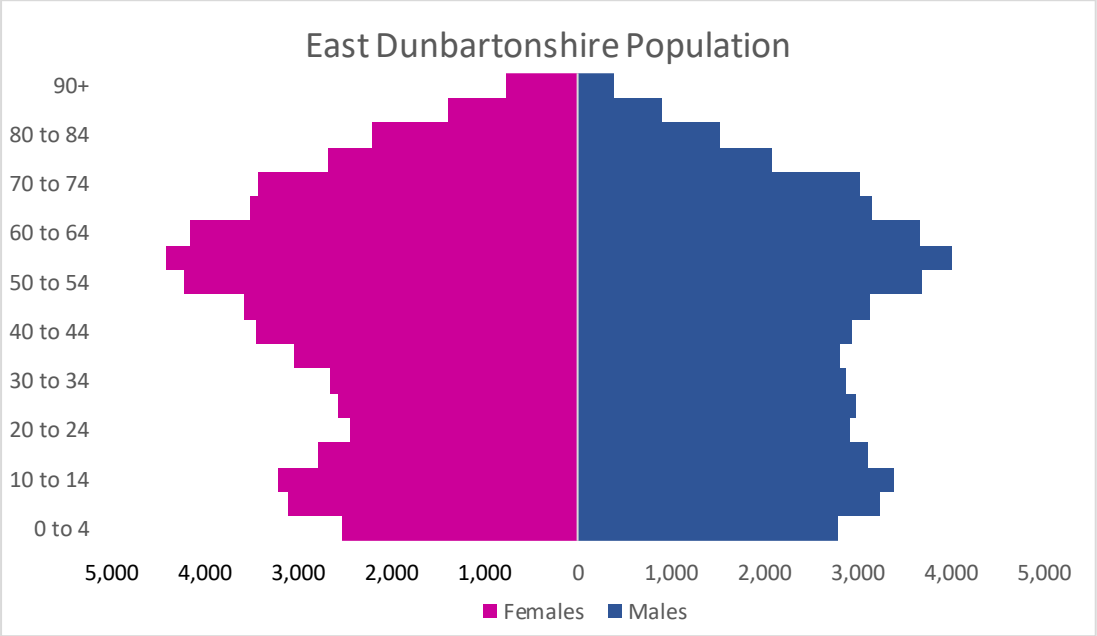
This document contains the financial statements for the 2022/23 operational year for East Dunbartonshire Integration Joint Board.

The management narrative outlines the key issues in relation to the HSCP financial planning and performance and how this has provided the foundation for the delivery of the priorities described within the Strategic Plan. The document also outlines future financial plans and the challenges and risks that the HSCP will face in meeting the continuing needs of the East Dunbartonshire population.

East Dunbartonshire

East Dunbartonshire has a population of approximately 108,900 (based on 2021 estimates, an increase of 0.1% on 2020 estimates) and is a mix of urban and rural communities. It has frequently been reported in quality of life surveys as one of the best areas to live in Scotland based on people's health, life expectancy, employment and school performance. Economic activity and employment rates are high and the level of crime is significantly below the Scottish average. Despite this, inequalities exist across the authority and there are pockets of deprivation where the quality of life falls well below the national average. The graph below shows how the population is split by gender:

Diagram 1: East Dunbartonshire Population Split by Gender



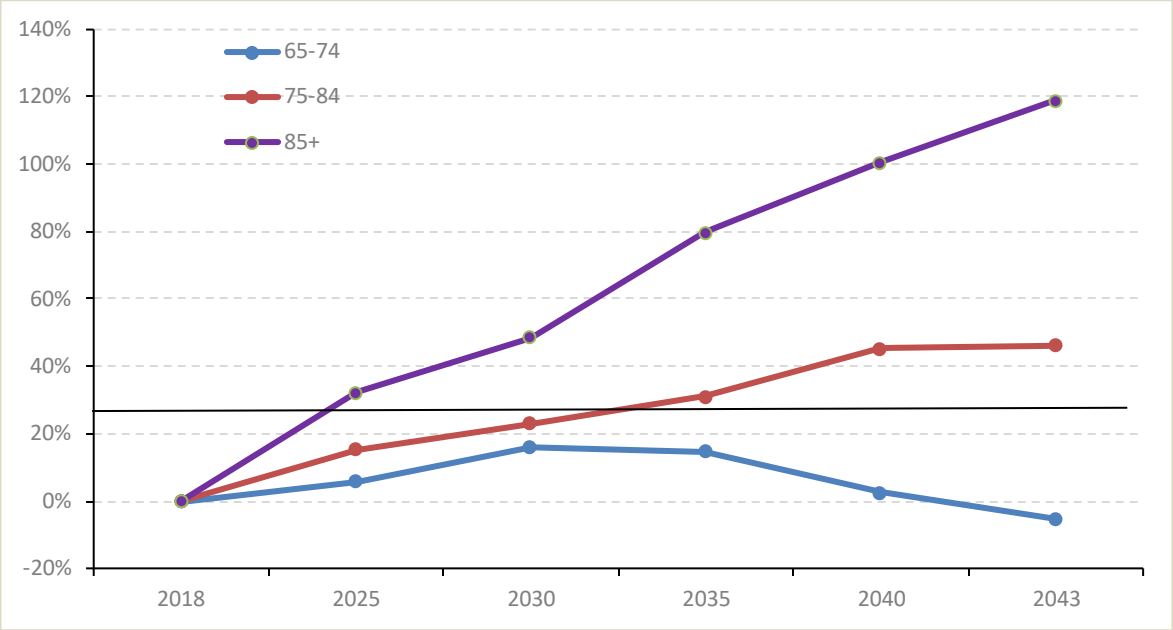
Source: NRS 2021 mid-year population estimate

The National Records of Scotland (NRS) population projections suggest there will be an increase of 7.6% in the overall population of East Dunbartonshire from 2018 – 2043 due to significant estimated rise in the population aged over 65 years.

The figure below shows the proportion of increase projected in the older population from 2018-2043. The largest increase is in individuals aged over 85yrs, which is projected to rise by over 100% from 3,203 to 7,017 people. This projected rise in East Dunbartonshire's older population,

many of whom will be vulnerable with complex needs, suggests that demand for health and social care services will rise accordingly.

Diagram 2: East Dunbartonshire population projection % by age group 2018-2043



The demographic pressures for older people present particular challenges within East Dunbartonshire.

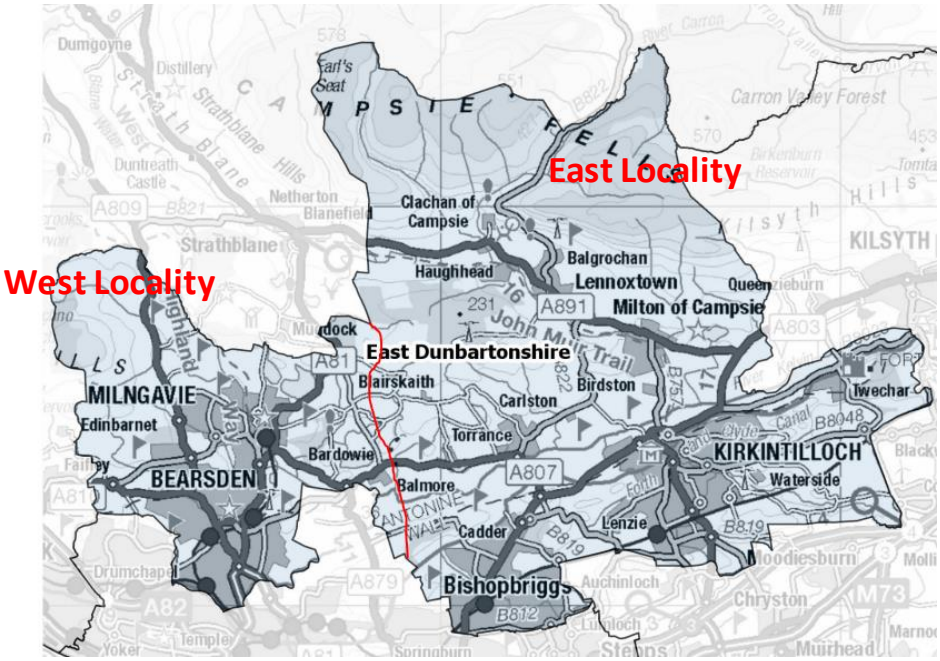
There has also been a significant increase in the number of children being referred to Social Work Services, with 40% increases in referrals reported in the Integrated Children's Services Plan. Non-engaging families was the most common area of concern alongside neglect, domestic violence and parental alcohol misuse. Child Protection registrations have doubled in the 10 years to 2018. There has also been a sharp rise in parental mental health being identified as a significant concern. This is an area of cross-cutting focus between children and adult services.

Demand on services for other adult care groups and for children's disability services has also increased. The number of young people with disabilities transitioning to adult services is experiencing a notable increase, both numerically and in terms of complexity. This can be demonstrated by an anticipated increase in the Adult Joint Learning Disability Team over the next three years as children move on into adult services equivalent to over 7% of its total caseload.

Localities

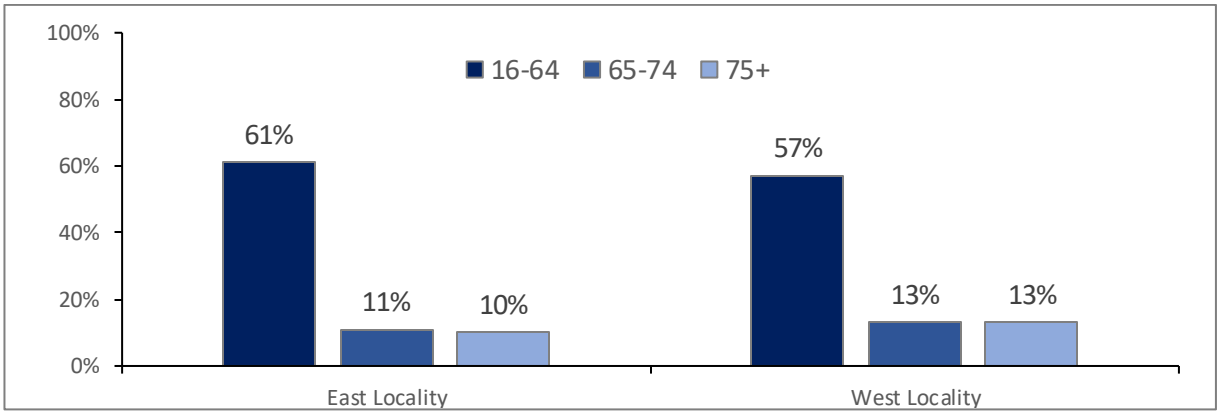
To allow the HSCP to plan and deliver services which meet the differing needs within East Dunbartonshire, the area has been split into two geographical localities; East Dunbartonshire (East), referred to as East locality and East Dunbartonshire (West), referred to as West locality.

Diagram 3: East Dunbartonshire Locality Map



The East Locality includes 62% (66,911) of East Dunbartonshire's population, while the West Locality accounts for 38% (41,729) of the population. The demographic breakdown by locality showed a slightly older population in the West locality for ages 65+.

Diagram 4: Population breakdown by locality 2019



Life Expectancy

The NRS publication showed that East Dunbartonshire continued to have the second highest life expectancy at birth in Scotland for males and females. The life expectancy of females at birth in East Dunbartonshire is around 3 years higher than males. Life expectancy at the age of 65 years was also higher than Scotland for both male and females in East Dunbartonshire.

Life expectancy and healthy life expectancy provide useful measures for planning services. Healthy life expectancy estimates the number of years an individual will live in a healthy state. Therefore, the number of years people are expected to live in 'not healthy' health is the difference between life expectancy and healthy life expectancy. Table 1 shows the number of years people

were estimated to live in 'not healthy' health, with East Dunbartonshire having a lower estimate than Scotland.

Diagram 5: Number of years 'not healthy' health (3-year average 2019-21)

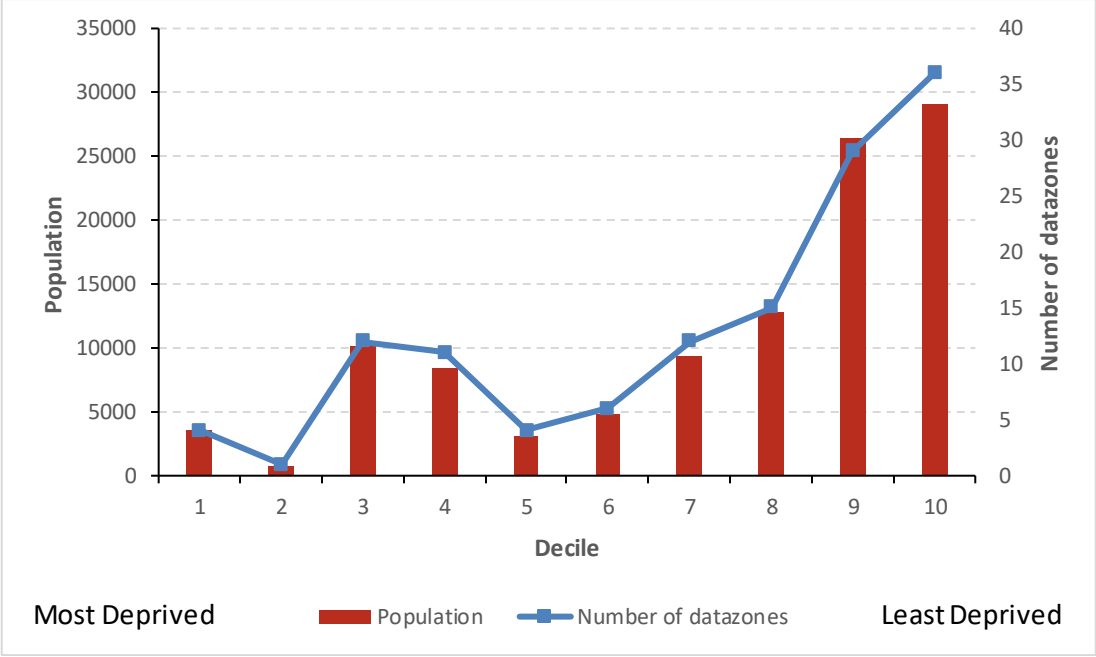
Local Authority	Expected period in 'not healthy' health	
	Males	Females
East Dunbartonshire	13.6	17.9
Scotland	16.1	20.7

Source: NRS

Deprivation

The Scottish Index of Multiple Deprivation (SIMD) ranked datazones, small areas with an average population of 800 people, from the most deprived to the least deprived. Using deciles, with 1 being the most deprived and 10 being least deprived, the chart below illustrates the number of people and datazones in each decile in East Dunbartonshire.

Diagram 6: East Dunbartonshire population by SIMD decile



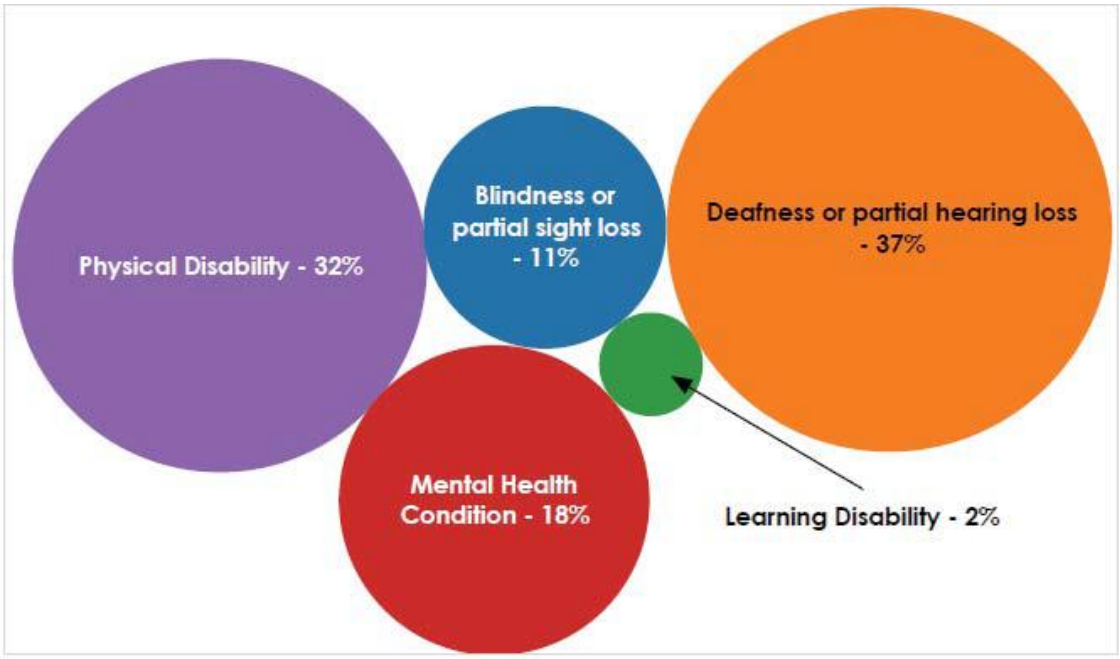
Although the majority of the population lived in the least deprived deciles', there were 4 datazones areas in East Dunbartonshire categorised amongst the most deprived in Scotland, three in the Hillhead area of Kirkintilloch and one in Lennoxtown.

Population Health

In the Census in 2011 (the 2021 census has been delayed until 2022), 84.9% of East Dunbartonshire residents described their health as good or very good (Scotland 82.2%). This was the highest at 98% among the younger population (0-29yrs) but the percentage decreased with age to only 62% of those aged 75yrs and above describing their health as good or very good. In the West Locality, 66% of people aged 65yrs and above described their health as good or very good, compared to 57% in the East Locality.

The 2011 Census included a question on particular disabilities including sensory impairment, physical disability, mental health condition or learning disability. There were 5.6% of the adult population in East Dunbartonshire who reported a disability (Scotland 6.7%).

Diagram 7: Reported Disability by Percentage in East Dunbartonshire



The number of long term conditions rises with age and we need to support those with complex needs so that they may manage their conditions and lead an active, healthy life. The most diagnosed long term condition in East Dunbartonshire is hypertension. The prevalence for this condition, cancer and atria fibrillation, are all notably higher than the rate for Scotland.

Analysis of the Burden of Disease study indicates that years of life lost to disability and premature mortality in East Dunbartonshire is the second lowest in Scotland. This is understood to be a reflection of relatively low deprivations levels across the authority as a whole. East Dunbartonshire experiences above average prevalence of Parkinson's certain cancers, certain respiratory diseases, certain digestive diseases, sensory conditions and self-harm (the latter for all ages).

The Health and Social Care Partnership

East Dunbartonshire HSCP is the common name of East Dunbartonshire Integration Joint Board and is a joint venture between NHSGGC and East Dunbartonshire Council. It was formally established in September 2015 in accordance with the provisions of the Public Bodies (Joint Working) (Scotland) Act (2014) and corresponding Regulations in relation to a range of adult health and social care services. The partnership's remit was expanded from an initial focus on services for adults and older people to include services for children and families, and criminal justice services in August 2016.

The HSCP Board, East Dunbartonshire Council (EDC) and NHS Greater Glasgow and Clyde (NHSGGC) aim to work together to strategically plan for and provide high quality health and social care services that protect children and adults from harm, promote independence and deliver positive outcomes for East Dunbartonshire residents.

East Dunbartonshire HSCP Board has responsibility for the strategic planning and operational oversight of a range of health and social care services whilst EDC and NHSGGC retains

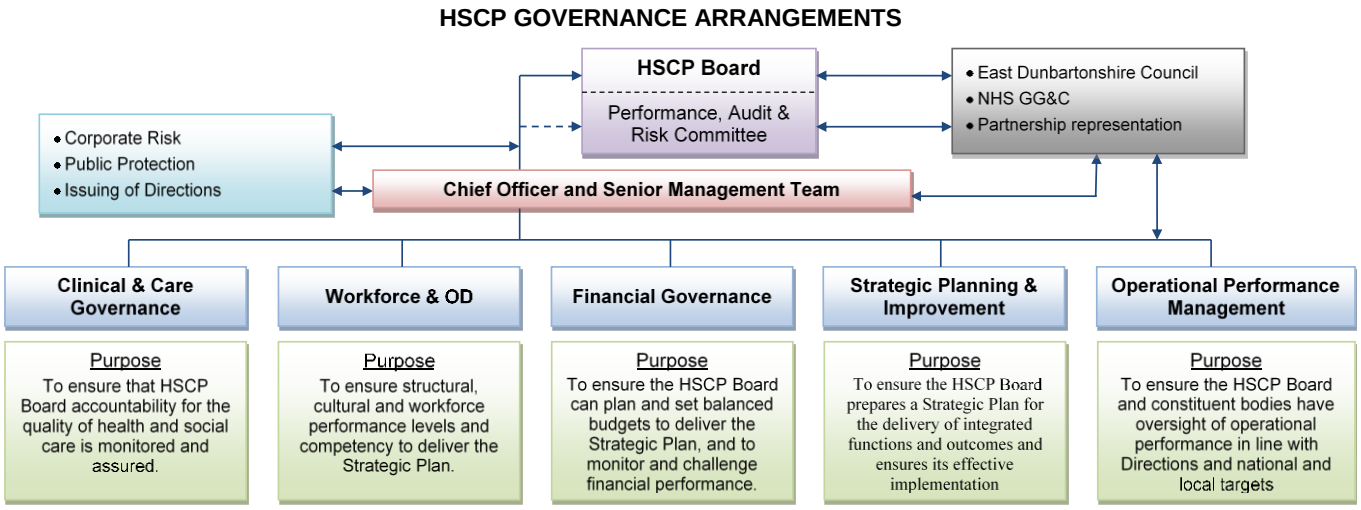
responsibility for direct service delivery of social work and health services respectively, as well as remaining the employer of health and social care staff. The HSCP Chief Officer is responsible for the management of planning and operational delivery on behalf of the Partnership overall.

Members of the Board for the period 1 April 2022 - 31 March 2023 were as follows:

Voting Board Members 2022/23	Organisation
Jacqueline Forbes (Chair from 25 June 2021)	NHSGGC Non -Executive Director
Ian Ritchie	NHSGGC Non- Executive Director
Ketki Miles	NHSGGC Non-Executive Director
Calum Smith (Vice Chair from 23rd June 2022)	EDC Councillor
Susan Murray (board member from 26th May 2022)	EDC Councillor
Alan Moir	EDC Councillor
Jim Goodall (Vice Chair until end March 2022)	EDC Councillor
Sheila Mechan (board member until 26th May 2022)	EDC Councillor
Non-Voting Board Members	**Organisation**
Caroline Sinclair – Chief Officer/Chief Social Work Officer	EDC
Jean Campbell – Chief Finance and Resources Officer	NHSGGC
Paul Treon – Clinical Director until January 2023, post now vacant	NHSGGC
Leanne Connell – Interim Chief Nurse	NHSGGC
Adam Bowman – Acute Representative	NHSGGC
Ann Innes – Voluntary Sector Representative	East Dunbartonshire Voluntary Association
Gordon Cox – Service User Representative	
Fiona McManus – Carer Representative	
Allan Robertson – Trades union Representative	NHSGGC
Craig Bell – Trades Union Representative	EDC

Diagram 8 (below) HSCP Governance Arrangements

This represents accountability and governance arrangements for the planning and delivery of community health and social care services.



(This framework includes all delegated hosted services)

Our partnership vision remains unchanged - "Caring Together to make a Positive Difference" and is underpinned by 5 core values as set out below.

Diagram 9: Tree of Core Values

The Strategic Plan

Every HSCP Board is required to produce a Strategic Plan that sets out how they intend to achieve, or contribute to achieving, the National Health and Wellbeing Outcomes.

In January 2022, the HSCP Board approved a new HSCP Strategic Plan for the period 2022-25[1]. This new plan reflects on the progress the Partnership has made and sets out the strategic direction for the next three years. Our vision remains unchanged, and our refreshed strategic priorities continue to reflect and support delivery of the national outcomes. Demonstrating our achievement towards these will be the focus of annual performance reporting from this year.

However, it is important to acknowledge that the landscape of health and social care has changed markedly in the few short years since the last plan was published. Our aspiration to improve and develop services and partnerships in our 2018-21 Strategic Plan was affected significantly by financial pressures, which were shared with the Health Board and Council. This was compounded by increasing demand pressures, both in terms of increasing volume and increasing complexity of levels of care. The impact of the Covid-19 pandemic has been substantial and may continue to be felt over the full period of our Strategic Plan 2022-25.

For these reasons, our Strategic Plan 2022-25 has aspirations based on the realities of the pressures being faced in the health and social care sectors and building towards a fair, equitable, sustainable, modern and efficient approach to service delivery. Some of these areas of redesign will take longer than the period of the Strategic Plan to deliver. Without new resource streams, any requirement to invest further in one service area will require greater efficiency or disinvestment in another. Implementing the Plan will also continue to be based on certain assumptions and dependencies that can in reality be fragile. Our overall focus will be to:

- Invest in early intervention and prevention;
- Empower people and communities by encouraging more informal support networks at a local level;
- Ensure that people have access to better information earlier, to allow them to access the right support at the right time, from the right person.

These developments should deliver better outcomes for people and will also make for a more efficient, sustainable system of care and support.

The illustration below provides an overview of the Strategic Plan 2022-25. It shows the relationship between the strategic priorities and enablers and the actions that will be taken forward

in support of these. A copy of the Strategic Plan 2022-25 can be found on the HSCP Website: East Dunbartonshire Health and Social Care Partnership Board | East Dunbartonshire Council.

Diagram 10: HSCP Strategic Plan on a Page

EAST DUNBARTONSHIRE HSCP STRATEGIC PLAN ON A PAGE							
OUR VISION Caring Together To Make A Difference			OUR VALUES Honesty, Integrity, Professionalism, Empathy and Compassion, Respect				
Empowering People	**Empowering Communities**	**Prevention and Early Intervention**	**Public Protection**	**Supporting Families and Carers**	**Improving Mental Health and Recovery**	**Post Pandemic Renewal**	**Maximising Operational Integration**
Improving personalisation	Building informal support options	Extending rehabilitation and reablement	Prioritising our Key Public Protection Statutory Duties	Supporting carers with their own needs and in their caring role	Improving adult recovery services	Understanding and responding to the impact of the pandemic	Right Care Right Place: urgent and unscheduled health and social care redesign
Reducing inequality and inequity of outcomes	Building local integrated teams	Supporting diversion from prosecution		Implementing The Promise for children and young people	Improving mental health support for children and young people		
Improving information and communication	Modernising day services	Improving school nursing services		Strengthening corporate parenting	Improving post-diagnostic dementia support		Developing integrated quality management arrangements
Workforce and Organisational Development		**Medium Term Financial and Strategic Planning**		**Collaborative Commissioning and Whole System Working**		**Infrastructure and Technology**	
Supporting the wellbeing of the health and social care workforce		Maximising available resources		Co-designing solutions with the third and independent sectors		Modernising health and social care facilities	
Equipping the workforce and workplace during and after the pandemic		Balancing investment and disinvestment		Supporting primary care improvement		Maximising the potential of digital solutions	
Implementing a skills framework for supporting children's mental health and wellbeing		Delivering financial sustainability		Redesigning the Public Dental Service			
HSCP Improvement Plans		**Wider Partnership Improvement Plans**		**Council & Health Board Improvement Plans**		**Hosted Services Improvement Plans**	

It is predicted we will continue to see significant change in the make-up of our growing population, with an increase in people living longer with multiple conditions and complex needs who require health and social care services. This rise in demand is expected to increase pressure on financial resources, rendering current models of service delivery unsustainable. We have shaped this plan to move in a strategic direction that is responsive and flexible for the future.

This is further supported by a HSCP Annual Delivery Plan outlining the key priorities for service redesign and improvement in delivery of the Strategic Plan and is supported by a range of operational plans, work-streams and financial plans to support delivery. This is also the vehicle through which the HSCP will seek to deliver financial sustainability over the short to mediu m term by reconfiguring the way services are delivered within the financial framework available to it.

The Strategic Plan also links to the Community Planning Partnership's Local Outcome Improvement Plan (LOIP) whereby the HSCP has the lead for, or co-leads: Outcome 3 – "Our children and young people are safe, healthy and ready to learn",

- Outcome 5 – "Our people experience good physical and mental health and well being with access to a quality built and natural environment in which to lead healthier and more active lifestyles" and
- Outcome 6 – "Our older population and more vulnerable citizens are supported to maintain their independence and enjoy a high quality of life, and they, their families and carers benefit from effective care and support services".

The Strategic plan sets out Climate Change as one of the key challenges for the HSCP over the next few years.

Climate Action

All Public Bodies, including Health & Social Care Partnerships, are required by the Scottish Government to reduce greenhouse gas emissions, adapt to a changing climate and promote sustainable development. The HSCP's constituent bodies employ the HSCP workforce and hold capital, fleet and infrastructure, so responsibility sits primarily with East Dunbartonshire Council and NHS Greater Glasgow and Clyde, with the HSCP adhering to the policies of these two organisations. The HSCP will contribute to carbon reduction over the period of the Strategic Plan by:

- Reducing business miles;
- Developing localised services;
- Promoting flexible working policies;
- Reducing waste, and;
- Maximising energy efficiency.

The Strategic Priorities and Enablers will be geared to contribute to these objectives, particularly through the following actions:

Strategic Priority	Action	Reducing Climate Impact
Empowering Communities	Building local integrated teams	Reducing travelling costs for staff, by operating within practice localities and collaborating closely with primary care GP practices.
	Modernising day services	Providing support within existing community assets, so reducing scale of building-based services with associated environmental impact.
Strategic Enabler	**Action**	**Reducing Climate Impact**
Workforce and Organisational Development	Supporting the wellbeing of the health and social care workforce	Promoting flexible working practices, including home working that can positively reduce greenhouse gas emissions and building-based space requirements.
Infrastructure and Technology	Modernising health and social care facilities	Developing local, integrated health and social care facilities, fewer in number and operating to higher efficiency standards, with services and resources under one roof.

	Maximising the potential of digital solutions	Increasing the availability of online, digital and virtual solutions, for people who would benefit from these options. These approaches reduce the need for travelling to building bases.

A Strategic and Environmental Impact Screening Assessment of this HSCP Strategic Plan has been undertaken as part of its preparation.

The key areas where the HSCP anticipates climate change reductions relates to building and fleet management – neither of these functions are delegated to the HSCP with each partner body retaining responsibility for the delivery of these areas. The HSCP would therefore be reliant on capital funding from the respective parent organisations to make relevant improvements to buildings (asset ownership retained by the relevant parent organisations) but hold an earmarked reserve specific to accommodation redesign which could be accessed as a contribution towards any works in this area. The upgrading of fleet care to electric vehicles is planned for 2023/24 but given the scale of the initial phase of this programme, is not expected to have a material cost to the HSCP and indeed will secure some level of saving on fuel and other related costs which will further mitigate costs in this area. Both initiatives will be through collaborative working with our partners as part of wider Council / NHS initiatives.

The HSCP has not set any specific targets for reducing emissions but rather has set out how it will work collaboratively with our partner bodies to deliver actions which will contribute to the climate change agenda.

Covid-19 Pandemic Impact and Response

The HSCP has been actively responding to the Covid-19 pandemic since March 2020. During 2022/23, the recovery phase has continued and moved onto a business as usual footing. Restrictions and guidance in place during the pandemic have been largely relaxed or modified significantly with a number of measures remaining in place to manage the ongoing implications left from the pandemic:

- The Covid-19 vaccination programme to the most vulnerable continues to be delivered through a NHSGGC board wide approach, with vaccinations within people's homes delivered through the HSCP as well as ongoing support to local care homes.
- PPE Hubs have remained in place distributing PPE and testing kits to our own services and those delivered by the third, independent sector and unpaid carers. These arrangements ceased from the 1st April 2023 and have become part of normal ordering processes with some residual support continuing to unpaid carers.
- Support to staff through wellbeing initiatives continues.
- Provider sustainability financial support continued during 2022/23 subject to changing guidance throughout the year with Social Care Support Funding (SCSF) being made available until the 31st March 2023.
- Continued contribution to the development of Mental Health Assessment Units to minimise attendance of Mental Health patients at Emergency Departments and also deliver a streamlined service for assessments. Given the success of this model, recurring funding streams have been identified to ensure this remains in place going forward.

Funding consequences

The HSCP's response to the Covid-19 pandemic has resulted in continued additional costs being incurred during 2022/23. These costs have been met in their entirety from Covid-19 reserves balances held by the HSCP for this purpose. The nature and extent of these costs has reduced significantly during 2022/23 with changes to guidance on financial support to adult and social care providers, testing and public health policies in relation to Covid-19 compared to when funding was provided to IJBs at the end of financial year 2021/22. This has resulted in the Scottish Government reclaiming surplus Covid-19 reserves to be redistributed across the sector to meet wider current Covid-19 priorities. For East Dunbartonshire HSCP this represented a return of surplus Covid-19 reserves of £7.034m.

The HSCP, along with all other HSCPs, continued to submit financial returns on a regular basis through the health board to the Scottish Government, detailing the financial costs associated with the actions being taken in response to and recovery from the pandemic. These costs were separately tracked internally for monitoring and reporting purposes and to evidence spend against the residual earmarked reserves balances held within the HSCP for this purpose.

Longer term funding impacts are difficult to predict at this stage, as future funding settlements are subject to a greater degree of uncertainty and the longer term impacts on costs are also highly uncertain. Although it is expected that there will be significant changes in demand pressure patterns as a result of Covid-19, mapping and quantifying these is difficult as there remains much unknown regarding the medium and long term impacts of the pandemic. Demand trends will be closely monitored for any implications for future service delivery.

HSCP BOARD OPERATIONAL PERFORMANCE FOR THE YEAR 2022/23

Performance is monitored using a range of performance indicators set out in reports to the HSCP Board quarterly and annually. These measures and the supporting governance arrangements are set out in the HSCP Performance Management Framework. Service uptake, waiting times, performance against standards and operational risks and pressures are closely reviewed and any negative variation from the planned strategic direction is reported to the HSCP Board including reasons for variation and planned remedial action to bring performance back on track.

A full report on performance is set out each year in an East Dunbartonshire HSCP Annual Performance Report. The 2022/23 report is scheduled to be presented to the HSCP Board for approval on 29 June 2023 and published by the end of July 2023.

It is not proposed to replicate in full the contents of the HSCP Annual Performance Report (APR) 2022-23 in this document. However, core to the APR is a set of indicators prescribed by the Scottish Government as a mechanism to measure HSCP performance in pursuit of the National Health and Wellbeing Outcomes. These National Core Integration Indicators are supplemented by a further set of indicators devised by the Scottish Government's Ministerial Strategic Group to measure performance across a number of key objectives. Given that these national measures are adopted by all HSCPs, they are included below.

For more detailed performance, improvement and development information, including a wide range of local indicators, the HSCP Annual Performance Report 2022-23 will be published to the web link below, by 31 July 2023: East Dunbartonshire Health and Social Care Partnership Board | East Dunbartonshire Council

The indicators below are subject to a detailed methodological framework and are also impacted by data completeness issues that are not usually fully resolved by Public Health Scotland until the autumn. Notes on the methodology are set out in an annex to the East Dunbartonshire HSCP Annual Performance Report 2022-23.

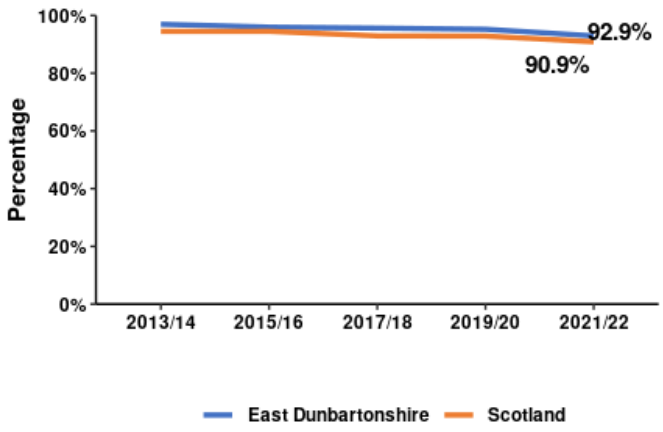
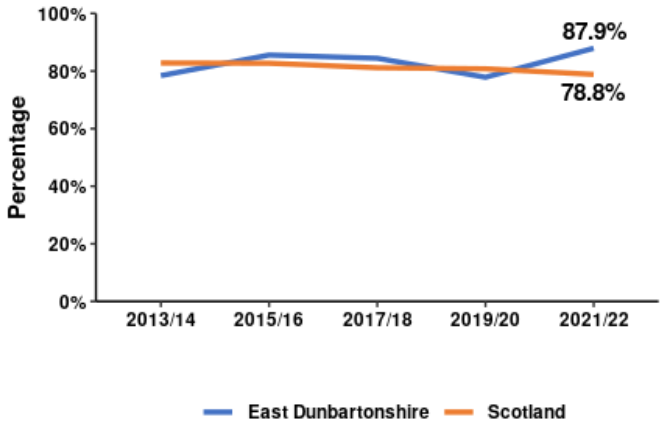
This section provides the HSCP's performance against national core integration indicators (Notes on methodology at Annex 5):.

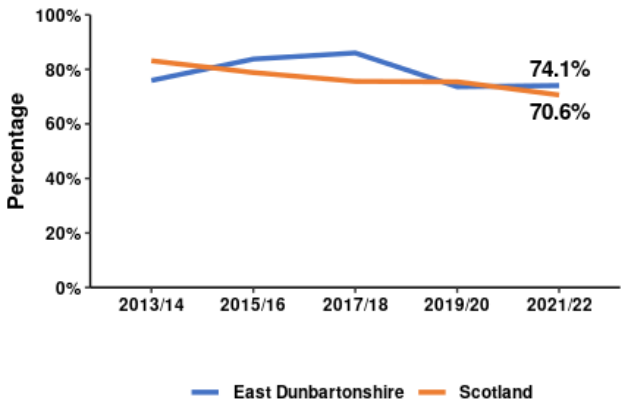
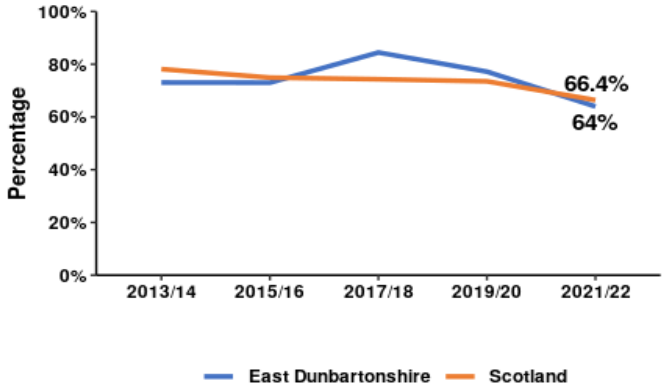
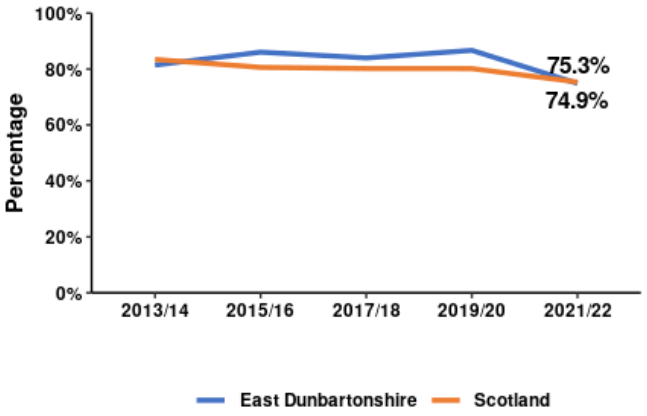
RAG KEY

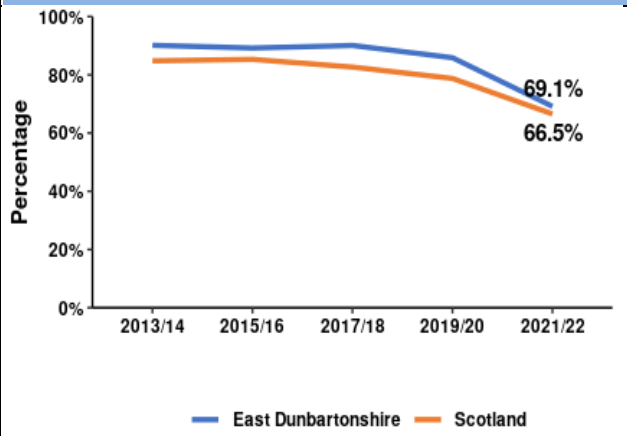
Positive performance improved in 2022-23

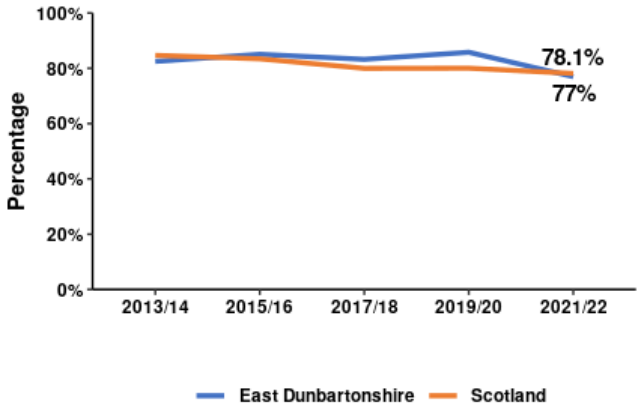
Performance steady (within 5% change in either direction). Arrow direction denotes improving/declining performance

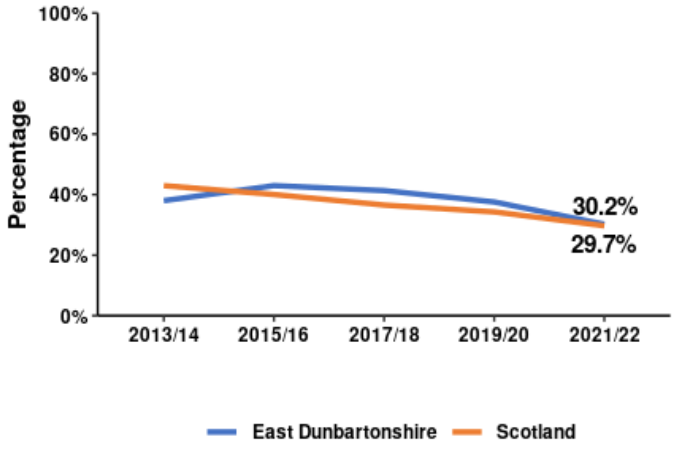
Performance declined in 2022-23

Indicator, Rating and Rank		Performance Trend
1) Percentage of adults able to look after their health very well or quite well (National Outcome 1) (Objective: increase)		
National ranking (biennial): 7	Comparison with Previous Survey:	
2) Percentage of adults supported at home who agree that they are supported to live as independently as possible (National Outcome 2) (Objective: increase)		
National ranking (biennial): 3	Comparison with previous survey:	

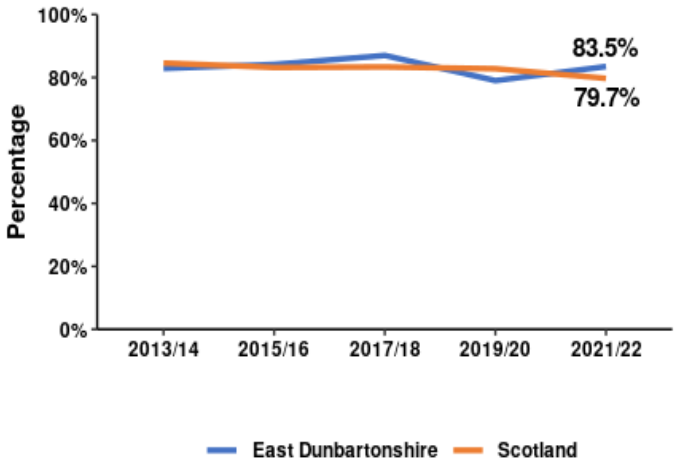
Indicator, Rating and Rank	Performance Trend
3) Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided (National Outcome 2, 3) (Objective: increase) National ranking (biennial): 9 ⇧ | Comparison with previous survey: ⇧	
Indicator, Rating and Rank	**Performance Trend**
4) Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated (National Outcome 3, 9) **(Objective: increase)** National ranking: 21 ⇩ | Comparison with Previous Year: ⇩	
5) Total percentage of adults receiving any care or support who rated it as excellent or good (National Outcome 3) (Objective: increase) National ranking (biennial): 21 ⇩ | Comparison with previous survey: ⇩	
6) Percentage of people with positive experience of the care provided by their GP Practice (National Outcome 3) (Objective: increase)	

Indicator, Rating and Rank		Performance Trend
National ranking (biennial): 13 ↓	Comparison with previous survey: ↓	

Indicator, Rating and Rank		Performance Trend
7) Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life (National Outcome 4) (Objective: increase)		
National ranking (biennial): 20 ↓	Comparison with previous survey: ↓	

8) Total combined percentage of carers who feel supported to continue in their caring role (National Outcome 6) (Objective: increase)		
National ranking: 16 ↓	Comparison with Previous Year: ↓	

<table>
<tr><th colspan="2">Indicator, Rating and Rank</th><th>Performance Trend</th></tr>
<tr><td colspan="2">9) Percentage of adults supported at home who agreed they felt safe (National Outcome 7)

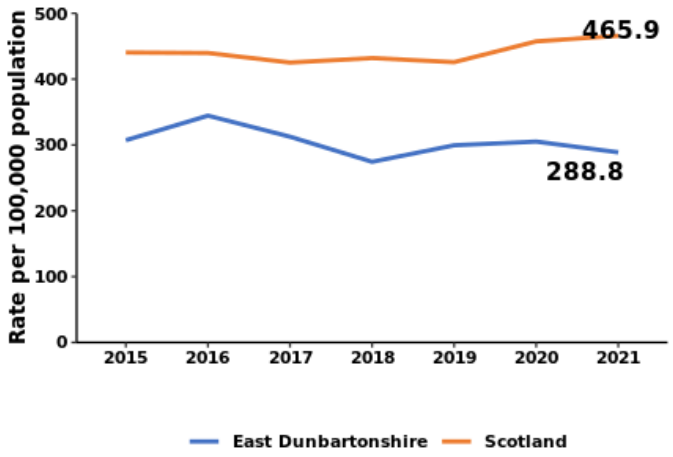
(Objective: increase)</td><td rowspan="2"> 
</td></tr>
<tr><td>National ranking:

8

  </td><td>Comparison with Previous Year:

  </td></tr>
</table>

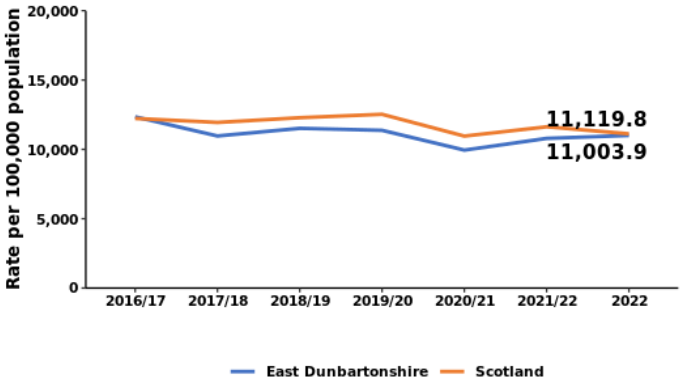
<table>
<tr><th>Indicator, Rating and Rank</th><th>Performance Trend</th></tr>
<tr><td colspan="2">11) Premature mortality rate for people aged under 75yrs per 100,000 persons (National Outcome 1,5)

(Objective: decrease)</td><td rowspan="2"> 
</td></tr>
<tr><td>National ranking:

1

  </td><td>Comparison with Previous Year:

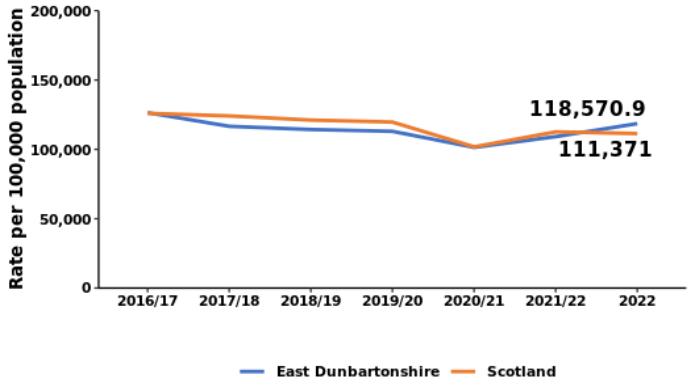
  </td></tr>
<tr><td colspan="2">12) Emergency admission rate (per 100,000 population) (National Outcome 1,2,4,5)

(Objective: decrease)</td><td rowspan="2"> 
</td></tr>
<tr><td>National ranking:

14

  </td><td>Comparison with Previous Year:

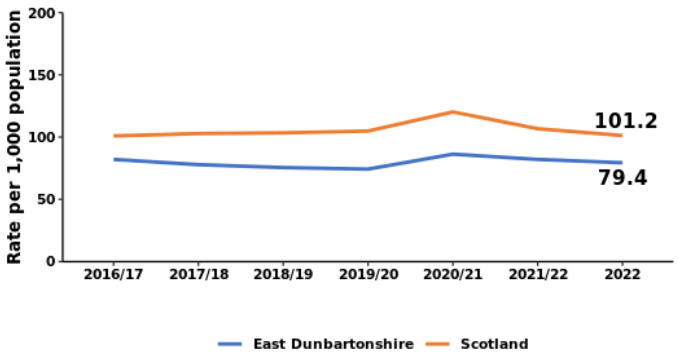
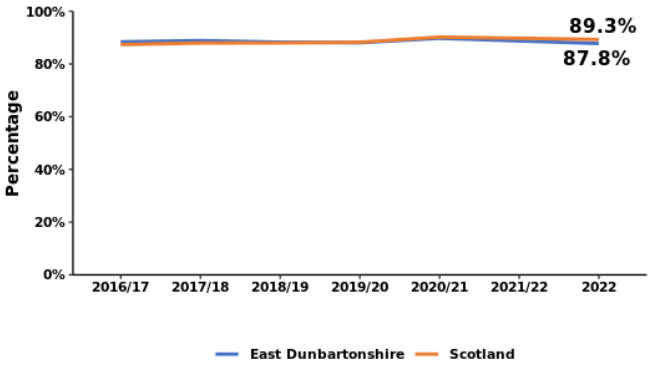
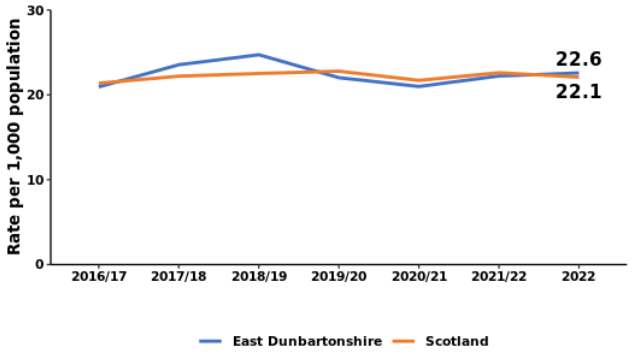
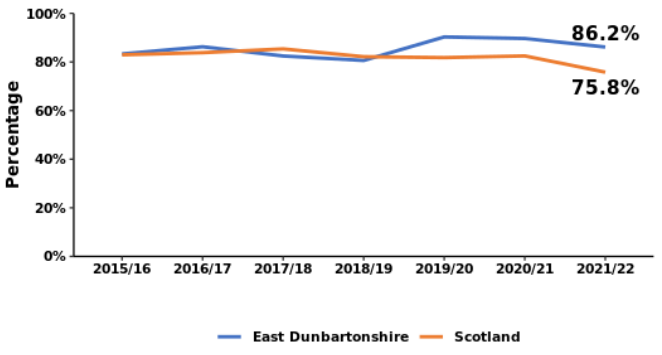
  </td></tr>
<tr><td colspan="2">13) Emergency bed day rate (per 100,000 population) (National Outcome 2,4,7)

(Objective: decrease)</td><td rowspan="2"> 
</td></tr>
<tr><td>National ranking:

19

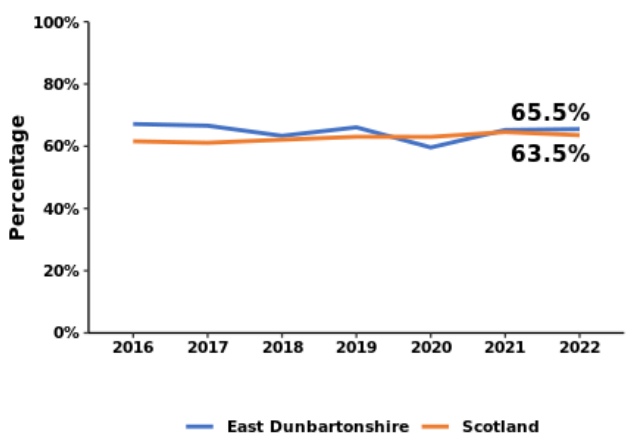
  </td><td>Comparison with Previous Year:

  </td></tr>
</table>

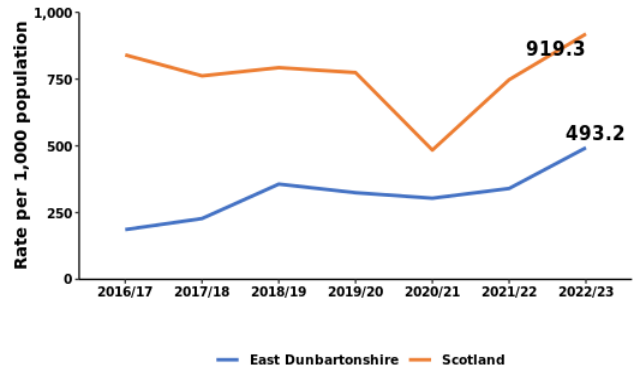
Indicator, Rating and Rank		Performance Trend
14) Readmission to hospital within 28 days (per 1,000 population) (National Outcome 2,4,7,9) (Objective: decrease)		
National ranking: 6	Comparison with Previous Year:	
15) Proportion of last 6 months of life spent at home or in a community setting (National Outcome 2,3,9) (Objective: increase)		
National ranking: 29	Comparison with Previous Year:	
16) Falls rate per 1,000 population aged 65+ (National Outcome 2,4,7,9) (Objective: decrease)		
National ranking: 18	Comparison with Previous Year:	
17) Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (National Outcome 3,4,7) (Objective: increase)		
National ranking: 4	Comparison with Previous Year:	

<table>
<tr><th>Indicator, Rating and Rank</th><th>Performance Trend</th></tr>
<tr><td>18) Percentage of adults with intensive care needs receiving care at home (National Outcome 2)

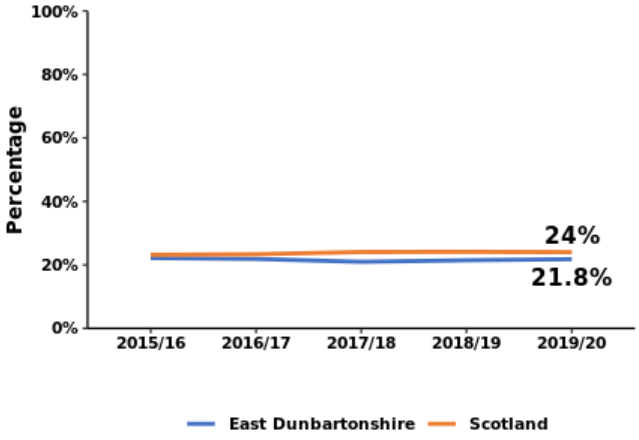
(Objective: increase)

National ranking: 13 ⇧ | Comparison with Previous Year: ⇧</td><td> 
</td></tr>
<tr><td>19) Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) (National Outcome 2,3,4,9)

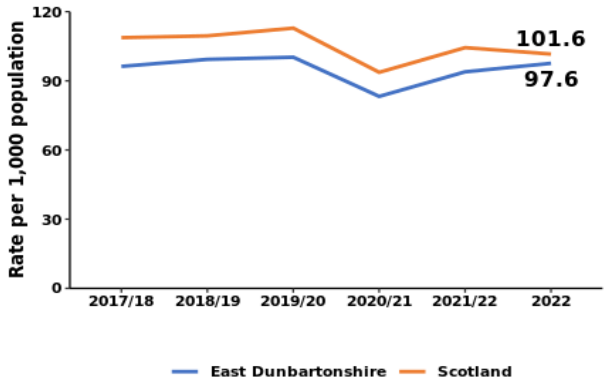
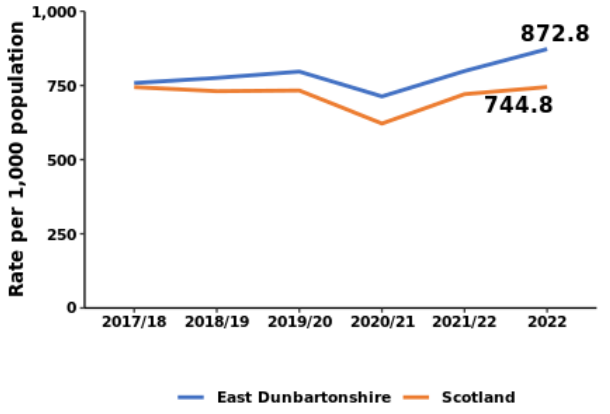
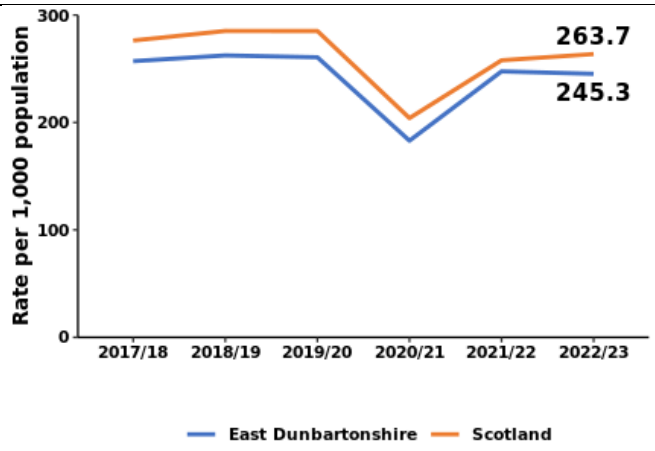
(Objective: decrease)

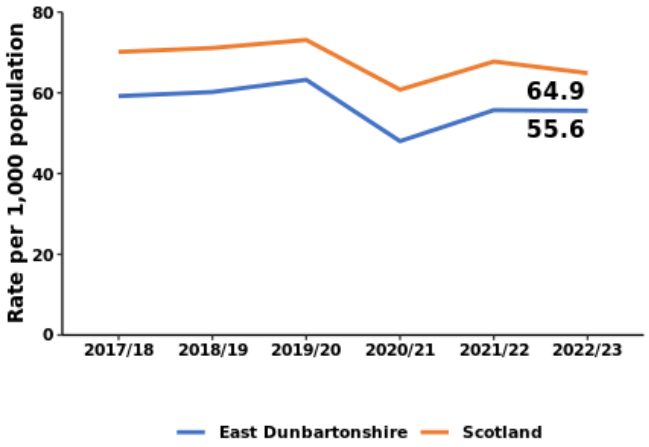
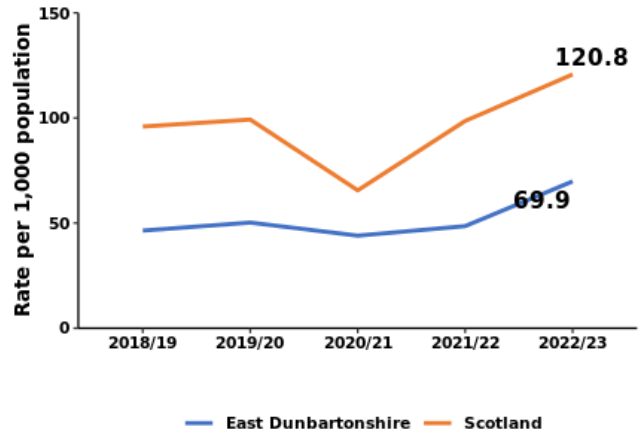
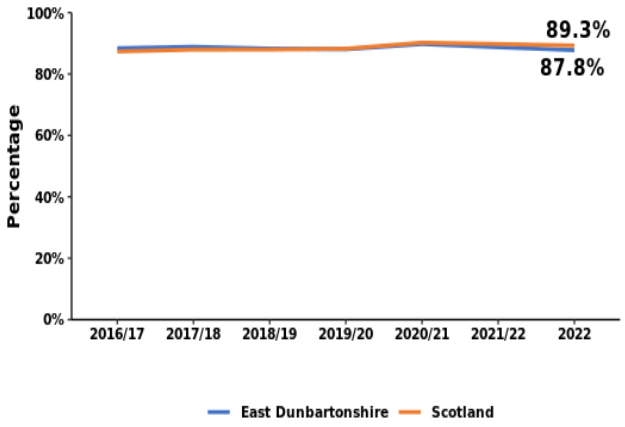
National ranking: 8 ⇔ | Comparison with Previous Year: ⇩</td><td> 
</td></tr>
<tr><td>20) Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (National Outcome 2,4,7,9)

(Objective: decrease)

National ranking: 8 ⇩ | Comparison with Previous Year: ⇩</td><td> 
</td></tr>
</table>

This section provides the HSCP's performance against Scottish Government Ministerial Strategic Group (MSG) indicators:

Indicator and Rating	Performance Trend
1. Unplanned admissions – rate per 1000 population (National Outcomes 1,2,3,4) (Objective: decrease) ⬇ (Performance ahead of Scottish average)	
2. Unplanned bed days - rate per 1000 population (National Outcomes 2,4,7) (Objective: decrease) ⬇ (Performance behind Scottish average)	
3. A&E attendances - rate per 1000 population (National Outcomes 1,2,9) (Objective: decrease) ⬆ (Performance ahead of Scottish average)	

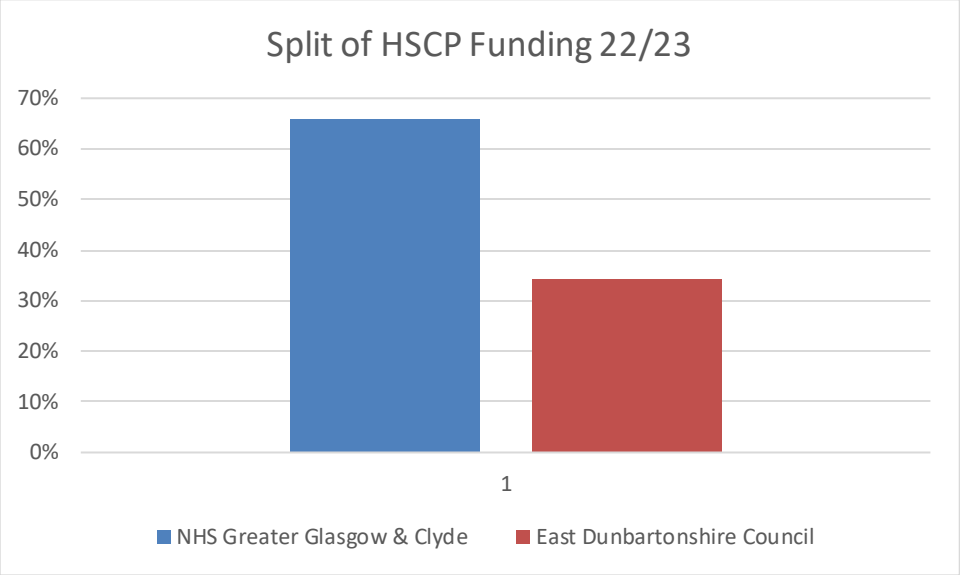
Indicator	Performance Trend
4. Admissions from A&E – rate per 1000 population (National Outcomes 1,2,3,4) (Objective: decrease) ⇧ (Performance ahead of Scottish average)	
5. Delayed discharge bed days - rate per 1000 population (National Outcomes 2,3,4,9) (Objective: decrease) ⇩ (Performance ahead of Scottish average)	
6. Last 6 months of life spent at home or in a community setting – (% of population) (National Outcomes 2,3,9) (Objective: increase) ⇩ (Performance broadly in line with Scottish average)	

(MSG Indicator 7: Data awaited from Public Health Scotland)

HSCP BOARD'S FINANCIAL POSITION AT 31 MARCH 2023

The activities of the HSCP are funded by EDC and NHSGGC who agree their respective contributions which the partnership uses to deliver on the priorities set out in the Strategic Plan.

Diagram 11: Split of HSCP Funding 2022/23



The scope of budgets agreed for inclusion within the HSCP for 2022/23 from each of the partnership bodies were:-

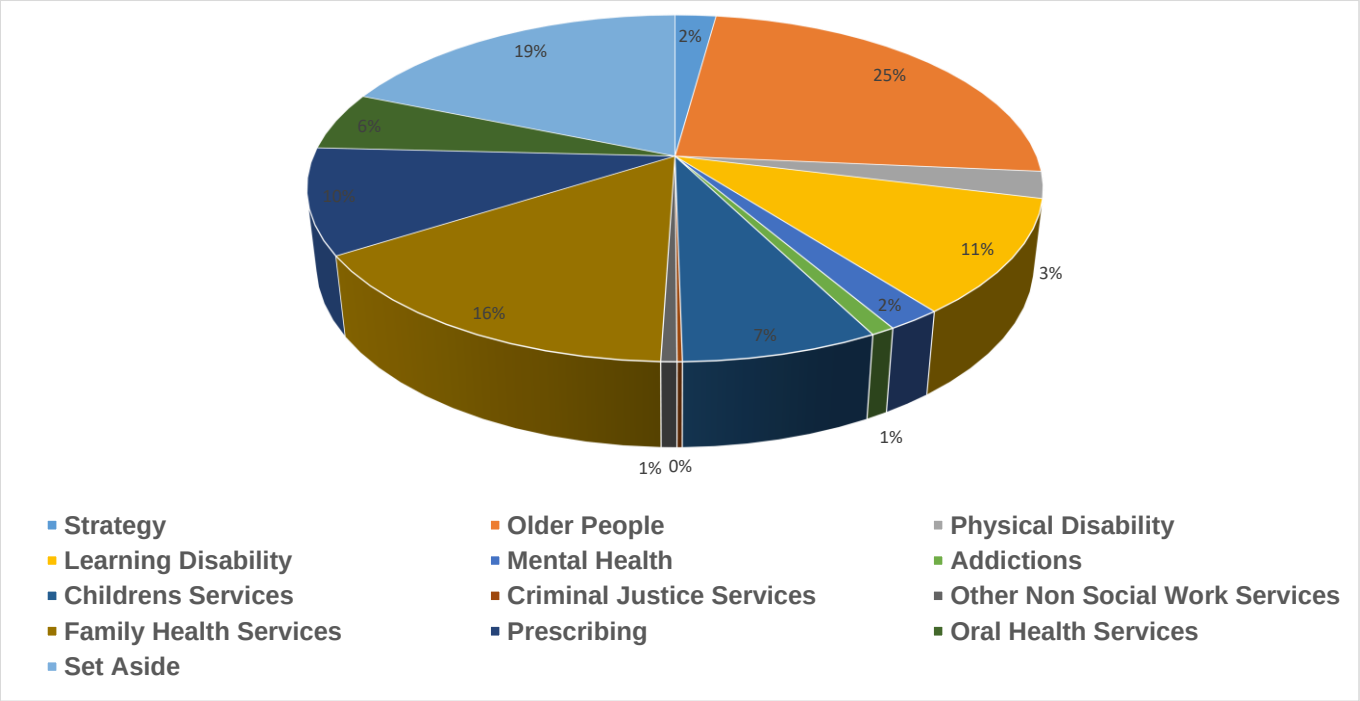
HSCP Board Budgets 2022/23 (from the 1 April 2022 to the 31 March 2023)

	Original Budget 2022/23 £000	In Year Adjustments £000	Final Budget 2022/23 £000
Functions Delegated by East Dunbartonshire Council	70,640	797	71,437
Functions Delegated by NHSGGC	89,880	6,856	96,736
Set Aside – Share of Prescribed Acute functions	38,514	1,792	40,306
TOTAL	**199,034**	**9,445**	**208,479**

The increases to the original budget for 2022/23 relate largely to non-recurring funding allocations during the year relating to oral health, family health services and SG funding to support alcohol and drugs, primary care improvements and Action 15 mental health monies.

The budget is split across a range of services and care groups as depicted below:-

Diagram 12: Care Group Budget 2022/23



HOSTED SERVICES

East Dunbartonshire HSCP is one of six in the Greater Glasgow and Clyde area. Some health services are organised Greater Glasgow-wide, with a nominated HSCP hosting the service on behalf of its own and the other five HSCPs in the area. The Health Budget includes an element relating to Oral Health Services (£11.7m) which is a service hosted by East Dunbartonshire HSCP and delivered across the other five partnership areas within NHSGGC's boundaries.

The full extent of this budget is reflected in these accounts as prescribed within the Integration Scheme. There are services hosted within other NHSGGC partnerships which have similar arrangements and which support the population of East Dunbartonshire.

Diagram 13: The extent to which hosted services delivered across Greater Glasgow and Clyde are consumed by the population of East Dunbartonshire

2021/22 £000	Service Area	2022/23 £000
524	MSK Physio	571
52	Retinal Screening	61
183	Podiatry	303
324	Primary Care Support	340
412	Continence	502
646	Sexual Health	704
862	Mental Health Services	1,259
22	Augmentative and Alternative Communications	27
831	Oral Health	1,114
833	Alcohol & Drugs	815
177	Prison Healthcare	196
199	Healthcare in Police Custody	183
2,497	General Psychiatry	3,116
1,080	Old Age Psychiatry	1,947
8,642	**Total Cost of Services consumed within East Dunbartonshire**	**11,138**

The levels of expenditure have increased in a number of areas since 2021/22 due to an increase in mental health bed usage within general and old age psychiatry bringing levels back to more normalised levels post-Covid. There is also an increase within oral health due to increasing expenditure during the year related to adult winter planning funding which saw the recruitment to a number of additional temporary posts.

SET ASIDE BUDGET

The set aside budget relates to certain prescribed acute services including Accident and Emergency, General Medicine, Respiratory care, Geriatric long stay care etc. where the redesign and development of preventative, community based services may have an impact and reduce the overall unplanned admissions to the acute sector, offering better outcomes for patients and service users.

Each Health Board, in partnership with the Local Authority and Integration Authority, 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. To date work has focused on the collation of data in relation to costs and activity and the development of an Unscheduled Care Commissioning Plan which will set the priorities for the commissioning arrangement for un-scheduled care bed usage across NHSGGC.

An allocation has been determined by NHSGGC for East Dunbartonshire of £40.306m for 2022/23 in relation to these prescribed acute services. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

The set aside resource for delegated services provided in acute hospitals is determined by analysis of hospital activity and actual spend for that year. For 2022/23, the overall expenditure for NHSGGC has increased and this is reflected in an increase to the actual figures for East Dunbartonshire. There has also been an increase in the share of overall activity for East Dunbartonshire across Acute Medicine, Older People, Respiratory and emergency department attendances.

The costs associated with Covid-19 that are included within the set aside total, were £14.2m for NHS Greater Glasgow and Clyde. These costs were fully funded by the Scottish Government.

KEY RISKS AND UNCERTAINTIES

The period of public sector austerity and reduction in the overall level of UK public sector expenditure is anticipated to extend over the medium term horizon. This is compounded by recurring impact on public sector budgets of the Covid-19 pandemic and the cost of living crisis causing price increases across a number of areas directly impacting health and social care and the purchase of care provision from the market.

Future Scottish Government grant settlements remain uncertain with further reductions in government funding predicted to 2023/24. The Partnership, through the development of an updated strategic plan, has prepared a Medium Term Financial Strategy 2023 – 28 aligned to its strategic priorities. The aim is to plan ahead to meet the challenges of demographic growth and policy pressures, taking appropriate action to maintain budgets within expected levels of funding and to maximise opportunities for delivery of the Strategic Plan through the use of reserves. This was presented in the context of the ongoing impact of the Covid-19 pandemic and will be reviewed on an annual basis and updated to reflect up to date assumptions and known factors which may have changed since the original strategy was written. It is accepted that the medium to longer term impacts of the pandemic are yet to be fully felt and assessed.

The most significant risks faced by the HSCP over the medium to longer term are:-

- The increased demand for services alongside reducing resources. In particular, the demographic increases predicted within East Dunbartonshire is significant with the numbers of older people aged 75+ set to increase by 67% over the period 2018-2043 (source: NRS). Even more significantly given the age profiles of people receiving the greatest proportion of services, numbers of older people aged 85+ are set to increase by 119% over the same period.
- East Dunbartonshire has a higher than national average proportion of older people aged 75+, therefore these projected increases will have a significant, disproportionate and sustained impact on service and cost pressures.
- The cost and demand volatility across the prescribing budget which has been significant over the years as a result of a number of drugs continuing to be on short supply resulting in significant increase in prices as well as demand increases in medicines within East Dunbartonshire. These issues were particularly significant during the latter half of the financial year and are expected to remain challenging during 2023/24. This represents the HSCP's singular biggest budget area.
- The achievement of challenging savings targets from both partner agencies that face significant financial pressure and tight funding settlements, expected to continue in the medium to long term.
- The capacity of the private and independent care sector who are struggling to recruit adequate numbers of care staff to support service users which is being felt more acutely south of the border but remains a concern locally in a highly competitive market.

The HSCP Performance, Audit & Risk Committee (PAR) approved an updated risk management strategy in June 2023 and we continue to maintain a corporate risk register for the HSCP which identified the key areas of risk that may impact the HSCP and the range of mitigating actions implemented to minimise any associated impact. This is subject to regular review with the latest version presented to the PAR in June 2023.

The key areas identified (as at June 2023) are:

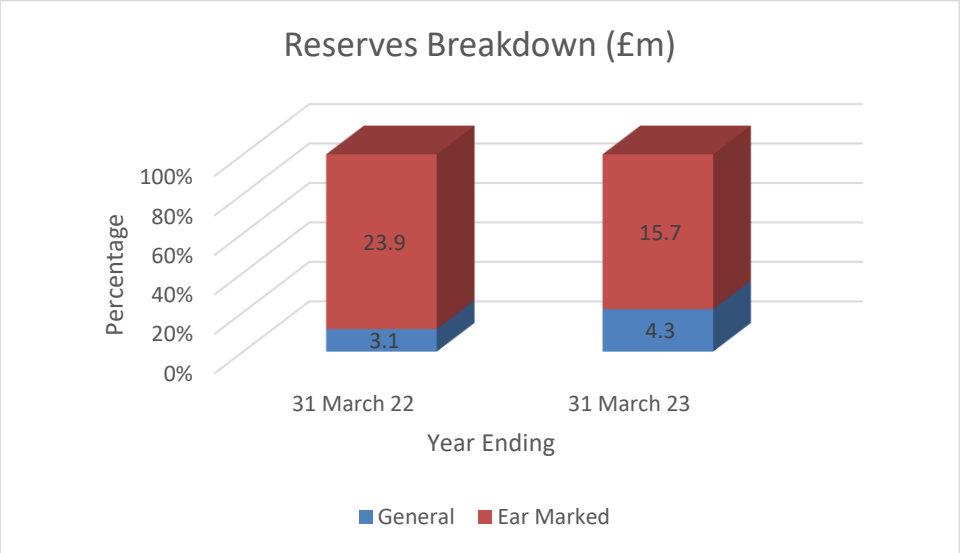
Key Strategic Risks	Mitigating Actions
Inability to support early, effective discharge from hospital	Review further options for increasing capacity within care home provision and care at home through recruitment drive and further re-direction of staff. Additional investment through Adult Winter Planning funding to increase capacity across the HSCP in direct care services to support early and effective discharge.
Inability to achieve recurring financial balance	Liaison with other Chief Finance Officers network. Monitoring of delivery of efficiency plans for the coming year through the HSCP Annual Delivery Plan board. Financial recovery plan in place as needed and work with staff and leadership teams to identify areas for further efficiencies / service redesign to be escalated in year. Development of a medium term financial plan to support longer term projections.
Risk of failure to achieving transformational change and service	Early collaborative planning with EDC and NHSGGC re support requirements. Work through staff and leadership teams to identify further efficiency and redesign options to bring forward

redesign plans within necessary timescales	in year. Development and scrutiny of annual delivery plans including actions for investment / dis investment.
Inability to recruit and retain the appropriate numbers of trained staff to meet requirements resulting in reduction in service or failure to meet statutory duties. Specific workforce pressure areas are Mental Health Officers, qualified Social Workers, Personal Carers, Health Visitors, Psychologists and General Practitioners (independent contractors).	Develop workforce plan for 2022-2025 in line with HSCP Strategic Plan. Revised recruitment protocol in place to support SMT overview of workforce issues. Funding from SG to support additional social work and mental health officer workforce capacity to be progressed and implemented. Review options for 'market forces' review of pay and grading. Further amalgamate health visiting contacts, consider skill mix where appropriate and other mechanisms for delivery of services.
Failure to deliver the MOU commitments within the Primary Care Improvement Plan.	Representation to SG for funding to support full extent of MOU commitments.
Failure of external care providers to maintain delivery of services particularly related to care home and care at home provision.	Enhanced support and monitoring across care home services, daily /weekly checks via TURAS, RAG rating, Provider Forums, dedicated Officer support, Established Sector Lead, Weekly oversight via ORG, early notification alerts via SXL & Network groups, process for review of provider sustainability and adequacy of rates for service delivery.

FINANCIAL PERFORMANCE 2022/23

The partnership's financial performance is presented in these Annual Accounts. The Comprehensive Income and Expenditure Statement (CIES) (see page 47) describes expenditure and income by care group across the IJB and shows an over spend of £6.928m against the partnership funding available for 2022/23. Adjusting this position for in year movements in reserves provides an underlying positive variance on budget of £4.387m for 2022/23 which represents operational service delivery for the year and has been reported throughout the year to the IJB through regular revenue monitoring updates.

This has reduced the overall reserves position for the HSCP from a balance of £26.990m at the year ending 31 March 2022 to that of a balance of £20.062m as at year ending 31 March 2023 (as detailed in the reserves statement on page 48.) The reserves can be broken down as follows:



The CIES includes £2.930m of expenditure related to the impact from Covid-19. The costs incurred during 2022/23 are set out in the table below.

Additional Covid-19 Costs - HSCP	2022-23 Revenue Total
Flu Vaccination & Covid-19 Vaccination (FVCV)	**181,186**
Additional Staff Costs (Contracted staff)	**239,379**
Additional Staff Costs (Non-contracted staff)	**57,374**
Additional Equipment and Maintenance	**513**
Additional PPE	**30,321**
Additional Capacity in Community	**140,547**
Children and Family Services	**895,242**
Covid-19 Financial Support for Adult Social Care Providers	**1,167,495**
Additional FHS Contractor Costs	**72,322**
Digital & IT costs	**4,086**
Loss of Income	**141,237**
Total Covid Costs - HSCP - All	**2,929,701**

Costs were covered through HSCP earmarked reserves, held for this specific purpose. The balance of reserves of £7.034m was returned to SG in the financial year to be redistributed across the sector to meet current Covid-19 priorities. The mechanism by which the funds were returned resulted in the contribution from NHSGG&C being reduced by this amount, as set out within note 11 on page 57.

Financial Outturn Position 2022/23

The budget for East Dunbartonshire HSCP was approved by the IJB on the 24th March 2022.This provided a total net budget for the year of £199.034m (including £38.514m related to the set aside budget). This included £0.449m of agreed savings to be delivered through efficiencies, service redesign and transformation to deliver a balanced budget for the year and moving forward into future years.

There have been a number of adjustments to the budget since the HSCP Board in March 2022 which has increased the annual budget for 22/23 to £208.479m. These adjustments relate mainly to non-recurring funding from SG specific to the dental health bundle, family health services,

PCIP, ADP and the pay award for NHS and social work staff. This is netted off against the reduction in the NHS contribution related to the return of Covid funding in year.

The partnership's financial performance across care groups is represented below:

Care Group Analysis	Annual Budget 2022/23 £000	Annual Expenditure 2022/23 £000	Year End Variance £000
Strategic & Resources	4,615	4,465	149
Older People & Adult Community Services	52,188	48,793	3,395
Physical Disability	5,314	5,093	221
Learning Disability	22,859	23,142	(283)
Mental Health	4,363	4,501	(138)
Addictions	1,916	1,307	609
Planning & Health Improvement	618	552	66
Childrens Services	15,632	14,930	702
Criminal Justice Services	416	455	(39)
Other Non Social Work Services	1,258	950	308
Family Health Services	33,220	33,218	2
Prescribing	21,095	22,027	(932)
Oral Health Services	11,713	12,738	(1,025)
Set Aside	40,306	40,306	0
Covid Expenditure	(7,034)	2,930	(9,964)
Net Expenditure	208,479	215,407	(6,928)

A breakdown of the projected underspend against the allocation from each partner agency is set out in the table below:

Partner Agency	Annual Budget 2022/23 £000	Actual Expenditure 2022/23 £000	Year End Variance 22/23 £000
East Dunbartonshire Council	71,437	77,737	(6,301)
NHS GG&C	137,042	137,670	(628)
TOTAL	208,479	215,407	(6,928)

The main reasons for the variances to budget for the HSCP during the year are set out below:

- Mental Health, Learning Disability, Addiction Services, Health Improvement (£0.255m under spend) - the overall variance relates to pressures in relation to increased taxi provision (as opposed to use of fleet transport) to support SW service users to access services, loss of income from charging due to numbers attending day services and in receipt of non-residential services not resuming to pre covid levels. This is offset by the numbers of care packages not resuming to pre covid levels anticipated at the time of setting the Budget for 2022/23, vacancies, ongoing recruitment and retention issues across nursing and psychology posts within MH and LD health services.

- Community Health and Care Services – Older People / Physical Disability (underspend of £3.616m) – there continued to be reduced levels of care home placements, supported living packages and care at home services purchased from the external market from that assumed at the time of setting the budget, due to the continuing impacts of Covid-19. Numbers are continuing to recover to more normalised levels. This mitigates pressures within the in-house care at home service and pressures in relation to equipment to support people to remain at home along with additional adult winter planning funding to increase capacity in this area. SG funding was made available in year for Adult winter planning which was not fully spent in year due to ongoing recruitment challenges in filling posts. This will be taken to earmarked reserves.

  This also includes the refund of monies of £1.1m related to charges for continuing care beds within Fourhills Care Home dating back to 1st April 2019 (£0.3m related to 19/20, £0.4m related to 20/21 and £0.4m related to 21/22).

- Children and Criminal Justice Services (underspend of £0.663m) – there continued to be recruitment and retention challenges across Children's services for the year. There was also reductions in external fostering and residential childcare placements as children move onto positive destinations. There continue to be pressures in relation to Unaccompanied Asylum Seeking Children (USAC) where placements within in house provision is at capacity and will require the purchase of externally purchased placements to accommodate these children.

- Housing Aids and Adaptations and Care of Gardens (underspend of £0.308m) - there are a number of other budgets delegated to the HSCP related to private sector housing grants, care of gardens and fleet provision. These services are .delivered within the Council through the Place, Neighbourhood and Corporate Assets Directorate – there has been a continuing underspend in relation to fleet recharges related to a downturn in transport provision needed as a consequence of Covid and a reduction in services requiring this type of transport. This is compounded by underspends across the care and repair service and private sector housing grants.

- Prescribing (overspend of £0.932m) - pressures in relation to price and volume increases across a range of medicines have been reported throughout the financial year which has resulted in an adverse variance in this area. A number of initiatives are in development to target the volume and types of prescriptions dispensed such as script-switch, review of use of formulary vs non formulary, waste reduction, repeat prescription practices. Prices across the market will continue due to global factors outwith the control of the HSCP, however use of alternative medicines will form part of the programme of initiatives being rolled out across East Dunbartonshire and more widely across GG&C.

- Oral Health (overspend of £1.025m) - the overspend relates to expenditure incurred in year on temporary staffing to address winter pressures and ventilation and equipment purchases in support of recovery of services following the pandemic to be funded from earmarked reserves set aside for this purpose. This was offset by some delays in filling vacancies during the year.

- Covid Expenditure (overspend of £9.964m) – there was expenditure related to Covid-19 during the year of £2.930m and the return of un-used reserves to SG of £7.034m. This expenditure will be met entirely from HSCP earmarked reserves held for this purpose.

Partnership Reserves

As at the 1 April 2022, the HSCP had a general (contingency) reserves balance of £3.1m. The surplus on operational service delivery generated during 2022/23 (£4.387m) will allow the HSCP to further that reserve in line with the HSCP Reserves Policy. This will provide the HSCP with some financial sustainability into future years and an ability to manage in year unplanned events and afford a contingency to manage budget pressures without the need to resort to additional partner contributions as a means of delivering a balanced budget.

The performance of the budget during 2022/23 supports the HSCP in the enhancement of a reserve to support the redesign of accommodation by a further £1m. This will increase the reserve already available to £3m to support the HSCP in delivery of its strategic priorities, primarily related to the delivery of the primary care improvement programme, moving services currently delivered within acute settings to local communities, such as Phlebotomy, and additional space to accommodate increased staffing capacity in response to Adult Winter Planning monies, adult social work capacity funding. In addition it will facilitate the creation of a digital redesign programme of £0.5m in response to the outcome of a national digital maturity assessment and the work already underway as a result of the Covid-19 pandemic where resort to digital platforms moved forward significantly and needs ongoing investment to maintain and develop further. At its meeting in March 2023, the IJB approved the use of an element of contingency reserves to create a smoothing reserve to underwrite the delivery of the savings programme for 2023/24 of £0.594m and also to enhance the prescribing reserve by £1m to mitigate anticipated pressures related to increased price and volume demands during 2023/24. This provides a remaining balance on general reserves of £4.371m.

IJB's are empowered under the Public Bodies (Joint Working) Scotland Act 2014 (section 13) to hold reserves and recommends the development of a reserves policy and reserves strategy. A Reserves policy was approved by the IJB on the 11 August 2016. This provides for a prudent reserve of 2% of net expenditure (less Set Aside) which equates to approximately £3.8m for the partnership. The level of general reserves is in line with this prudent level and provides the partnership with a contingency to manage any unexpected in year pressures moving into future years of financial uncertainty.

While contingency reserves have increased during 2022/23, there has been a net reduction in the level of earmarked reserves from £23.912m to £15.691m with the application of reserves in year to deliver on specific strategic priorities. During 2022/23, the HSCP used £12.891m of its earmarked reserves. In the main this related to the application of £2.930m towards Covid-19 expenditure incurred in year, the return of £7.034m to SG of the balance of Covid reserves as well as the use of reserves to support expenditure related to the delivery of PCIP, Action 15 and Oral Health priorities. There were some additions to earmarked reserves in year of £1.576m (related primarily to ADP, Adult Winter Support Funding and Community Link workers) along with the creation / enhancement of earmarked reserves as set out above totalling ££3.094m provides for an overall net reduction in earmarked reserves for the year of £8.221m. This will leave a balance on earmarked reserves of £15.691m.

A breakdown of the HSCP earmarked reserves is set out in note 10, page 56.

The total level of partnership reserves is now £20.062m as set out in the table on page 48.

Financial Planning

In setting the budget for 2023/24, the partnership had a funding gap of £3.894m following an analysis of cost pressures set against the funding available to support health and social care expenditure in East Dunbartonshire, this is set out in the table below:

	Delegated SW Functions (£m)	Delegated NHS Functions (£m)	Total HSCP (£m)
Recurring Budget 2022/23 (excl. Set aside)	69.918	92.118	162.036
SCS Budgets transferred to ED HSCP		30.074	30.074
Set Aside		38.382	38.382
Total Recurring Budget 2022/23	69.918	160.574	230.492
Financial Pressures - 23/24	6.724	1.640	8.364
2023/24 Budget Requirement	76.642	162.214	238.856
2023/24 Financial Settlement / Budget 2023-24	73.226	161.736	234.962
Financial Challenge 23/24	3.416	0.478	3.894
Savings Plan 23/24	(3.396)	(0.498)	(3.894)
Residual Financial Gap 23/24	**0.020**	**(0.020)**	**(0.000)**

Savings plans of £3.894m were identified to mitigate the financial pressures which delivered a balanced budget position moving into 2023/24. There are a number of significant financial risks to the HSCP moving into 2023/24 with uncertainty on the funding to support pay uplifts for Social Work staff, pressures in relation to prescribing expected to continue into the new financial year, pressures on contractual spend for Social Work care providers with funding only available to support the SLW element and risks to the delivery of the savings programme in full. This has necessitated the need to enhance prescribing reserves and to create a smoothing reserve to underwrite and phase in elements of the savings plan during 2023/24 with full delivery expected in future financial years.

The HSCP has a Medium Term Financial Strategy for the period 2023 – 2028 which outlines the financial outlook over the next 5 years and provides a framework which will support the HSCP to remain financially sustainable. It forms an integral part of the HSCP's Strategic Plan, highlighting how the HSCP medium term financial planning principles will support the delivery of the HSCP's strategic priorities.

There are a number of key opportunities and challenges for the HSCP at a national and local level. The most significant being the Review of Adult Social Care, elements of which have now been reflected in the new programme for government. This may see significant investment across a range of areas including the development of a National Care Services on an equal footing to the National Health Service, expansion of support for lower-level needs and preventive community support, increasing support to unpaid carers and sums paid for free personal care.

The HSCP has particular demographic challenges as set out previously on page 4.

The longer term impacts of the pandemic (Covid-19) are yet to be fully assessed and the impact of this on the delivery of health and social care services.

The Financial Challenge

The Medium Term Financial Strategy (MTFS) for the HSCP provides a number of cost pressures with levels of funding not matching the full extent of these pressures requiring a landscape of identifying cost savings through a programme of transformation and service redesign. The MTFS was updated as part of the Budget Setting for 2023/24 in March 2023.

The main areas for consideration within the MTFS for the HSCP are:-

- The medium term financial outlook for the IJB provides a number of cost pressures with levels of funding not matching the full extent of these pressures requiring a landscape of identifying cost savings through a programme of transformation and service redesign.
- The IJB is planning for a range of scenarios ranging from best to poor outcomes in terms of assumptions around cost increases and future funding settlements. This will require the identification of £17.2m to £38.4m of savings (previously £11.5m to £21.8m) with the most likely scenario being a financial gap of £17.2m over the next five years.
- This will extend to £42.3m (previously £28.9m) over the next 10 years, however this becomes a more uncertain picture as the future environment within which IJBs operate can vary greatly over a longer period of time.
- Based on the projected income and expenditure figures the IJB will require to achieve savings between £4.1m and £4.5m (previously £0.5m and £3.0m) each year from 2023/24s onwards.

The aim of the medium term financial strategy is to set out how the HSCP would take action to address this financial challenge across the key areas detailed below:

Key areas identified to close the financial gap

Delivering Services Differently through Transformation and Service Redesign

- Development of a programme for Transformation and service redesign which focuses on identifying and implementing opportunities to redesign services using alternative models of care in line with the ambitions of the HSCP Strategic Plan.

Efficiency Savings

- Implementing a range of initiatives which will ensure services are delivered in the most efficient manner.

Strategic Commissioning

- Ensuring that the services purchased from the external market reflect the needs of the local population, deliver good quality support and align to the strategic priorities of the HSCP.

Shifting the Balance of Care

- Progressing work around the un-scheduled care commissioning plan to address a shift in the balance of care away from hospital based services to services delivered within the community.

Prevention and Early Intervention

- Through the promotion of good health and wellbeing, self-management of long term conditions and intervening at an early stage to prevent escalation to more formal care settings.

Demand Management

- Implementing a programme focussed on managing demand and eligibility for services which enable demographic pressures to be delivered without increasing capacity. This is an area of focus through the Review of Adult Social Care.

J Forbes
IJB Chair

20th June 2023

C Sinclair
Chief Officer

20th June 2023

J Campbell
Chief Finance and Resources Officer
20th June 2023

STATEMENT OF RESPONSIBILITIES

Responsibilities of the HSCP Board

The HSCP Board is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that the proper officer of the board has responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this authority, that officer is the Chief Finance and Resources Officer.
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.
- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014 as modified by the Coronavirus (Scotland) Act 2020), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003).
- Approve the Annual Accounts.

I confirm that these Annual Accounts were approved for signature at a meeting of the Performance, Audit and Risk Committee on the xxxxxx.

Signed on behalf of the East Dunbartonshire HSCP Board.

J Forbes
IJB Chair
20th June 2023

Responsibilities of the Chief Finance and Resources Officer

The Chief Finance and Resources Officer is responsible for the preparation of the HSCP Board's Annual Accounts in accordance with proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

In preparing the Annual Accounts, the Chief Finance and Resources Officer has:

- selected suitable accounting policies and then applied them consistently
- made judgements and estimates that were reasonable and prudent
- complied with legislation
- complied with the local authority Code (in so far as it is compatible with legislation)

The Chief Finance and Resources Officer has also:

- kept proper accounting records which were up to date
- taken reasonable steps for the prevention and detection of fraud and other irregularities

I certify that the financial statements give a true and fair view of the financial position of the East Dunbartonshire HSCP Board as at 31 March 2023 and the transactions for the year then ended.

J Campbell
Chief Finance and Resources Officer
20th June 2023

REMUNERATION REPORT

Introduction

This Remuneration Report is provided in accordance with the Local Authority Accounts (Scotland) Regulations 2014. It discloses information relating to the remuneration and pension benefits of specified HSCP Board members and staff.

The information in the tables below was subject to external audit. The explanatory text in the Remuneration Report is reviewed by the external auditors to ensure it is consistent with the financial statements.

Remuneration: HSCP Board Chair and Vice Chair

The voting members of the HSCP Board are appointed through nomination by EDC and NHSGGC in equal numbers being three nominations from each partner agency. Nomination of the HSCP Board Chair and Vice Chair post holders alternates between a Councillor and a Health Board Non-Executive Director.

The remuneration of Senior Councillors is regulated by the Local Governance (Scotland) Act 2004 (Remuneration) Regulations 2007. A Senior Councillor is a Councillor who holds a significant position of responsibility in the Council's political management structure, such as the Chair or Vice Chair of a committee, sub-committee or board (such as the HSCP Board).

The remuneration of Non-Executive Directors is regulated by the Remuneration Sub-committee which is a sub-committee of the Staff Governance Committee within the NHS Board. Its main role is to ensure the application and implementation of fair and equitable systems for pay and for performance management on behalf of the Board as determined by Scottish Ministers and the Scottish Government Health and Social Care Directorates.

The HSCP Board does not provide any additional remuneration to the Chair, Vice Chair or any other board members relating to their role on the HSCP Board. The HSCP Board does not reimburse the relevant partner organisations for any voting board member costs borne by the partner. There were no taxable expenses paid by the HSCP Board to the Chair and Vice Chair.

The HSCP Board does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting HSCP Board members. Therefore no pension rights disclosures are provided for the Chair or Vice Chair.

Remuneration: Officers of the HSCP Board

The HSCP Board does not directly employ any staff in its own right; however specific post-holding officers are non-voting members of the Board. All staff working within the partnership are employed through either EDC or NHSGGC and remuneration for senior staff is reported through those bodies. This report contains information on the

HSCP Board Chief Officer and the Chief Finance and Resources Officer's remuneration together with details of any taxable expenses relating to HSCP Board voting members claimed in the year.

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the HSCP Board has to be appointed and the employing partner has to formally second the officer to the HSCP Board. The employment contract for the Chief Officer will adhere to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the HSCP Board. The Chief Officer, Mrs Sinclair was appointed from the 6th January 2020. Mrs Sinclair is employed by East Dunbartonshire Council and seconded to the HSCP Board.

Other Officers

No other staff are appointed by the HSCP Board under a similar legal regime. Other non-voting board members who meet the criteria for disclosure are included in the disclosures below. The HSCP Board Chief Finance and Resources Officer is employed by NHSGGC.

The Council and Health Board share the costs of all senior officer remunerations.

Total 2021/22 £	Senior Employees	Salary, Fees and Allowances £	Compensation for Loss of Office £	Total 2022/23 £
104,539	**C Sinclair** Chief Officer 6th January 2020 to present	110,849	0	110,849
92,220	**J. Campbell** Chief Finance and Resources Officer 9th May 2016 to present	94,638	0	94,638
196,759	**Total**	**205,487**	**0**	**205,487**

Pay band information is not separately provided as all staff pay information has been disclosed in the information above.

In respect of officers' pension benefits the statutory liability for any future contributions to be made rests with the relevant employing partner organisation. On this basis there is no pensions liability reflected on the HSCP Board balance sheet for the Chief Officer or any other officers.

The HSCP Board however has responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the HSCP Board. The following table shows the HSCP Board's funding

during the year to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions.

Senior Employee	In Year Pension Contributions		Accrued Pension Benefits		
	For Year to 31/03/22	For Year to 31/03/23		Difference from 31/03/22	As at 31/03/23
	£	£		£000	£000
C Sinclair	20,100	21,400	Pension	0 - 5	5 – 10
Chief Officer 6th January 2020 to present			Lump sum	0	0
J. Campbell	19,300	19,800	Pension	0 - 5	10 – 15
Chief Finance and Resources Officer 9th May 2016 to present			Lump sum	0	0
Total	**39,400**	**41,200**	**Pension**	**0 - 10**	**15 – 25**
			Lump Sum	**0**	**0**

The Chief Officer and the Chief Finance and Resources Officer detailed above are members of the Local Government Superannuation Scheme and the NHS Superannuation Scheme (Scotland) respectively. The pension figures shown relate to the benefits that the person has accrued as a consequence of their current appointment and role within the HSCP Board and in the course of employment across the respective public sector bodies. The contractual liability for employer's pension contribution rests with East Dunbartonshire Council and NHSGGC respectively. On this basis there is no pension liability reflected on the HSCP Board balance sheet. There were no exit packages payable during either financial year.

J Forbes
IJB Chair
20th June 2023

C Sinclair
Chief Officer
20th June 2023

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

The HSCP Board is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money and assets are safeguarded and that arrangements are made to secure best value in their use.

In discharging this responsibility, the Chief Officer has put in place arrangements for governance, which includes the system of internal control. The system is intended to manage risk to support the achievement of the HSCP Board's policies, aims and objectives. Reliance is placed on the NHSGGC and EDC systems of internal control that support compliance with both organisations' polices and promotes achievement of each organisation's aims and objectives, as well as those of the HSCP Board.

The system of internal control is designed to manage risk to a reasonable level, but cannot eliminate the risk of failure to achieve policies, aims and objectives and can therefore only provide reasonable but not absolute assurance of effectiveness.

The Governance Framework and Internal Control System

The system of internal control is based on a framework designed to identify and prioritise the risks to the achievement of the Partnership's key outcomes, aims and objectives and comprises the structures, processes, cultures and values through which the partnership is directed and controlled.

The system of internal control includes an ongoing process, designed to identify and prioritise those risks that may affect the ability of the Partnership to achieve its aims and objectives. In doing so, it evaluates the likelihood and impact of those risks and seeks to manage them efficiently, effectively and economically.

Governance arrangements have been in place throughout the year and up to the date of approval of the statement of accounts.

Key features of the governance framework in 2022/23 are:

- The HSCP Board comprises six voting members – three non-executive Directors of NHSGGC and three local Councillors from EDC. The Board is charged with responsibility for the planning of Integrated Services through directing EDC and the NHSGGC to deliver on the strategic priorities set out in the Strategic Plan. In order to discharge their responsibilities effectively, board members are supported with a development programme. This programme aims to provide opportunities to explore individual member and Board collective responsibilities and values that facilitate decision making, develop understanding of service provision within the HSCP and engage with staff delivering these services and specific sessions on the conduct of the business of the HSCP Board.

- HSCP Boards are 'devolved public bodies' for the purposes of the Ethical Standards in Public Life (Scotland) Act 2000, which requires them to produce a

code of conduct for members. The members of the HSCP Board have adopted and signed up to the Code of Conduct for Members of Devolved Public Bodies and have committed to comply with the rules and regularly review their personal circumstances on an annual basis.

- The HSCP Board has produced and adopted a Scheme of Administration that defines the powers, relationships and organisational aspects for the HSCP Board. This includes the Integration Scheme, Standing Orders for meetings, Terms of reference and membership of HSCP Board committees, the Scheme of Delegation to Officers and the Financial Regulations.

- The Strategic Plan for 2022-2025 outlines eight key priorities to be delivered over the three year period and provides specific commitments and objectives against each of these. It sets out the identified strategic priorities for the HSCP and links the HSCP's priorities to National Health and Wellbeing Outcomes.

- Financial regulations have been developed for the HSCP in accordance with the Integrated Resources Advisory Group (IRAG) guidance and in consultation with EDC and NHSGGC. They set out the respective responsibilities of the Chief Officer and the Chief Finance and Resources Officer in the financial management of the monies delegated to the partnership.

- The Risk Management Policy sets out the process and responsibilities for managing risk in the HSCP. The Corporate Risk Register was revised and approved in January 2023 and is reviewed by the Senior Management Team at least twice a year. Previously there was a separate Covid-19 Risk Register. From January 2023 the risks associated with the Covid pandemic were incorporated into the wider HSCP Corporate risks where they were considered to have an ongoing impact beyond the Covid pandemic and remain relevant.

- Performance Reporting – Regular performance reports are presented to the HSCP Board to monitor progress on an agreed suite of measures and targets against the priorities set out in the strategic plan. This includes the provision of exception reports for targets not being achieved identifying corrective action and steps to be taken to address performance not on target. This scrutiny is supplemented through the Performance, Audit and Risk Committee. A performance management framework has been developed and implemented across the HSCP to ensure accountability for performance at all levels in the organisation. This includes regular presentations on team / service performance to the Senior Management team at a more detailed level and informs higher level performance reporting to the partner agency Chief Executives as part of regular organisation performance reviews (OPRs) and ultimately to the HSCP Board.

- The Performance, Audit and Risk Committee advises the Partnership Board and its Chief Finance and Resources Officer on the effectiveness of the overall internal control environment.

- Clinical and Care Governance arrangements have been developed and led locally by the Clinical Director for the HSCP and through the involvement of the Chief Social Work Officer for EDC.

- Information Governance – the Public Records (Scotland) Act 2011 (Section1 (1)) requires the HSCP Board to prepare a Records Management Plan setting out the proper arrangements for the authority's public records. The HSCP Board updated and approved this in March 2021, prior to submission to the Keeper of the Records of Scotland. In addition, under the Freedom of Information (Scotland) Act, the HSCP Board published a Freedom of Information Publication Scheme in March 2017.

- The HSCP Board is a formal full partner of the East Dunbartonshire Community Planning Partnership Board (CPPB) and provides regular relevant updates to the CPPB on the work of the HSCP.

Roles and Responsibilities of the Performance, Audit and Risk Committee and Chief Internal Auditor

Board members and officers of the HSCP Board are committed to the concept of sound internal control and the effective delivery of HSCP Board services. The HSCP Board's Performance, Audit and Risk Committee operates in accordance with CIPFA's Audit Committee Principles in Local Authorities in Scotland and Audit Committees: Practical Guidance for Local Authorities.

The Performance, Audit and Risk Committee performs a scrutiny role in relation to the application of CIPFA's Public Sector Internal Audit Standards 2017 (PSIAS) and regularly monitors the performance of the Partnership's internal audit service. The appointed Chief Internal Auditor has responsibility to perform independent reviews and to report to the Performance, Audit and Risk Committee annually, to provide assurance on the adequacy and effectiveness of conformance with PSIAS.

The internal audit service undertakes an annual programme of work, approved by the Performance, Audit and Risk Committee, based on a strategic risk assessment. The appointed Chief Internal Auditor provides an independent opinion on the adequacy and effectiveness of internal control. East Dunbartonshire Council's Audit and Risk Manager is the Chief Internal Auditor for the Partnership. In this role, the assurance is based on the available information including HSCP audits, EDC internal audit reports relating to the Partnership and summary reports on NHSGGC internal audits that relate to the partnership. Internal audit have continued to take a risk based approach in completing the internal audit plan. There have been no impairments or restrictions of scope during the course of the year.

Based on Internal Audit work completed in 2022/23 in accordance with Public Sector Internal Audit Standards (PSIAS), the Chief Internal Auditor has concluded that the HSCP's internal control procedures were generally found to operate as intended, with reasonable assurance being provided on the integrity of controls. A number of additional recommendations have been made by the internal audit team in 2022/23 in order to improve controls further, and action plans developed with management to address the risks identified. The Chief Internal Auditor has conducted a review of all HSCP and EDC Internal Audit reports issued in the financial year, together with summary reports on NHSGGC Internal Audit work and Certificates of Assurance from the EDC and partnership Senior Management Team. Although no system of internal control can provide absolute assurance, nor can Internal Audit give that assurance, based on the audit work undertaken during the reporting period, the Chief Internal

Auditor is able to conclude that a reasonable level of assurance can be given that the system of internal control is operating effectively within the organisation.

Update on Previous Governance Issues

The 2021/22 Annual Governance Statement set out a number of Improvement Actions to enhance the governance arrangements within the partnership or which the partnership relies on to support effective internal controls. These are updated below:

- EDC Internal Audit Reports – EDC Internal Audit have performed a follow up review which confirmed that a high risk prior year issue remained in progress relating to contractual arrangements for Social Work Contract Monitoring. This is being addressed via a risk assessment template which documents the next steps for each service and is signed off by the Heads of Service. This will in turn provide a prioritised work plan thereby embedding this work into the business as usual arrangements in Strategic Commissioning, Procurement and Legal Services.

- External Reports – it was stated in last year's governance statement that the HSCP would take cognisance of external reports and develop action plans that seek to improve governance arrangements in line with best practice. This has occurred, with the partnership developing action plans in response to reports from Audit Scotland and the Care Inspectorate.

Review of Effectiveness

East Dunbartonshire HSCP Board has responsibility for reviewing the effectiveness of the governance and risk management arrangements including the system of internal control. This review is informed by the work of the Chief Officer and the Senior Management Team who have responsibility for the development and maintenance of the governance environment, the Annual Governance Report, the work of internal audit functions for the respective partner organisations and by comments made by external auditors and other review agencies and inspectorates.

The partnership has put in place appropriate management and reporting arrangements to enable it to be satisfied that its approach to corporate governance and risk management is both appropriate and effective in practice.

A range of internal audit assignments has been completed that reviewed the operation of internal controls of relevance to the HSCP Board. These were generally found to operate as intended, with reasonable assurance provided on the integrity of controls. A number of recommendations have been made for areas for further improvement and action plans developed to address the risks identified. Senior Officers have provided assurances that the issues raised by Internal Audit have been or will be addressed. Auditors will conduct testing following completion of the actions, as part of the 2023/24 audit programme.

There has been specific work undertaken by each partner's audit functions. The HSCP's Chief Internal Auditor has considered the conclusions on the areas reviewed by NHSGGC internal auditors in 2022/23. An opinion of reasonable assurance has been provided by the NHSGGC's auditors, Azets, whilst specific areas for

improvement have been highlighted in the course of the year. Similarly, consideration has been made of the opinion provided of reasonable assurance provided by the Council's auditors on its systems, governance and risk management systems.

In the course of the year it was identified by management that a material overpayment was made to NHSGGC. Actions have been identified to improve controls relating to the payment of recharges – these are detailed at the Governance Improvement Plans section below.

The HSCP Board has various meetings, which have received a wide range of reports to enable effective scrutiny of the partnership's performance and risk management updates including regular Chief Officer Updates, financial reports, performance reports, risk registers and service development reports, which contribute to the delivery of the Strategic Plan.

Governance Improvement Plans

The following areas of improvement have been identified for 2023/24, which will seek to enhance governance arrangements within the partnership:

- External Reports – the HSCP will take cognisance of external reports and develop action plans that seek to improve governance arrangements in line with best practice.

- Following the agreement of our authority's Records Management Plan (RMP) in December 2021, the Assessment Team for National Records Scotland have offered East Dunbartonshire Integrated Joint Board the opportunity to provide a Progress Update Review (PUR) on our records management provisions. This is a voluntary arrangement that will provide the IJB with feedback and advice. There may be actions for the HSCP and its partners following this review.

- Internal Audit Reports – Further to the completion of the internal audit work for 2022/23, and following up on previously raised internal audit actions, the main area that the Internal Audit Team highlighted as requiring further improvement was the contractual status of social care expenditure. Action plans have been agreed with management and any outstanding audit actions will continue to be monitored for compliance.

- Management Identified Improvements – As a result of the overpayment referred to above to NHSGGC that was identified, improvements will be made to communication between management and Finance colleagues of decisions with financial implications. In addition, at least annually there will be a review of the recharges in place to ensure that these remain appropriate and should continue.

Assurance

The system of governance (including the system of internal control) operating in 2022/23 provides reasonable assurance that transactions are authorised and properly recorded; that material errors or irregularities are either prevented or detected within a timely period; and that significant risks to the achievement of the strategic priorities and outcomes have been mitigated.

Certification

It is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the East Dunbartonshire HSCP Board's systems of governance.

J Forbes
IJB Chair
20th June 2023

C Sinclair
Chief Officer
20th June 2023

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

This statement shows the cost of providing services for the year according to accepted accounting practices.

2021/22 Gross Expenditure £000	2021/22 Gross Income £000	2021/22 Net Expenditure £000	Care Group	2022/23 Gross Expenditure £000	2022/23 Gross Income £000	2022/23 Net Expenditure £000
3,106	(62)	3,044	Strategic / Resources	3,815	(73)	3,742
1,360	(9)	1,351	Addictions	1,698	(7)	1,691
43,690	(1,026)	42,664	Older People	49,146	(1,595)	47,551
20,853	(374)	20,479	Learning Disability	23,877	(497)	23,380
5,009	(4)	5,005	Physical Disability	5,169	(76)	5,093
6,086	(566)	5,520	Mental Health	6,743	(685)	6,058
15,602	(807)	14,795	Children & Families	16,141	(1,211)	14,930
1,752	(1,406)	346	Criminal Justice	2,216	(1,760)	456
810	0	810	Other - Non Social Work	1,083	(100)	983
11,900	(1,114)	10,786	Oral Health	13,642	(904)	12,738
31,869	(555)	31,314	Family Health Services	34,248	(1,030)	33,218
19,937	(1)	19,936	Prescribing	22,028	(1)	22,027
6,245	(0)	6,245	Covid	9,964	(7,034)	2,930
35,982	*0*	35,982	Set Aside for Delegated Services to Acute Services	40,306	0	40,306
289	0	289	HSCP Board Operational Costs	304	0	304
204,490	**(5,924)**	**198,566**	**Cost of Services Managed By East Dunbartonshire HSCP**	**230,380**	**(14,973)**	**215,407**
	(212,712)	(212,712)	Taxation & Non Specific grant Income		(208,479)	(208,479)
204,490	**(218,636)**	**(14,146)**	**(Surplus) or deficit on Provision of Services**	**230,380**	**(223,452)**	**6,928**
		(14,146)	**Total Comprehensive Income and Expenditure**			**6,928**

MOVEMENT IN RESERVES STATEMENT

This statement shows the movement in the year on the HSCP Board's reserves. The movements which arise due to statutory adjustments which affect the General Fund balance are separately identified from the movements due to accounting practices.

Movements in Reserves During 2022/23	Contingency Reserve (non-earmarked)	Ear-Marked Reserves	Total General Fund Reserves
	£000	£000	£000
Opening Balance at 31 March 2022	**(3,078)**	**(23,912)**	**(26,990)**
Total Comprehensive Income and Expenditure (Increase) / Decrease 2022/23	(1,293)	8,221	6,928
Closing Balance at 31 March 2023	**(4,371)**	**(15,691)**	**(20,062)**

Movements in Reserves During 2021/22	Contingency Reserve (non-earmarked)	Ear-Marked Reserves	Total General Fund Reserves
	£000	£000	£000
Opening Balance at 31 March 2021	**(1,935)**	**(10,909)**	**(12,844)**
Total Comprehensive Income and Expenditure (Increase) / Decrease 2021/22	(1,143)	(13,003)	(14,146)
Closing Balance at 31 March 2022	**(3,078)**	**(23,912)**	**(26,990)**

BALANCE SHEET

The Balance Sheet shows the value as at the 31 March 2022 of the HSCP Board's assets and liabilities. The net assets of the HSCP Board (assets less liabilities) are matched by the reserves held by the HSCP Board.

31 March 2022 £000		Notes	31 March 2023 £000
26,990	Short term Debtors	9	20,062
	Current Assets		
26,990	**Net Assets**		**20,062**
(3,078)	Usable Reserve: Contingency	10	(4,371)
(23,912)	Usable Reserve: Earmarked	10	(15,691)
(26,991)	**Total Reserves**		**(20,062)**

The unaudited accounts were issued on 30 June 2023 and the audited accounts were authorised for issue on xxxx 2023. I certify that the financial statements present a true and fair view of the financial position of the East Dunbartonshire HSCP as at 31 March 2023 and its income and expenditure for the year then ended.

J Campbell
Chief Finance and Resources Officer
20th June 2023

NOTES TO THE FINANCIAL STATEMENTS

1. Significant Accounting Policies

General Principles

The Financial Statements summarise the transactions of East Dunbartonshire HSCP Board for the 2022/23 financial year and its position at the year-end of 31 March 2023.

The HSCP Board was established under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a Section 106 body as defined in the Local Government (Scotland) Act 1973. It is a joint venture between NHSGGC and East Dunbartonshire Council.

The Financial Statements are therefore prepared in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2022/23, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

The accounts are prepared on a going concern basis, which assumes that the HSCP Board will continue in operational existence for the foreseeable future. The historical cost convention has been adopted.

Accruals of Income and Expenditure

Activity is accounted for in the year that it takes place, not simply when settlement in cash occurs. In particular:

- Expenditure is recognised when goods or services are received and their benefits are used by the HSCP Board.
- Income is recognised when the HSCP Board has a right to the income, for instance by meeting any terms and conditions required to earn the income, and receipt of the income is probable.
- Where income and expenditure have been recognised but settlement in cash has not taken place, a debtor or creditor is recorded in the Balance Sheet.
- Where debts may not be received, the balance of debtors is written down.

Funding

The HSCP Board is primarily funded through contributions from the statutory funding partners, East Dunbartonshire Council and NHS Greater Glasgow and Clyde. Expenditure is incurred as the HSCP Board commissions specified health and social care services from the funding partners for the benefit of service recipients in East Dunbartonshire.

Cash and Cash Equivalents

The HSCP Board does not operate a bank account or hold cash. All transactions are settled on behalf of the HSCP Board by the funding partners. Consequently the HSCP Board does not present a 'Cash and Cash Equivalent' figure on the balance sheet.

The funding balance due to or from each funding partner, as at 31 March, is represented as a debtor or creditor on the HSCP Board's Balance Sheet.

Employee Benefits

The HSCP Board does not directly employ staff. Staff are formally employed by the funding partners who retain the liability for pension benefits payable in the future. The HSCP Board therefore does not present a Pensions Liability on its Balance Sheet.

The HSCP Board has a legal responsibility to appoint a Chief Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as employee costs. Where material the Chief Officer's absence entitlement as at 31 March is accrued, for example in relation to annual leave earned but not yet taken.

Charges from funding partners for other staff are treated as administration costs.

Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the HSCP Board's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March, whose existence will only be confirmed by later events. A contingent asset is not recognised in the HSCP Board's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

Reserves

The HSCP Board's reserves are classified as either Usable or Usable Ear-marked Reserves.

The balance of the General Fund as at 31 March 2023 shows the extent of resources which the HSCP Board can use in later years to support service provision and complies with the Reserves Strategy for the partnership.

The ear marked reserve shows the extent of resource available to support service re-design in achievement of the priorities set out in the Strategic Plan including funding which have been allocated for specific purposes but not spent in year.

VAT

The HSCP Board is not a taxable person and does not charge or recover VAT on its functions. The VAT treatment of expenditure in the HSCP Board's accounts depends on which of the partner organisations is providing the service as these agencies are treated differently for VAT purposes.

The services provided to the HSCP Board by the Chief Officer are outside the scope of VAT as they are undertaken under a special legal regime.

Indemnity Insurance

The HSCP Board has indemnity insurance for costs relating primarily to potential claim liabilities regarding Board member and officer responsibilities. The EDC and NHSGGC have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide. Unlike NHS Boards, the HSCP Board does not have any 'shared risk' exposure from participation in CNORIS. The HSCP Board participation in the CNORIS scheme is therefore analogous to normal insurance arrangements.

Known claims are assessed as to the value and probability of settlement. Where it is material the overall expected value of known claims taking probability of settlement into consideration is provided for in the HSCP was £0k, the balance will be payable in Board's Balance Sheet.

The likelihood of receipt of an insurance settlement to cover any claims is separately assessed and, where material, presented as either a debtor or disclosed as a contingent asset.

2. Prior Year Restatement

When items of income and expenditure are material, their nature and amount is disclosed separately, either on the face of the CIES or in the notes to the Accounts, depending on how significant the items are to the understanding of the HSCP's financial performance.

Prior period adjustments may arise as a result of a change in accounting policy, a change in accounting treatment or to correct a material error. Changes are made by adjusting the opening balances and comparative amounts for the prior period which then allows for a consistent year on year comparison.

There have not been any prior year re-statements.

3. Critical Judgements and Estimation Uncertainty

In applying the accounting policies set out above, the HSCP Board has had to make critical judgement relating to services hosted within East Dunbartonshire HSCP for other HSCPs within the NHSGGC area. In preparing the 2022/23 financial statements the HSCP Board is considered to be acting as 'principal', and the full costs of hosted

services are reflected within the financial statements. In delivering these services the HSCP Board has primary responsibility for the provision of these services and bears the risk and reward associated with this service delivery in terms of demand and the financial resources required.

The Annual Accounts contain estimated figures that are based on assumptions made by East Dunbartonshire HSCP about the future or that which are otherwise uncertain. Estimates are made taking into account historical expenditure, current trends and other relevant factors. However, because balances cannot be determined with certainty, actual results could be materially different from the assumptions and estimates made. In applying these estimations, the HSCP has no areas where actual results are expected to be materially different from the estimates used.

4. Events After the Reporting Period

The unaudited Annual Accounts were authorised for issue by the Chief Finance and Resources Officer on 20th June 2023. There were no events that occurred between 1 April 2022 and the date that the Annual Accounts were authorised for issue that would have an impact on the financial statements.

5. Expenditure and Funding Analysis by Nature

2021/22 £000		2022/23 £000
45,183	Employee Costs	53,350
344	Property Costs	445
5,053	Supplies and Services	6,702
56,964	Contractors	71,159
825	Transport and Plant	1,499
199	Administrative Costs	401
30,217	Family Health Service	34,186
19,178	Prescribing	22,028
36,975	Set Aside	40,306
282	HSCP Board Operational Costs	304
(4,591)	Income	(14,973)
190,629	Net Expenditure	215,407
(202,669)	Partners Funding Contributions and Non-Specific	(208,479)
(12,040)	**(Surplus) or Deficit on the Provision of Services**	**6,928**

6. HSCP Board Operational Costs

2021/22 £000		2022/23 £000
261	Staff Costs	274
28	Audit Fees	30
289	**Total Operational Costs**	**304**

External Audit Costs

The appointed Auditors to ED HSCP were Mazars. Fees payable to Mazars in respect of external audit service undertaken were in accordance with the Code of Audit Practice.

7. Support Services

Support services were not delegated to the HSCP Board through the Integration Scheme and are instead provided by the Health Board and Council free of charge as a 'service in kind'. The support services provided is mainly comprised of: financial management and accountancy support, human resources, legal, committee administration services, ICT, payroll, internal audit and the provision of the Chief Internal Auditor.

All support services provided to the HSCP Board were considered not material to these accounts.

8. Taxation and Non-Specific Grant Income

2021/22 £000	PARTNER FUNDING CONTRIBUTIONS	2022/23 £000
62,753	Funding Contribution from East Dunbartonshire Council	71,437
149,959	Funding Contribution from NHS Greater Glasgow & Clyde	137,042
212,712	**Taxation and Non-specific Grant Income**	**208,479**

The funding contribution from the NHSGGC shown above includes £40.306m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by NHSGGC which retains responsibility for managing the costs of providing the services. The HSCP Board however has responsibility for the consumption of, and level of demand placed on, these resources.

The funding contributions from the partners shown above exclude any funding which is ring-fenced for the provision of specific services. Such ring-fenced funding is presented as income in the Cost of Services in the Comprehensive Income and Expenditure Statement.

9. Debtors

31 March 2022 £000		31 March 2023 £000
0	NHS Greater Glasgow and Clyde	0
26,990	East Dunbartonshire Council	20,062
26,990	**Debtors**	**20,062**

The short term debtor relates to the balance of earmarked reserves to support specific initiatives for which the Scottish Government made this funding available and is money held by the parent bodies as reserves available to the partnership. There is also an element related to general contingency reserves – the detail is set out in the note below. All debtor balances are held by EDC at the end of each financial year.

10. Usable Reserve: General Fund

The HSCP Board holds a balance on the General Fund for two main purposes:

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.

- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the HSCP Board's risk management framework.

The table below shows the movements on the General Fund balance, analysed between those elements earmarked for specific planned future expenditure, and the amount held as a general contingency.

Balance at 31 March 2022 £000	HSCP RESERVES	Transfers Out 2022/23 £000	Transfers In 2022/23 £000	Balance at 31 March 2023 £000
(1,100)	HSCP Transformation	0	0	(1,100)
(2,000)	HSCP Accommodation Redesign	0	(1,000)	(3,000)
0	HSCP Smoothing Reserve	0	(594)	(594)
0	HSCP Digital Redesign	0	(500)	(500)
(282)	SG - Integrated Care / Delayed Discharge	0	0	(282)
(3,600)	Oral Health	1,025	0	(2,575)
(1,292)	SG - Primary Care Improvement	976	0	(316)
(687)	SG – Action 15 Mental Health	542	0	(145)
(652)	SG – Alcohol & Drugs Partnership	0	(588)	(1,240)
(229)	GP Premises	0	0	(229)
(185)	Prescribing	0	(1,000)	(1,185)
(9,963)	Covid	9,963	0	0
(341)	Community Living Charge	0	0	(341)
(2,217)	Adult Winter Planning Funding	190	(476)	(2,503)
(51)	Mental Health Recovery & Renewal	0	(68)	(119)
0	Community Link Workers	0	(267)	(267)
(278)	MH Estate Funding	23	0	(255)
(1,035)	Miscellaneous Reserves	171	(176)	(1,040)
(23,912)	Total Earmarked	12,890	(4,669)	(15,691)
(3,078)	Contingency	0	(1,293)	(4,371)
(26,990)	**General Fund**	**12,890**	**(5,962)**	**(20,062)**

11. Related Party Transactions

The HSCP Board has related party relationships with the EDC and NHSGGC. In particular the nature of the partnership means that the HSCP Board may influence, and be influenced by, its partners. The following transactions and balances included in the HSCP Board's accounts are presented to provide additional information on the relationships.

Transactions with NHS Greater Glasgow and Clyde

2021/22 £000	PARTNER FUNDING CONTRIBUTIONS	2022/23 £000
(149,959)	Funding Contribution received from the NHS Board	(137,042)
115,613	Expenditure on Services by the NHS Board	119,264
130	Key Management Personnel: Non-Voting Bioard Members	137
(34,216)	**Net Transactions with the NHS Board**	**(17,641)**

Key Management Personnel: The non-voting Board members employed by the NHS Board and recharged to the HSCP Board include the Chief Officer and the Chief Finance and Resources Officer. These costs are met in equal share by the EDC and NHSGGC. The details of the remuneration for some specific post-holders are provided in the Remuneration Report.

Balances with NHS Greater Glasgow and Clyde

31 March 2022 £000		31 March 2023 £000
0	Debtor balances: Amounts due from the NHS Board	0
0	**Net Balance with the NHS Board**	**0**

Transactions with East Dunbartonshire Council

2021/22 £000	PARTNER FUNDING CONTRIBUTIONS	2022/23 £000
(62,753)	Funding Contribution received from the Council	(71,437)
82,665	Expenditure on Services by the Council	95,839
	Key Management Personnel: Non-Voting Bioard	
130	Members	137
28	Support Services	30
20,070	**Net Transactions with the Council**	**24,569**

Balances with East Dunbartonshire Council

31 March 2022 £000		31 March 2023 £000
26,990	Debtor balances: Amounts due from the Council	20,062
26,990	**Net Balance with the Council**	**20,062**

12. Contingent Assets and Liabilities

A contingent asset or liability arises where an event has taken place that gives the HSCP Board a possible obligation or benefit whose existence will only be confirmed by the occurrence or otherwise of uncertain future events not wholly within the control of the HSCP Board. Contingent liabilities or assets also arise in circumstances where a provision would otherwise be made but, either it is not probable that an outflow of resources will be required or the amount of the obligation cannot be measured reliably.

Contingent assets and liabilities are not recognised in the Balance Sheet but disclosed in a note to the Accounts where they are deemed material.

The HSCP Board is not aware of any material contingent asset or liability as at the 31 March 2023.

13. New Standards issued but not yet adopted

The Code requires the disclosure of information relating to the impact of an accounting change that will be required by a new standard that has been issued but not yet adopted. The HSCP Board considers that there are no such standards which would have significant impact on its annual accounts.

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

Agenda Item Number: 4b. APPENDIX 2

East Dunbartonshire Health & Social Care Partnership Board
Local Code of Good Governance – Assurance Review & Assessment
Owner: Chief Finance & Resources Officer Status: Draft Approval Date: Review Date: 20th June 2023

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of the law.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Integration Scheme • Governance Arrangements, Structures and Terms of Reference (Partnership Board and Performance, Audit & Risk Committee) • Standing Orders • Code of Conduct • Local Code of Good Governance • Declaration of Interests • Minutes of meetings of Partnership Board and Performance, Audit & Risk Committee • Strategic Plan 2022-25 • HSCP Vision & Values Statement • Workforce & Organisational Development Strategy - Health & Social Care Partnership Board Development • Participation & Engagement Strategy • Strategic Partnership Agreements • Financial Regulations • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Annual Audit Report 2021/22 by Audit Scotland as external (third party) auditors • Audit Plans (Internal and Third Party)	• Standing Orders • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Statutory Officers and Statutory Appointments • Financial Regulations/Procedures • Financial Reporting and Scrutiny across Management Structures (e.g., budget monitoring) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Chief Social Work Officer Annual Report • Information Governance (including Freedom of Information, Records Management Plan, Information Sharing and Information and Physical Security) • Employee Code of Conduct • HR Policies and Procedures (including Whistleblowing Policy) • Declaration of Interests (required staff) • Gifts and Hospitality Declaration • Anti-Bribery/Fraud Policy	• Standing Orders • Schedule of Reserved Decisions • Scheme of Delegation and Standing Financial Instructions • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Financial Procedures • Financial Reporting and Scrutiny across Management Structures • Clinical Governance and Integrated Clinical and Professional Governance Arrangements and Reporting • Information Governance (Freedom of Information, Records Management, Information Sharing and Information Security) • Staff Survey (iMatters) • Employee Conduct Policy • NHSGGC Board Members Code of Conduct • eKSF Processes/Objective Setting • HR Policies and Procedures (including Whistleblowing Policy) • Complaints Handling Procedure

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of the law.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • Complaints Handling Procedure • Work to refresh the Equalities Mainstream Report and creation of EQIA post to oversee compliance • Impact Assessment Framework (including EQIAs, SEIA, Risk Assessments, Data Impact Assessments) • Integrated Clinical and Care Governance Arrangements and Reporting • Internal Audit Report of the Partnership Board's Governance, Performance and Financial Management Arrangements • Corporate Risk Register, Covid risk Register, Financial Risk Register • HSCP Risk Management Plan • Regular HSCP Updates on key developments to Board during Covid-19 pandemic / recovery through CO Update	• Complaints Handling Procedure • Impact Assessment Framework (including EQIAs, SEIA, Risk Assessments, Data Impact Assessments) • Health and Safety Arrangements (including policies and procedures and audits) • Workforce Plan (including Organisational Development Strategy) • Supervision and Personal Development Plan Framework • Staff Induction • Staff Survey • Communications Strategy • Staff Engagement Opportunities • Risk Register • Risk Management Plan	• Impact Assessment Framework (including EQIAs, SEIA, Risk Assessments, Data Impact Assessments) • Health and Safety Arrangements (including policies and procedures and audits) • Workforce Plan (including Organisational Development Strategy) • Supervision and Personal Development Plan Framework • Staff Induction • Staff Survey • Communications Strategy • Staff Engagement Opportunities • Risk Register • Risk Management Plan

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Ensuring openness and comprehensive stakeholder engagement.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Governance Arrangements and Structure (Partnership Board and Performance, Audit & Risk Committee) • Partnership Board Membership (incl. Stakeholder Members for patients/service users, carers, third sector and Trade Unions) • Live streaming of IJB meetings to support virtual meeting arrangements and access to wider public • Publication of Partnership Board and Performance, Audit & Risk Committee papers and minutes of public meetings • Strategic Plan 2022-25 • Annual and Quarterly Public Performance Report • On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning, Older People Daycare, Recovery) • Strategic Partnership Agreements • Locality Group Work Plans • Participation and Engagement Strategy • Work to refresh the Equalities Mainstreaming Report • Locality Engagement Networks • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • Complaints Handling Procedure • Comprehensive consultation and engagement of policy and strategy development • HSCP website • Public, Service User and Carer Support Group • HSCP Staff Partnership Forum	• Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Strategic Planning arrangements • Performance Management Framework and Reporting (HGIOS) • Information Governance (Freedom of Information, Records Management and Information Sharing) • Publication of Committee papers • Workforce Plan (including Organisational Development Strategy) • Supervision Framework • Staff Survey • Practice Governance (social care) arrangements • Communications Strategy • Equalities Arrangements (including EQIAs) • Trade Union liaison and engagement (Joint Management Group)	• NHSGGC Feedback Service • NHSGGC Local Delivery Plan • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Performance Management Framework and Reporting • Information Governance (including Freedom of Information, Records Management, Information Sharing and Information Security) • Publication of Board papers • Workforce Plan (including Organisational Development Strategy) • Supervision Framework • Staff Governance Framework • Staff Survey (iMatters) • Communications Strategy • Staff Engagement Opportunities • Equalities Arrangements (including EQIAs) • Trade Union liaison and engagement – Area Partnership Forum

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Defining outcomes in terms of sustainable economic, social and environmental benefits.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Strategic Plan 2022-25 includes our approach to climate change work, the completion of a Strategic & Environmental Screening Assessment and specific actions on the HSCP contribution to the Climate action agenda • Actions set out in the HSCP Business Improvement Plan to contribute to Council sustainability and Climate Change agenda linked to LOIP objectives. • Annual and Quarterly Performance Report • On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning, Older People's Social Support , Recovery) • Locality Group Work Plans • Participation and Engagement Strategy • Work to refresh the Equalities Mainstreaming Report • Locality Engagement Networks • Performance Management Framework and Reporting • Annual and Quarterly Public Performance Report	• Strategic Planning arrangements • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Performance Management Framework and Reporting • Annual Performance Report • Local Outcome Improvement Plan (LOIP)	• NHSGGC Moving Forward Together Strategy • NHSGGC Local Delivery Plan • NHSGGC Remobilisation Plan 3 • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Performance Management Framework and Reporting • Annual Performance Report

Governance Principle	Level of Compliance (Fully; Partial; or Not)	
Determining the interventions necessary to optimise the achievement of intended outcomes.	Fully Compliant	
Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Strategic Plan 2022-25 • HSCP Annual Delivery Plan and oversight through Annual Delivery Plan Board • Medium Term Financial Strategy 2022 - 2027 • Risk Management Strategy and Procedure and Reporting • Integrated Corporate Risk Register, reviewed and updated quarterly • Business Continuity Plan • Preparation of Budgets in accordance with Strategic Plan • Budget Monitoring and Reporting • Approved savings, transformation and recovery Plans • Annual and Quarterly Public Performance Reports • Performance Management Framework and Reporting to SMT • Audit Plans and Assurance (Internal and Third Party) • On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning, Fair Access to Community Care) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme)	• Strategic Planning arrangements • Risk Management Strategy and Procedure and Reporting • Resilience Plans and Arrangements (Business Continuity and Emergency Plans) • Preparation of Budgets in accordance with organisational objectives, strategies and the medium term financial plan • Budget Monitoring and Reporting • Medium Term Financial Strategy • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information and Physical Security) • Health and Safety Arrangements (including policies and procedures and audits)	• NHSGGC Moving Forward Together Strategy • NHSGGC Local Delivery Plan • NHSGGC Remobilisation Plan • Risk Management Strategy and Procedure and Reporting • Resilience Plans and Arrangements (Business Continuity and Emergency Plans) • Budget Monitoring and Reporting • Preparation of Budgets in accordance with organisational objectives and strategies • Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical Governance and Integrated Clinical and Professional Governance Arrangements and Reporting • Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information Security) • Health and Safety Arrangements (including policies and procedures and audits)
• Standing Orders • Code of Conduct • Scheme of Delegation	• Workforce Plan (including Organisational Development Strategy)	• Workforce Plan (including Organisational Development Strategy)

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Determining the interventions necessary to optimise the achievement of intended outcomes.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Local Code of Good Governance • Workforce & Organisational Development Strategy - Health & Social Care Partnership Board Development • Complaints Handling Procedure • Equalities Mainstream Report • Integrated Clinical and Care Governance Arrangements and Reporting • Integrated Operational Management Teams • Leadership group meetings • Leadership Forums • Vision & Values Statement and engagement and communication across teams • Leadership development programmes • Development Programme for IJB members. • Internal Audit Report of the Partnership Board's Governance, Performance and Financial Management Arrangements • Staff Partnership Forum (TU Liaison and engagement)	• Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Elected Member Induction • Staff Induction • Leadership and Staff Development and Training Opportunities • Supervision and Personal Development Plan Framework • Staff Groups for Equalities and Diversity • Trade Union liaison and engagement (Joint Management Group	• Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Clinical and Care Governance Arrangements and Reporting • Board Members Induction • Staff Induction • Leadership, First Line Management and Staff Development and Training Opportunities • Supervision and Personal Development Plan Framework • Staff Groups for Equalities and Diversity • Trade Union liaison and engagement – Area Partnership Forum

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Managing risk and performance through robust internal control and strong public financial management.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Integration Scheme • Financial Regulations • Standing Orders • Performance, Audit & Risk Committee – Terms of Reference and scrutiny • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Annual review and update of Internal Control checklists across SMT Heads • Annual Audit Report (Audit Scotland) • Annual Governance Statement • Strategic Plan 2022-25 • HSCP Medium Term Financial Strategy 2022 – 2027 • Reserves Strategy • Risk Management Strategy and Procedure and Reporting • Integrated Corporate Risk Register • Business Continuity Plan • Preparation of budgets in accordance with Strategic Plan • Budget Monitoring and Reporting • Approved savings, transformation and recovery Plans • HSCP Transformation board • Annual and Quarterly Public Performance Reports	• Financial Regulations • Standing Orders • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Audit Committee – Terms of Reference • Risk Management Strategy and Procedures and Reporting • Anti-Bribery/Fraud Policy • Audit Plans and Assurance (Internal and Third Party) • Annual Governance Statement • Medium Term Financial Strategy • Budget Monitoring and Reporting • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information and Physical Security) • Procurement regulations, training and development • Contract Management Framework • Project Management Framework (Council Transformation Board)	• Schedule of Reserved Decisions • Scheme of Delegation and Standing Financial Instructions • Governance Arrangements and Reporting (including Management Structures, Groups and Forums) • Financial Procedures • Annual Governance Statement • Budget Monitoring and Reporting • Financial Reporting and Scrutiny across Management Structures • Risk Management Strategy and Procedures and Reporting • Fraud Policy • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Records Management, Information Sharing and Information Security) • Financial Improvement Plan and project board

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Managing risk and performance through robust internal control and strong public financial management.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Performance Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme)		

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Implementing good practices in transparency, reporting and audit to deliver effective accountability.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Integration Scheme • Financial Regulations • Governance Arrangements and Structure (Partnership Board and Performance, Audit & Risk Committee) • Publication of Partnership Board and Performance, Audit & Risk Committee papers and minutes of public meetings • Live streaming of IJB meetings to support virtual meeting arrangements and access to wider public • Strategic Plan 2022-25 • Annual and Quarterly Public Performance Report	• Committee Reporting Framework and Schedule • Publication of Committee papers • Financial Regulations/Procedures • Financial Reporting and Scrutiny across Management Structures (e.g., Budget Monitoring) • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Risk Management Strategy and Procedure and Reporting	• Committee Reporting Framework and Schedule • Publication of Board papers • Financial Regulations/Procedures • Financial Reporting and Scrutiny across Management Structures (e.g., Budget Monitoring) • Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • Risk Management Strategy and Procedure and Reporting • Performance Management Framework and Reporting

Governance Principle	Level of Compliance (Fully; Partial; or Not)
Implementing good practices in transparency, reporting and audit to deliver effective accountability.	Fully Compliant

Sources of Assurance		
Partnership Board	**EDC**	**NHSGGC**
• Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet) • HSCP Annual Audit Plan • Annual Audit Report • Risk Management Strategy and Procedure and Reporting • Integrated Corporate Risk Register • Business Continuity Plan • Preparation of budgets in accordance with Strategic Plan • Budget Monitoring and Reporting • Approved Savings and Recovery Plans • Annual and Quarterly Public Performance Reports • Management Framework and Reporting • Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • HSCP website	• Performance Management Framework and Reporting • Annual Performance Report • Audit Plans and Assurance (Internal and Third Party) • Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • Council Website	• Audit Plans and Assurance (Internal and Third Party) • Clinical and Care Governance Arrangements and Reporting • Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) • Board Website

Signature
Name: Jean Campbell
Title: Chief Finance & Resources Officer
East Dunbartonshire HSCP Board

ACHIEVEMENT OF BEST VALUE

Best Value Audit June 2023 – HSCP Evaluation		
1.	Who do you consider to be accountable for securing Best Value in the IJB	Integration Joint Board Integration Joint Board Performance, Audit & Risk Committee HSCP Chief Officer HSCP Chief Finance & Resources Officer Senior Management Team HSCP Leadership Group and Forum Parent Organisations around support services, assets and all staff who are involved in commissioning and procurement. All staff involved in the prescription of packages of care, drugs and drugs (acting in line with agreed policies etc.)
2.	How do you receive assurance that the services supporting the delivery of strategic plans are securing Best Value	Performance management reporting on a quarterly basis to IJB. Explicit links between financial and service planning through Annual Service Delivery Planning, HOS plans, Service Plans to ensure a golden thread that links back to our over-arching Strategic Plan. Scrutiny of delivery through our Annual Delivery Plan Board and SMT with regular updates and scrutiny to PAR Committee on key priorities. Application of HSCP Performance Reporting and Quality Management Frameworks Monthly Performance Reports Annual Performance Report Audit and Inspection Reports Integration Joint Board Meetings – consideration of wide range of reports in furtherance of strategic planning priorities. Engagement with Finance leads from partner organisations Performance, Audit & Risk Committee scrutiny Clinical & Care Governance Group Strategic Planning Group Senior Management Team scrutiny (HSCP) Service specific Leadership Groups and operational management supervision Corporate Management Teams of the Health Board and Council Service specific performance updates to SMT on a regular basis. Operational Performance Review: scrutiny by CEOs of Council and Health Board Housing, Health & Social Care Forum

Best Value Audit June 2023 – HSCP Evaluation		
		Business Improvement Planning (BIP) and How Good is our Service (HGIOS) reports to Council, including Local Government Benchmarking Framework analysis. HSCP Commissioning Strategy and Market Facilitation Plan The IJB also places reliance on the controls and procedures of our partner organisations in terms of Best Value delivery.
3.	Do you consider there to be a sufficient buy-in to the IJB's longer term vision from partner officers and members	Yes, the IJB has approved a Medium Term Financial Strategy 2022 - 2027 setting out the financial outlook, challenges and strategy for managing the medium term financial landscape. This is reviewed annually. This is aligned to its Strategic Plan which clearly sets out the direction of travel with work underway to develop and engage on the next iteration of the Strategic Plan. The IJB has good joint working arrangements in place and has benefited from ongoing support, within the resources available, in support of service redesign, from members and officers within our partner organisations over the past 12 months in order to deliver the IJBs longer term vision. Engagement with partner agency finance leads to focus on budget performance, financial planning in support of delivery of strategic priorities. Bi Annual OPR meetings with partner agency Chief Executives to focus on performance and good practice and any support required to progress initiatives. (frequency impacted through Covid-19 response / recovery and to be re-established)
4.	How is value for money demonstrated in the decisions made by the IJB	Monthly budget reports and scrutiny at service level and regular budget meetings with managers across the HSCP. IJB development sessions Chief Finance & Resources Officer Budget Monitoring Reports to the IJB Review of current commissioning arrangements across the HSCP to ensure compliance with Procurement rules through Parent Organisation processes in support of service delivery. All IJB papers carry a section that clearly outlines the financial implications of each proposal as well as other implications in terms of legal, procurement, HR, equality and diversity and linkage to the IJBs strategic objectives. The IJB engages in healthy debate and discussions around any proposed investment decisions and savings proposals, many of which are supported by additional IJB development sessions. In addition IJB directions to the Health Board and Council require them to deliver our services in line with our strategic priorities and Best Value principles – 'Optimise efficiency,

Best Value Audit June 2023 – HSCP Evaluation		
		effectiveness and flexibility'. This has been enhanced in light of the final strategic guidance on directions with regular oversight and monitoring of delivery through PAR Committee and IJB.
5.	Do you consider there to be a culture of continuous improvement?	The HSCP has an overarching Quality Management Framework that establishes a cultural and operational commitment to continuous improvement. This is being implemented across the HSCP with a Governance post now in place to provide effective oversight and monitoring of consistent quality aspects set out within the framework. Focus on self-evaluation work as a means for identifying improvement and preparation for strategic inspections. The HSCP Clinical & Care Governance Group provides strategic leadership in developing a culture of continuous improvement with representation across all professional disciplines and operational service groups with a focus on improving the quality of services delivered throughout the partnership. There is a range of activity in this area: • A number of HSCP service areas now have service improvement plans in place and a focused approach to quality/continuous improvement (QI). Examples of these improvements are captured and reported through the Clinical & Care Governance Group and reported to the IJB. • The Public Service User and Carers group has been involved in developing improvement activity on areas highlighted through engagement events. • In addition, a number of service reviews and redesign work strands are underway/or planned to maximise effectiveness, resources and improve the patient/service users journey across East Dunbartonshire. • The HSCP Annual Delivery Plan is focussed on proactively developing our health and social care services in line with national direction and statutory requirements; optimising the opportunities joint and integrated working offers; and ensuring any service redesign is informed by a strategic planning and commissioning approach (subject to regular IJB reports). • Lessons learned through Covid-19 response has escalated a number of areas of improvement e.g. through maximising use of digital, virtual meetings, focus on aspects of quality improvement through enhanced support to care home sector. • HSCP Organisational Development and Training, Learning and Education resources support services in undertaking improvement activity.

Best Value Audit June 2023 – HSCP Evaluation		
		• A wide range of stakeholder consultation and engagement exercises, to evaluate the quality of customer experience and outcomes. • Regular service audits, both internal and arm's length. • An extensive range of self-evaluation activity, for example case-file assessment against quality standards. • There are opportunities for teams to be involved in Quality Improvement development, which includes ongoing support and coaching for their improvement activity through our organisational development lead. • Workforce planning and OD/service improvement (SI) activity is planned, monitored and evaluated through our Human Resources and Organisational Development leads. • A Quality and Improvement Framework has been developed to support continuous improvement within the in-house Care at Home Service.
6.	Have there been any service reviews undertaken since establishment – have improvements in services and/or reductions in pressures as a result of joint working?	A robust process for progressing service reviews is in place with support from the Council's transformation team where appropriate. A number of reviews have been undertaken including: • Review of locality management arrangements to support locality working including alignment of contractual arrangements for care at home services. • Review of Learning Disability Services - Whole System Review of services to support individuals with a learning disability including daycare provision and supported accommodation. Overarching Adult Learning Disability Strategy established that sets out redesign priorities. Fair access and resource allocation policy approved and implemented to manage current and future demand on a sustainable basis and to achieve Best Value. LD Day service element concluded in 22/23 with successful move to the Allander Resource Centre as part of a wider community development. Further work will progress on employment opportunities and maximising supports within the community as well as re-patriating individuals in high cost daycare provision out with the area. Work underway to progress improvements and developments across LD in house and commissioned supported accommodation. • Review of Mental Health & Addiction Services through an updated needs assessment with an action plan for progression in line with recovery based approach and strategic realignment of commissioned services. • Review of Older People's Daycare and Social Supports model concluded during 22/23 with the development of an updated needs assessment and Older People's Formal

Best Value Audit June 2023 – HSCP Evaluation		
		and Informal Social Supports and Daycare Strategy. This included the approval of a revised model for the delivery of centre based daycare which will facilitate investment into more community based supports. The HSCP is also participating in a number of reviews in collaboration with NHS GGC such as • Un scheduled Care Review / Commissioning Plan/ Design and Delivery Plan • Mental Health Review and 5 year Strategy • Primary Care Improvement Plan (PCIP) and delivery of the GP contract requirements There are a number of work streams to be progressed through the HSCP Annual Delivery Plans which sets out the transformation activity for the year and the strategic areas of work the HSCP will be progressing during 23/24.
7.	Have identified improvement actions been prioritised in terms of those likely to have the greatest impact.	The oversight for any improvement activity identified through service review, inspection reports, incident reporting or complaints learning is through the Clinical and Care Governance Group. This is reported through the SMT, the Performance, Audit & Risk Committee and the IJB to ensure priority is afforded to progress areas of high risk with scope for most improvement. The Annual Delivery Board has a role to consider and oversee service redesign which will deliver service improvement including robust business cases and progress reporting to ensure effective delivery in line with strategic planning priorities and quality care governance and professional standards.
8.	What steps are taken to ensure that quality of care and service provided is not compromised as a result of cost saving measures.	All savings proposals are subject to a full assessment which includes: • Alignment to Strategic Plan • Alignment to quality care governance and professional standards including risk assessment by Professional Lead • Equalities impact assessed • Risk assessment by responsible Heads of Service and mitigating actions introduced • Stakeholder engagement as appropriate Where possible, the HSCP look to take evidence based approaches or tests of change to ensure anticipated benefits are realised and there is no compromise to care.
9.	Is performance information reported to the board of sufficient	Regular budget and performance monitoring reports to the IJB give oversight of performance against agreed targets with narrative covering rationale, situational analysis and improvement actions for areas where performance is off

Best Value Audit June 2023 – HSCP Evaluation		
	detail to enable value of money to be assessed	target. These reports are presented quarterly as well as the detailed Annual Performance Report. Financial performance reported every cycle to IJB. Plans to revise format of performance report to include finance narrative to provide linkages of impact of performance on the partnership financial position. The Annual Service Delivery Plan aligns key priorities for service redesign and transformation to the delivery of efficiency savings which are regularly reported through the Financial monitoring reports to the IJB and regular scrutiny of the transformation plan through the Performance, Audit and risk committee.
10.	How does the IJB ensure that management of resources (finances, workforce etc.) is effective and sustainable	Workforce and Organisational Development plan linked to strategic plan. Oversight through Staff Partnership Forum and reporting through the IJB. Service review process involves staff partnership representation for consideration of workforce issues. Regular budget and performance monitoring reports to the IJB give oversight of this performance. Financial planning updates to the IJB on budget setting for the partnership highlighting areas for service redesign, impact and key risks. Regular review and update on reserves positions as a means of providing contingency to manage any in year unplanned events. All IJB reports contain a section outlining the financial implications of each paper for consideration.

Agenda Item 4d: APPENDIX 4

CIPFA Financial Management Code – Self Assessment and Action Plan

FM Ref	Requirement	What we are currently doing	Areas for Development
1. The responsibilities of the chief finance officer and leadership team			

A	The leadership team can demonstrate that the services provided by the IJB provide value for money	• The IJB has the following in place to ensure best value:-
		  • Regular reports to every IJB in relation to financial performance
		  • Update and presentations to IJB development sessions on relevant matters related to finance for scrutiny
		  • All reports to the IJB for decisions are clear and can include:-
		  ○ Implications for service users and patients
		  ○ Results of consultations
		  ○ Equality impacts
		  ○ Financial consequences and how these will be funded
		  ○ Where relevant contribution to current and future saving plans
		  • The IJB receives updates on commissioned expenditure and how contracts are being managed.
		  • The HSCP is part of a number of national contracting frameworks to secure economies of scale and better value contracts
		  • The IJB undertakes an annual best value assessment against SG criteria which evidence and demonstrates how it is delivering best value.
		  • External inspection reports for services such as care services are reported to the IJB Performance , Audit & Risk (PAR) Committee	

		• The IJB receives quarterly performance reports, and a statutory Annual Performance Report is produced, in which performance activity is mapped to against the 9 national health and wellbeing outcomes, so that performance management activity across the Partnership is effectively focussed on outcomes. • The IJB has a culture of continuous improvement supported by the Annual Delivery Plan Board which develops and monitors the IJBs transformation and service redesign agenda which seeks to identify service improvements and secure best value. • Annually External Audit assess these arrangements to ensure best value is delivered for the IJB. The most recent audit concluded that the IJB has put in place appropriate arrangements to demonstrate the achievement of Best Value, supported by performance management activity which is effectively focussed on national health and wellbeing outcomes.	
B	The IJB complies with the CIPFA Statement on the Role of the Chief Finance Officer (CFO) in Local Government (2016)	• The Chief Finance & Resources Officer (CFRO) is a key member of the HSCP's Strategic Management Team. • The CFRO is actively involved in all material business decisions and offers challenge and influence on decisions made. This is evidenced through the CFRO's attendance and participation at key business meetings such as the IJB Senior Management Team, Lead the Annuals Delivery Plan Board, HSCP Business Meetings, Partner Body meetings as required and individual transformation programme boards to support major programmes, most recently day care supports for older people.	

		• The CFRO champions the promotion and delivery of good financial management. This is reflected in the management structure within the organisation and the reporting of financial performance to all key management groups. The Annual Delivery Plan Board provides a forum for a strategic overview of financial management as well as offers strategic oversight for future financial management. • The IJBs Financial Regulations clearly outlines the role and responsibilities of the Chief Officer, Chief Finance & Resources Officer and all budget holders in relation to financial management. • The CFRO is a professionally qualified accountant with significant experience as a CFRO. The HSCP's finance team is suitably resourced and experienced in support of the CFRO undertaking their role. There are well established training programmes in place to ensure the continuous learning development and resilience of the team.	
2. Governance and financial management style			
C	The leadership team demonstrates in its actions and behaviours responsibility for governance and internal control.	• The IJB and Senior Leadership Team has a shared vision and commitment to deliver outcomes in line with the IJBs strategic plan. • Behaviours are underpinned by various codes of conduct developed for both IJB Board Members and HSCP employees.	• Continue to review outcome of internal audit reviews of internal controls taking remediation actions where required.

		• The importance of governance and internal controls is reflected in the HSCP's Scheme of Delegation which has clear responsibilities defined for all staff members and establishes the levels at which financial management responsibilities lie in terms of decisions and approvals of spend. This covers all levels of staff including those with the highest position in the organisation. • An annual assessment of compliance with governance and internal controls is undertaken by the Leadership Team for both partner bodies and is part of the annual assurance for both internal and external auditors. This is reported through the Annual Governance Statement within the annual accounts. • Internal audit reviews provide assurance on a range of internal controls. The outcome of these is reported to IJB PAR Committee with actions identified where required and progress in delivering actions monitored. • Annually External Audit assess these arrangements to ensure arrangements are appropriate and operate effectively. The most recent audit concluded that there were no issues with arrangements in place.	
D	The IJB applies CIPFA/SOLACE "Delivering Good Governance in Local Government: Framework (2016)".	• The IJB has adopted governance arrangements consistent where appropriate with the six principles of the CIPFA/SOLACE framework "Delivering Good Governance in Local Government Framework. The system of internal control is designed to manage risks to a reasonable level based on a risked based approach.	• Continue to progress actions plans to improve the contractual underpinning of social work commissioned spend.

		• The Annual Governance Statement (AGS) outlines how the IJB has complied with its Code of Corporate Governance. The statement for 2022/23 confirms there are no significant governance concerns. The governance in relation to the purchase emergency or short notice commissioned care, highlighted in the 2021/22 AGS has seen significant improvement as has the arrangements for contractual underpinning for Social Work Contract monitoring.	

E	The Financial Management style of the IJB supports financial sustainability	• The IJB's financial management style can be described as 'enabling transformation' using the CIPFA FM Financial Management hierarchy Model.
		
		• The IJB has a framework in place to manage its financial affairs including:-
		  • Financial regulations
		  • Scheme of delegation
		  • Financial regulations and standing orders of both Partner Bodies
		  • Medium Term Financial Outlook
		  • Reserve Strategy
		
		• The Leadership Team has a collaborative approach to developing financial strategies for financial sustainability and this can be evidenced in the way the budget and medium term financial outlook are updated and developed each year with active participation and support from all services.
			• Continue to update the Medium Term Financial Outlook in the context of the changing financial environment within which the IJB operates and continue focus on transformation and service redesign opportunities which deliver a balanced budget into future financial years and deliver financial sustainability for the IJB.

		• The Finance Team support all services in developing financial strategies and reporting and advising on all finance matters. • The IJB has a culture of continuous improvement supported by the Annual Delivery Plan Board which develops and monitors the IJBs transformation and service redesign agenda and seeks to identify service improvements and secure best value. • The IJB has set a balanced budget in each year of its existence. • The Medium Term Financial Outlook considers the sustainability of the IJB over the medium term, including an assessment of funding, cost and demand pressures and the risks over the medium term. This includes a review of reserves. The annual budget process for 2023-24 highlighted the need to continue to focus on a transformative agenda and deliver service as efficiently as possible to ensure future financial sustainability, while acknowledging that the options are limited and will inevitably have an impact on the level of services on offer. • There is a scheme of delegation in place for the HSCP which has clear responsibilities defined for all staff members and establishes the levels at which financial management responsibilities lie in terms of decisions and approvals of spend.	

3. Medium to long term financial management			
F	The IJB has carried out a credible and transparent financial resilience assessment	• The Medium Term Financial Outlook considers the sustainability of the IJB over the medium term, including an assessment of funding, cost and demand pressures and the risks over the medium term. This includes a review of reserves. • The Medium Term Financial Outlook includes sensitivity analysis which identifies the implications if planning assumptions change and what the impact of this would be for the financial position of the IJB. • The Medium Term Financial outlook describes the strategy available to the IJB to deliver financial sustainability over the medium term. It also recognises the scale of the financial gap is such that discussions need to continue with Partner Bodies in relation to funding. • While the IJB approved a balanced budget for 2023-24, as well as a robust savings programme there was a reliance on reserves to underwrite / smooth in the delivery of a number of high risk savings. Resort to reserves is a short term solution and cannot be relied upon in future years, therefore the IJB needs to continue to deliver transformation and service redesign options going forward to deliver a balanced budget each year. • The IJB also has an established reserves policy which is reviewed annually.	• The outturn report which will be presented to the IJB in June will include a review of all reserves including proposals, where available, to create reserves which will support delivery of service redesign such as digital solutions, accommodation redesign to support service delivery as well as mitigating any anticipated in year budget pressures which will offer a greater level of financial sustainability.

G	The IJB understands its prospects for financial sustainability in the longer term and has reported this clearly to members.	• The IJB's Annual Budget, Annual Accounts, Medium Term Financial Outlook and Risk Register reflect the main risks to sustainability. These are subject to regular review to ensure these remain robust and relevant for the IJB. The frequency of these reports are annually to the IJB- or PAR Committee, with the exception of the corporate risk register which is taken quarterly. • The Medium Term Financial Outlook assesses both cost and demand pressures and forecasts for funding and uses this to develop a financial strategy over the medium term to address these risk. This is used by the Leadership Team to support the development of plans which aim to deliver financial balance over the longer term. The delivery of plans and options for transformation and service redesign are monitored through the Annual Delivery Plan Board. • The Medium Term Financial Outlook includes sensitivity analysis which identifies the implications if planning assumptions change and what the impact of this would be for the financial position of the IJB. • Development Sessions with IJB members and the Leadership Team are undertaken as part of the annual budget process and these include an overview of the longer term financial sustainability and risks based on the Medium Term Financial Outlook. In addition this is updated and reported to the IJB on an annual basis.	

H	The IJB complies with the CIPFA Prudential Code for Capital Finance in Local Authorities	This is not relevant as the IJB does not have capital programmes or borrowing powers.	
I	The IJB has a rolling multi-year medium-term financial plan consistent with sustainable service plans.	• The IJB has a Medium Term Financial Outlook which is reviewed and updated annually and presented to the IJB for approval in support of delivering the IJBs strategic plan. • The Medium Term Financial Outlook is underpinned by a range of other strategies including commissioning strategies, workforce planning and property and ICT strategies which also support delivery of the IJBs strategic plan. • The Medium Term Financial Outlook is prepared in conjunction with all service areas and reflects all significant demand and cost pressures being experienced both at a local and national level. The plan also considers the strategy for responding to the challenges. • The Medium Term Financial Outlook includes sensitivity analysis which identifies the implications if planning assumptions change and what the impact of this would be for the financial position of the IJB.	Consider the allocation of specific targets to areas of transformation and service redesign over the medium term. Focus has been on annual targets for each service area once the extent of the financial certainty is known. This should include a wider process of engagement and consultation with key stakeholders.
4. The annual budget			
J	The IJB complies with its statutory obligations in respect of the budget setting	• The IJB is fully aware of the need to set a balanced budget as established in s108(2) of the Local Government (Scotland) Act 1973 and s93(3) of the Local	

	process.	Government Finance Act 1992. The need to meet this requirement is set out within the annual budget report. • A balanced budget was agreed by the IJB on 23/03/2023 for 2023/24.	
K	The budget report includes a statement by the CFO on the robustness of the estimates and the statement on the adequacy of the proposed financial reserves.	The requirement for a CFO statement in relation to this is a specific legislative requirement in England and Wales, but not in Scotland. • The 2023/24 Budget report includes a statement from the CFRO on the implications of the budgets on general reserves and the adequacy of these reserves in relation to the financial risks which face the IJB. • This report also highlights where there are risks linked to financial estimates. An example of this in 2023/24 is the prescribing budget where there has been significant price and volume volatility during 2022/23, delivery of the savings programme – both areas requiring resort to under writing through reserves to smooth in delivery and mitigate the impact during 2023/24. • The Medium Term Financial Outlook includes sensitivity analysis which demonstrates the implications if estimates differ from assumptions and the potential impact this could have on IJB finances. • The IJB has a reserve policy which is based on national recommended practice. The Medium Term Financial Outlook, the budget report and the IJB outturn report provide information on levels of general reserves and whether they are sufficient to ensure ongoing	

		sustainability. These reports include actions to manage reserves in the most effective way to support the financial performance if the IJB.	
5. Stakeholder engagement and business cases			
L	The IJB has engaged where appropriate with key stakeholders in developing its long-term financial strategy, medium-term financial plan and annual budget.	• The IJB undertakes comprehensive engagement with all stakeholders when it develops its strategic plan which determines the strategic priorities which the IJB sets out to deliver over the medium term. This engagement provides stakeholders an opportunity to have their say on what their priorities are and this is used to shape the strategic plan, which is then used in shaping the budget both annually and over the medium term. • The IJB has some engagement with stakeholders in developing its annual budget in relation to specific budget proposals, for example where stakeholders are part of the development of transformation plans and also where the impact of savings require detailed EQIAs and therefore consultation with stakeholders. • Stakeholders are well represented on the IJB and annually participate in the discussion as plans are developed and presented to the IJB both in terms of the annual budget and the medium term financial outlook. As well as formal reporting this is included in development sessions with IJB members as the budget develops. • In preparing the annual budget each year, the Leadership Team works in collaboration with both Partner Bodies to	The IJB could be engaging more widely with stakeholders on the development of the annual budget and proposals for transformation and service redesign more widely and on the medium / longer term implications for the IJB.

		ensure that pressures are fully understood as well as the implications of changes to funding for services.	
M	The IJB uses an appropriate documented option appraisal methodology to demonstrate the value for money of its decisions.	• As part of the annual budget process consideration is given to options for savings. This process includes a detailed assessment which includes an assessment of impacts on service users, patients, operational delivery and financial risks. Where relevant this will also include a consideration of options and a recommendation in relation to the preferred option. • Option appraisal is also used as part of capital planning for the IJB when making investment decisions. This is well documented and business case and options appraisal follow project management methodology in line with the processes established by both the Council and Health Board, which includes project management documentation, governance and review meetings and a lesson learned process on follow up post completion which reviews value received and benefit realisation. • Options appraisals are also used, where relevant, as part of transformation programmes. These are well documented and where relevant are reported to the IJB with a clear assessment and recommendation for the IJB to consider. • In line with best practice all options appraisals include both qualitative and quantitative assessments of options.	

6. Monitoring financial performance			
N	The leadership team takes action using reports, enabling it to identify and correct emerging risks to its budget strategy and financial sustainability.	• The Medium Term Financial Outlook is prepared in conjunction with all service areas and leadership teams are asked to identify any emerging risks for consideration as part of the annual budget strategy and the medium term financial outlook. • This discussion is also used to identify specific pieces of work required to mitigate risks moving forward and to agree actions to deliver on this. • Financial performance reports are produced and presented monthly to a variety of leadership, management and team meetings including CFRO / HOS meetings, SMT, the IJB which identify major areas of variations from budget plans. These are discussed and remediation identified where required to bring income or expenditure back in line with expectations. • Deeper dive meetings take place around areas of significant pressure and this includes analysis of historic trends and forecasting of future trends. These meetings also review the impact of actions taken to reduce expenditure to understand the impact being achieved. • Financial forecasting is undertaking during the year to understand changes to in year budget plans and the impact on financial sustainability. This is reported formally to the IJB and provides the IJB with an opportunity to agree a financial strategy to resolve issues in year. This is further updated and reported when final actuals are known at year end.	

		• All teams review risk on a regular basis and this is recorded on the risk register. This is reviewed and reported regularly to the SMT and IJB to ensure oversight and governance. This is used to highlight emerging risks including those which would impact on the budget.	
O	The leadership team monitors the elements of its balance sheet that pose a significant risk to its financial sustainability.	• The main element to the IJB balance sheet relates to reserves balances. Regular reports are produced in relation to the movements in reserves during the financial year and reported each cycle to the IJB. • Financial reports include an update to the IJB on the level of reserves drawn down and or contribution to reserves. The use of reserves also referenced in the budget report, outturn report, annual accounts and the medium term financial outlook.	Improved reporting to IJB on bad debt provision and movements / write offs. While this is held on the Council balance sheet it has relevance to the IJB as impacts on the financial expenditure for the IJB during the year.
7. External Financial Reporting			
P	The chief finance officer has personal responsibility for ensuring that the statutory accounts provided to the local IJB comply with the Code of Practice on Local IJB Accounting in the United Kingdom.	• The IJBs CFRO is responsible for the preparation of the IJBs annual accounts in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom and by the deadlines set in legislation. These responsibilities are set out in the Statement of Responsibilities included in the annual accounts, which is signed by the CFRO. • The CFRO oversees the production of the accounts and ensures those completing them gave access to the Code of Practice and are trained and offered professional guidance as required.	

		• These responsibilities are also included in the CFRO's job description. • The IJB has met all of its statutory reporting deadlines for the submission of draft accounts to the external auditor by 30 June (even during the pandemic when deadlines were relaxed).	
Q	The presentation of the final outturn figures and variations from budget allow the leadership team to make strategic financial decisions.	• The IJBs financial outturn for year is presented to the IJB along with a comprehensive analysis of variations to budget and the drivers of any such variation. • Information from the final outturn is used strategically to inform future budget-setting exercises.	

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 5~~xx~~.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20TH JUNE 2023**
REPORT REFERENCE:	**HSCP/200623/05~~xx~~**
CONTACT OFFICERS:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER, TELEPHONE 0141 232 8216** **GILLIAN MCCONNACHIE, HSCP CHIEF INTERAL AUDITOR, TELEPHONE 0141 574 5642**
SUBJECT TITLE:	**MAZARS – AUDIT OF EAST DUNBARTONSHIRE IJB'S FINANCIAL STATEMENTS FOR THE YEAR ENDING 31 MARCH 2023**

1.0 PURPOSE

1.1 The purpose of this report is to seek committee approval on the proposed response to the letter attached at **Appendix 1**, on behalf of the PAR Committee, to Mazars request for information to support the discharge of their responsibilities under International Standards for Auditing.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.0 Approve the response to Mazars questionnaire, attached as **Appendix 2**, to support and further the discharge of their responsibilities under International Standards for Auditing (ISA) relating to fraud, laws and regulations, litigation and claims and going concern.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 Auditing standards require our external auditors, Mazars, to obtain an understanding of how the Performance, Audit and Risk Committee exercises oversight over East Dunbartonshire IJB's management processes and arrangements. This requires to be updated annually and requires a response to a series of questions focussed on preventing fraud in the annual accounts, compliance with law and regulations, litigation and claims and issues related to the IJB as a going concern.

3.2 In order to properly discharge the External Auditors responsibilities under International Standards for Auditing, evidence is required of how management and 'those charged with governance' are discharging their responsibilities in these specific areas.

3.3 The draft responses to the questions posed by Mazars are set out in **Appendix 2** for committee member's consideration and comment ahead of a final submission by the 31st July 2023.

4.0 IMPLICATIONS

The implications for the Committee are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2022-2025 Priorities;-

1. Empowering People
2. Empowering Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery
7. Post-pandemic Renewal
8. Maximising Operational Integration

4.2 Frontline Service to Customers – None

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – Completion of the questionnaire aids the IJB in meeting its statutory obligation with regards to external audit of the accounts.

4.5 Financial Implications – None

4.6 Procurement – None

4.7 ICT - None

4.8 Economic Impact – None

4.9 Sustainability – None

4.10 Equalities Implications – None

4.11 Other – None

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The risks related to the potential for fraud, non-compliance with laws and regulations, litigation and claims and the ability of the IJB to remain a going concern are set out in the draft responses to the External Auditors.

6.0 IMPACT

6.1 **STATUTORY DUTY –** Completion of the questionnaire aids the IJB in meeting its statutory obligation with regards to external audit of the accounts.

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The IJB relies on the internal controls in place within the Council for the detection of fraud and mitigation of risks related to compliance with relevant laws, litigation and claims.

6.3 **NHS GREATER GLASGOW & CLYDE** - The IJB relies on the internal controls in place within NHSGGC for the detection of fraud and mitigation of risks related to compliance with relevant laws, litigation and claims.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** – Letter from Mazars to the Performance, Audit and Risk Committee Members

8.2 **Appendix 2** – Response to External Auditors, Mazars, questionnaire regarding International Auditing Standards.

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Performance, Audit and Risk Committee
East Dunbartonshire Integration Joint Board
10 Saramago Street
Kirkintilloch
G66 3BF

Date: 19 May 2023

Direct line: 07816 354 994

Email: tom.reid@mazars.co.uk

Dear Performance, Audit and Risk Committee Members,

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

Introduction

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

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

Background

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

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

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

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

The ISA views fraud as either:

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

What are auditors required to do?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Background

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

What are auditors required to do?

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

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

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

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

Background

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

What are auditors required to do?

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

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

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

Background

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

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

What are auditors required to do?

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

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

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

The way forward

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

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

Yours sincerely,

T. Reid

Tom Reid
Audit Director
Mazars LLP

Appendix 2 - Response to External Auditors, Mazars, questionnaire under International Auditing Standards.

Questions	HSCP PAR Response
1) How does the Committee, in its role as those charged with governance, exercise oversight of management's processes in relation to:	
• undertaking an assessment of the risk that the financial statements may be materially misstated due to fraud or error (including the nature, extent and frequency of these assessments);	The HSCP relies on the processes and controls implemented by the partner organisations with regards to fraud. The HSCP does not have a bank account - all transactions are operated through either the Council or the NHSGGC's systems. Nonetheless, management considers the fraud risk with specific reference to the HSCP's accounts. In support of this, the Performance, Audit and Risk (PAR) Committee receives update reports on internal audit work carried out in both partner organisations. The risk of material error is considered in the production of the accounts, through controls in place and through reasonableness reviews. The Committee relies on the work of management and assurances provided by them, and by the work of the external auditors on the financial statements and their integrity. The work of internal auditors and other scrutiny bodies provides further assurances insofar as this work relates to the risk of fraud in the financial statements.
• identifying and responding to risks of fraud in the organisation, including any specific risks of fraud which management have identified or that have been brought to its attention, or classes of transactions, account balances, or disclosure for which a risk of fraud is likely to exist;	Risks are identified and responded to by Senior HSCP management. Internal audit perform a risk based audit plan - this includes fraud risk - and make recommendations for improving controls to reduce risks. These recommendations are then implemented by management and reported on to the Performance, Audit & Risk Committee.
• communicating to employees of views on business practice and ethical behaviour (for example by updating, communicating and monitoring against the organisation's code of conduct); and	Guidance available on partner respective intranet platforms setting out process for reporting suspected fraud. Ad hoc fraud presentations available to HOS and managers. Engagement with relevant fraud teams within partner organisation to provide advice and guidance on process to follow if suspecting fraud. Through the Code of Conduct which was approved by the IJB for Staff, all staff are obliged to comply with the Board's Corporate Governance documentation, which includes the responsibilities of managers and other staff arising from the Board's Fraud Policy. Staff are aware of their responsibilities as set out in GGC and EDC policies. The Council and the NHS have a range of policies and procedures to support ethical behaviour. There is online training via NHSGG&C in Counter Fraud and escalations. Monitoring is carried out via completion of conflict of interest forms for IJB members.
• communicating to those charged with governance the processes for identifying and responding to fraud or error?	Areas of high risk are reviewed by Internal Audit. These risks are highlighted to the Performance, Audit & Risk Committee for oversight.

Questions	HSCP PAR Response
2) How does the Committee oversee management processes to identify and respond to the risk of fraud and possible breaches of internal control? Is the Committee aware of any breaches of internal control during 2022/23? Please provide details.	Internal control processes in place to mitigate fraud across a range of critical processes and subject to regular audit review. Fraud events recorded within respective partner agency fraud teams. The PAR Committee receives a range of assurances and reports during the year which touch upon aspects of internal control: Annual Audit Plans, Annual Internal Audit report and assurance statement, internal audit progress reports, annual governance statement, risk management update on Corporate Risk Register. An annual internal control checklist is prepared by Senior management and informs Chief Officer sign off on the effectiveness of internal controls during each financial year.
3) Has the Committee knowledge of any actual, suspected or alleged fraud during the period 1 April 2022 – 31 March 2023? Where appropriate please provide details.	Oral health is provided with regular Counter Fraud Service updates from the Board's Fraud Liaison Officer in relation to areas of concerns relating to independent dental contractors and potential fraud issues. Any formal investigations are co-ordinated with the service and counter fraud, this is then reported through the Greater Glasgow and Clyde's Reference Committee. Ad-hoc concerns or information received from a third party is shared with counter fraud services and investigated as appropriate. From the mainstream NHS or Council service, any concerns raised are referred to the appropriate Counter-fraud service. There are currently no investigations ongoing in the area of primary care dental services (GDS) and one ongoing in relation to secondary care. Regular audits are undertaken to support Self Directed Support Payments (SDS) and any irregularities are progressed through the Council's Fraud Team – there was one case concluded in 21/22 which has now been referred to HMRC for further review. Self Directed Support Payments were subject to an internal audit review and processes and procedures have been tightened in this area with further improvements under review. These are reflected within internal audit report action and areas for improvement identified through the annual governance statement and reported through updates to the PAR Committee and as part of year end reporting.
4) Has the Committee any suspicion that fraud may be occurring within the organisation? Please provide details. • Has the Committee identified any specific fraud risks within the organisation? Please provide details. • Does the Committee have any concerns that there are areas within the organisation that are at risk of fraud? Please provide details. • Are there particular locations within the organisation where fraud is more likely to occur? Please provide details.	Regular audits are undertaken to support Self Directed Support Payments (SDS) and any irregularities are progressed through the Council's Fraud Team – there was one case concluded in 21/22 which has now been referred to HMRC for further review. As above, dental fraud and self directed support identified as areas of risk. As above. Dental surgeries have been identified as an area of risk.

Questions	HSCP PAR Response
5) Is the Committee satisfied that internal controls, including segregation of duties, exist and work effectively? Please provide details. • If not, where are the risk areas? • What other controls are in place to help prevent, deter or detect fraud?	Yes, Services comply with each partner agency Standing Financial Instructions (SFIs) and is monitored by Heads of Service and HSCP Chief Officer. This includes clarity on tendering and payment processes. Staff are aware of the financial processes pertaining to their sphere of responsibility and ensure compliance with SFI's. Staff teams participate in learning and training opportunities with regard SFI's and in regular discussion and meetings with finance leads. Internal audit functions provide opinions on internal controls in operation and have concluded that reasonable assurance can be provided on the system of internal control for 2022/23. The work of internal audit validates internal controls and where appropriate makes recommendations for improvement. Reconciliations, committee reporting of financial results, controls embedded in systems (e.g. procurement systems), Corporate Procurement team, Internal Audit activity, work of the Corporate fraud team (Council) and Counter Fraud Services (NHS), fraud and whistleblowing email addresses and online reporting facilities including the facility to report allegations anonymously.
6) Is the Committee satisfied that staff are encouraged to report their concerns about fraud, and the types of concerns they are expected to report? Please provide details.	Staff have several potential routes for reporting fraud and are periodically reminded of these. <u>The Council route is via the following:</u> https://www.eastdunbarton.gov.uk/fraud Fraud by filling in the Report Fraud form on the above link or by: Emailing fraud@eastdunbarton.gov.uk(link sends e-mail) Calling customer services on 0300 123 4510 Writing to the Corporate Fraud Team, 2-4 West High Street, Kirkintilloch, G66 1AD <u>The NHS fraud reporting routes are as follows:</u> If you suspect fraud in NHS Scotland, you can report it in confidence by calling 08000 15 16 28 or using the online form. Suspected fraud in NHSScotland can also be reported by writing to: Counter Fraud Services 3 Bain Square Livingston West Lothian EH54 7DQ
7) From a fraud and corruption perspective, what are considered by the Committee to be high risk posts within the organisation? Please provide details. • How are the risks relating to these posts identified, assessed and managed?	Segregation, oversight and controls mitigate this risk as far as possible. Nonetheless the senior management team involved in the procurement/commissioning of higher value social work contracts would be considered to be higher risk positions due to the level of oversight, approval and being responsible for committee reporting. Due to segregation of duties within the payments process fraud would be difficult to perpetrate. Residual risks remain relating to the risk of collusion with a supplier is addressed via Anti Bribery Policies.

Questions	HSCP PAR Response
8) Is the Committee aware of any related party relationships or transactions that could give rise to instances of fraud? Please provide details. • How are the risks associated with fraud related to such relationships and transactions mitigated?	No. Conflict of interest forms are held by the Chief Solicitor & Monitoring Officer of the Council and by the Corporate Business Manager within the HSCP for IJB voting members and senior management who are regularly part of Board and PAR Committee meetings. There is a register of gifts which can be accessed via staffnet / Intranet. Staff are required to register any gifts that are received and they must be approved by their line manager. Disclosure of significant related party relationships is required for both voting members and senior officers in positions of influence through the Conflict of Interest and Code of Conduct forms which are published on the HSCP website.
9) Is the Committee aware of any entries made in the accounting records of the organisation that it believes or suspects are false or intentionally misleading? Please provide details. • Are there particular balances where fraud is more likely to occur? Please provide details. • Is the Committee aware of any assets, liabilities or transactions that it believes were improperly included or omitted from the accounts of the organisation? Please provide details. • Could a false accounting entry escape detection? If so, how? • Are there any external fraud risk factors which are high risk of fraud? Please provide details.	No. We are not aware of any accounting entries which are suspected to be false or intentionally misleading. Should management become aware of any suspect accounting entries, these would be subject to immediate investigation through Internal Audit. The extent of internal controls in place, the review by both internal and external audits provide additional assurance for transactions which are in excess of the materiality value, make the presence of false and misleading statements unlikely. Conflict of interest forms are held by the Chief Solicitor & Monitoring Officer of the Council and by the Corporate Business Manager within the HSCP for IJB voting members and senior management who are regularly part of Board and PAR Committee meetings. Direct Payments carry a higher fraud risk. Regular audits are carried out on these accounts and DPs have also been a focus of Internal Audit with a view to continually improving the control environment. No - the extent of assets held by the IJB and disclosed in the accounts relates to reserves balances only, contingent assets and liabilities are not recognised in the balance sheet but disclosed in a note to the Accounts where they are deemed material and the Board is not aware of any material contingent asset or liability as at the 31 March 2023. Controls are in place to minimise the risk, such as secondary review of journals, preparation and review of reconciliations, review against budgets and analytical review of actual expenditure. Higher risks may relate to the awarding of larger value contracts. More likely but lower value frauds relate to dental fraud and self directed support fraud.
10) Is the Committee aware of any organisational, or management pressure to meet financial or operating targets? Please provide details.	No incentives are offered for meeting financial or operating targets. There is, nonetheless a pressure on HSCP staff to achieve financial savings for continued financial sustainability. This is unlikely to lead to individuals falsifying accounting records as the remuneration of employees is not structured in this way.
11) How does the Committee gain assurance that all relevant laws and regulations have been complied with. For example: • Is the Committee aware of the process management has in place for identifying and responding to changes in laws and regulations? Please provide details. • What arrangements are in place for the Committee to oversee this process?	See below Senior Management horizon scan for new and changing laws and regulations. The legal implications of HSCP Board papers are considered, alongside any statutory duties. The Council's Chief Monitoring Officer is also the IJB Standards Officers and routinely provides advice to HSCP Management on any legal matters and receives copies of all IJB reports prior to finalisation. The Board and the PAR are informed of any significant new legislation and the implications for the HSCP.

Questions	HSCP PAR Response
• Is the Committee aware of the arrangements management have in place, for communicating with employees, non-executive directors, partners and stakeholders regarding the relevant laws and regulations that need to be followed? Please provide details. • Does the Committee have knowledge of actual or suspected instances where appropriate laws and regulations have not been complied with, and if so is it aware of what actions management is taking to address it? Please provide details.	As above, the Board and the PAR are kept informed of any changes and these papers are made publicly available. In addition, HSCP policies reflect relevant legislation and are publicly available. Where non compliance with laws or regulations represents a material risk, action is taken to address. In some instances other risks may outweigh legal risks and so decisions may be taken for non compliance. Where this is the case, this should be documented and appropriately signed off. An example of this is when a procurement waiver form is signed by Head of Service to not comply with the Council's standing orders and potentially procurement legislation. There may be other risks that outweigh procurement risks such as risks to service users.
12) Is the Committee aware of any actual or potential litigation or claims that would affect the financial statements? Please provide details.	We are not aware of any actual or potential litigation or claims which would impact the financial statements which relate to the delegated functions to the IJB. The Internal Control checklists requires the disclosure of any such claims and is completed by HSCP Senior management and signed off by the Chief Officer which provides assurance to the PAR Committee on these matters.
13) How has the Committee assessed and satisfied itself that it is appropriate to adopt the going concern basis in preparing the financial statements?	The HSCP had £20.602m of Usable reserves as at March 2023. The net pressures facing the HSCP for 2023/24 is £3.894m, however savings totalling this figure have been identified for the year. There are a number of areas where savings have been identified that are considered to be of a higher risk where it may take some time to phase these in during the course of 2023/24, where SG guidance is awaited on changes to charging for non-residential care or where the implementation of a service review will take time to fully implement. In recognition of this the HSCP would be seeking to under write these initiatives with a 'smoothing' reserve for 2023/24 until these savings are fully implemented. This provides a balanced budget position for the HSCP for 2023/24 in support of ongoing sustainability. The level of reserves, compliance with the IJB Reserves policy and continued focus on the need for service redesign and transformation provides financial sustainability in the medium term and this along with the anticipated pressures for the HSCP over the next 5 years are reflected within the HSCP Medium Term Financial Strategy 2023-2028.
14) Has the Committee identified any events or conditions since the assessment was undertaken which may cast significant doubt on the organisation's ability to continue as a going concern? Please provide details.	No - the IJB was able to set a balanced budget for 2023/24 with a programme of savings to implement. The Medium Term Financial Strategy sets out the challenges over the next 5 years with a plan in place through service redesign and transformation to deliver recurring financial sustainability into future years.

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 06.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20th JUNE 2023**
REPORT REFERENCE:	**PERF/200623/06**
CONTACT OFFICER:	**ALAN CAIRNS / ALISON WILLACY (J/S) PLANNING, PERFORMANCE AND QUALITY MANAGER**
SUBJECT TITLE:	**HSCP ANNUAL PERFORMANCE REPORT 2022/23**

1.0 PURPOSE

1.1 The purpose of this report is to update the Committee on the HSCP Annual Performance Report 2022-23 that details progress in line with the HSCP Strategic Plan 2022-25 and National Health and Wellbeing Outcomes.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit and Risk Committee:

2.1 Considers the HSCP Annual Performance Report 2022-23 at **Appendix 1.**

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3 BACKGROUND/MAIN ISSUES

3.1 Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 places an obligation on Integration Joint Boards to publish a performance report annually. The minimum contents of annual performance reports are prescribed by regulation and guidance and include:

1. An assessment of performance in relation to the national health and wellbeing outcomes
2. A description of the extent to which the arrangements set out in the strategic plan and the expenditure allocated in the financial statement have achieved, or contributed to achieving, the national health and wellbeing outcomes;
3. Information about the integration authority's performance against key indicators or measures in relation to the national health and wellbeing outcomes over the reporting year and 5 preceding years (where complete);
4. Financial planning and performance;
5. Best value in planning and carrying out integration functions;
6. Performance in respect of localities;
7. Inspection and regulation of services;
8. Any such other information related to assessing performance during the reporting year in planning and carrying out integration functions as the integration authority thinks fit.

3.2 In addition to hard data and evidence in line with the HSCP Strategic Priorities and national outcomes, the document contains important qualitative content that highlights examples of the excellent work that is developed and delivered locally, to improve personal outcomes for the people we support.

3.3 The Performance Report structure has been reviewed and redesigned this year to realign it to the strategic priorities, enablers and measures of success identified in the 2022-25 Strategic Plan.

4 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022-25;-

1. Empowering People
2. Empowering Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery
7. Post-pandemic Renewal
8. Maximising Operational Integration

4.2 Frontline Service to Customers – None.

4.3 Workforce (including any significant resource implications) – None.

4.4 Legal Implications – None.

4.5 Financial Implications – None.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None.

4.11 Other – None.

5 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 None

6 IMPACT

6.1 **STATUTORY DUTY** – The preparation of an Annual Performance Report is a statutory duty that is set out in the Public Bodies (Joint Working) (Scotland) Act 2014

6.0 **EAST DUNBARTONSHIRE COUNCIL** – The report includes indicators and measures of quality and performance relating to services provided by the Council, under Direction of the HSCP Board.

6.2 **NHS GREATER GLASGOW & CLYDE** – The report includes indicators and measures of quality and performance relating to services provided by NHS Greater and Clyde, under Direction of the HSCP Board.

6.3 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8 APPENDICES

8.1 **Appendix 1** – HSCP Annual Performance Report 2022-23

East Dunbartonshire
Health & Social Care
Partnership

Annual Performance Report 2022/23

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow
and Clyde

CONTENTS

Introduction

Health and Social Care Partnerships (HSCPs) were introduced in 2015 to bring together a range of community health and social care services. The responsibility for organising these services previously lay with Councils and Health Boards, but now sits with HSCP Boards (sometimes called Integration Joint Boards). The idea behind creating HSCPs was to integrate health and social care services much more closely under a single manager, with a single combined budget, delivering a single plan to meet a single set of national outcomes in a way that better meets local needs and removes barriers for people using services. The "single plan" is called the HSCP Strategic Plan. It sets out how HSCP Boards will plan and deliver services for their area over the medium term, using the integrated budgets under their control. In East Dunbartonshire we have integrated a wide range of adult and children's community health and social care services, including criminal justice services.

All Health and Social Care Partnerships (HSCPs) are required to publish an Annual Performance Review that sets out progress towards the delivery of its Strategic Plan and in pursuance of:

- the nine National Health & Wellbeing Outcomes;
- the development of locality planning and improvement
- financial performance and Best Value

In addition, we have included information on:

- Our performance as assessed through external inspection and regulation
- Good practice examples

Our Priorities

The pressure on delivering health and social care has continued to be intense throughout the period of this report, due in part to the continuing impact and consequences of the Coronavirus pandemic. With fluctuating emergency response arrangements and the impact on services and staffing levels, the HSCP has had to continue to adapt to a fast pace of change and respond quickly to frequently changing circumstances and regulations. This was been particularly felt during the winter months, when pressure on services was exceptional, contributed to by a return to high influenza rates and the rebounding of demand that was inevitably under-presented during successive periods of lockdown. It is clear that it will take a period of time for health and social care capacity to rebalance and recover from the impact of the last three years.

The HSCP and its staff have risen to these challenges and have continued to work to support the most vulnerable people in our community and promote social justice, equality and safety. Our considerable achievements and innovative practice this year are evident in this report. It is also important to note that the pandemic has affected our ability to deliver some of our regular performance targets, due to the impact on services and staff. Where targets have been achieved, it is also important to recognise the external influences that may have impacted on these achievements. For this reason, the review of

performance in 2022/23 has to be viewed through the lens of the unique set of circumstances that we have all been living through.

Our focus over the last 12 months has also been to align our priorities to our new HSCP Strategic Plan 2022/25, so this Annual Performance Report will look a little different to previous years, as we have structured it to reflect our new strategic priorities and enablers. Our overall aim continues to be to ensure the people of East Dunbartonshire receive the best service possible in a way that is fair, responsive and person-centred.

We were reminded through our Staff Award nominations this year of the outstanding work delivered on a daily basis by our committed workforce, that so consistently go the extra mile for the people that they support. It felt particularly special to be able to hold the Awards ceremony in person this year, after such a challenging period for everyone.

We would wish to extend our enormous gratitude to all the staff, partners and individuals in the HSCP, to volunteers and community groups, to informal carers and families, for the enormous efforts that they have made to the people we have supported over the last 12 months.

Jacquie Forbes

Chair

East Dunbartonshire HSCP Board

Caroline Sinclair

Chief Officer

East Dunbartonshire HSCP

Part 1. Strategic Planning and Delivery

Strategic Plan

Every HSCP Board is required to produce a Strategic Plan that sets out how they intend to achieve, or contribute to achieving, the National Health and Wellbeing Outcomes. Strategic Plans should also have regard to the National Integration Delivery Principles. These national outcomes and principles are set out at **Annex 1**.

In January 2022, the HSCP Board approved a new HSCP Strategic Plan for the period 2022/25[1]. This new plan reflects on the progress the Partnership has made and sets out the strategic direction for the next three years. Our vision remains unchanged, and our refreshed strategic priorities continue to reflect and support delivery of the national outcomes. Demonstrating our achievement towards these will be the focus of annual performance reporting from this year.

However, it is important to acknowledge that the landscape of health and social care has changed markedly in the few short years since the last plan was published. Our aspiration to improve and develop services and partnerships in our 2018/21 Strategic Plan was affected significantly by financial pressures, which were shared with the Health Board and Council. This was compounded by increasing demand pressures, both in terms of increasing volume and increasing complexity of levels of care. The impact of the Covid-19 pandemic has been substantial and may continue to be felt over the full period of our Strategic Plan 2022/25.

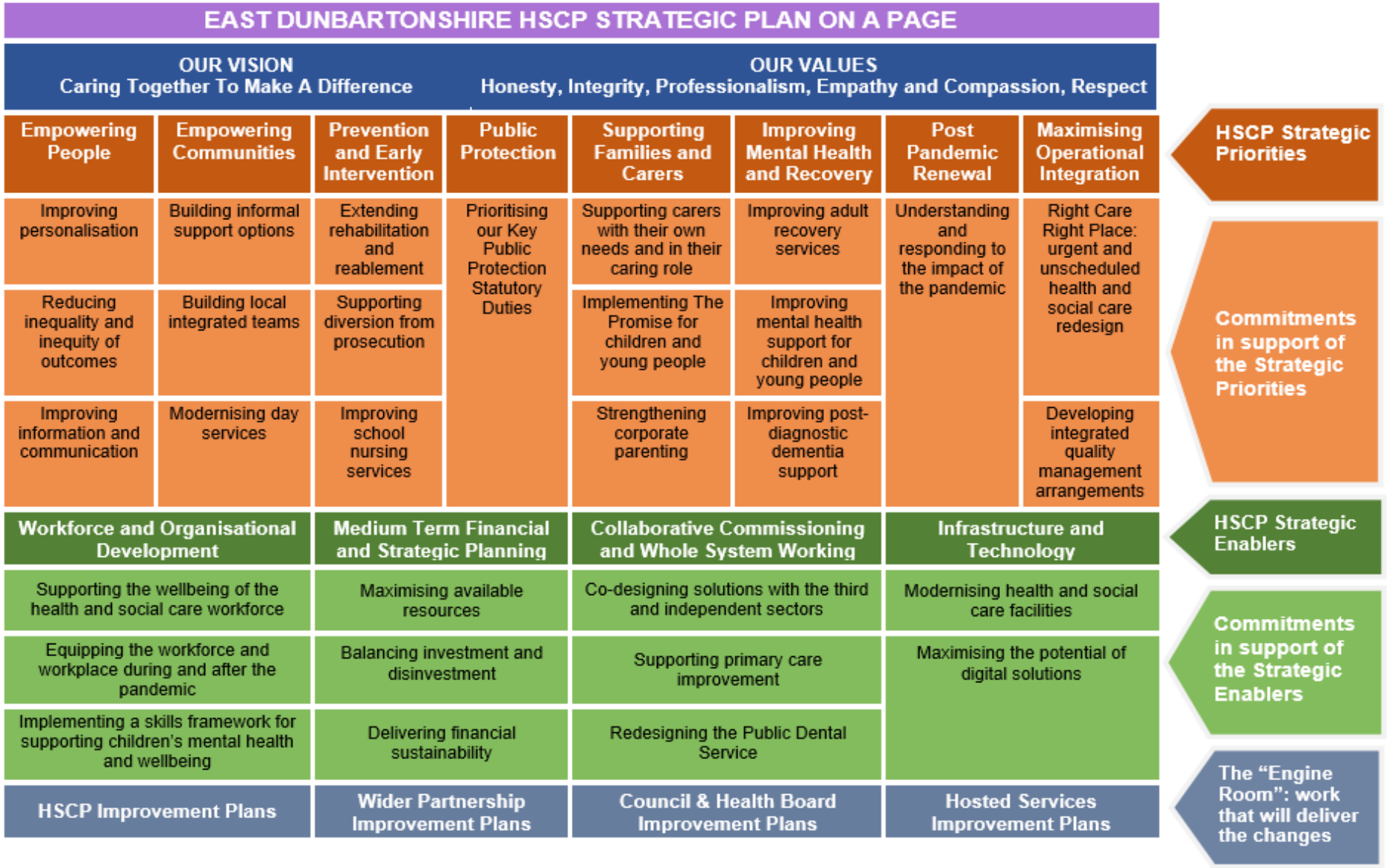
For these reasons, our Strategic Plan 2022/25 has aspirations based on the realities of the pressures being faced in the health and social care sectors and building towards a fair, equitable, sustainable, modern and efficient approach to service delivery. Some of these areas of redesign will take longer than the period of the Strategic Plan to deliver. Without new resource streams, any requirement to invest further in one service area will require greater efficiency or disinvestment in another. Implementing the Plan will also continue to be based on certain assumptions and dependencies that can in reality be fragile. Our overall focus will be to:

- Invest in early intervention and prevention;
- Empower people and communities by encouraging more informal support networks at a local level;
- Ensure that people have access to better information earlier, to allow them to access the right support at the right time, from the right person.

These developments should deliver better outcomes for people and will also make for a more efficient, sustainable system of care and support.

[1] East Dunbartonshire Health and Social Care Partnership Board | East Dunbartonshire Council

The illustration below provides an overview of the Strategic Plan 2022-25. It shows the relationship between the strategic priorities and enablers and the actions that will be taken forward in support of these.



Annual Delivery Plan

Each year a number of improvement actions in support of the Strategic Plan are drawn down into an Annual Delivery Plan. Supporting detail is held in service-level plans, locality plans and service commissioning plans, which collectively set out how the high level strategic priorities and enablers will be pursued.

The HSCP Board monitors progress in achieving the objectives in the Annual Delivery Plan, regularly throughout the year. The Board achieves this with support from the Strategic Planning Group and the Audit Performance & Risk Committee to ensure active governance over how well these aspects of the Strategic Plan are being implemented.

There were a total of 31 initiatives to be taken forward within the Delivery Plan during 2022/23. Many of these initiatives are expected to take more than one year to complete. By the end of 2022/23, progress towards these projects were as follows:

- 24 were successfully completed.
- 1 was programmed to continue beyond 2022/23, but were on track for completion within their overall timescales.
- 6 were reported to be at risk of delay and will be carried forward into the 2023/24 Delivery Plan or into the Heads of Service Delivery Plan for 2023/24.

A summary of the completed Annual Delivery Plan 2022/23 is set out below, with more detail provided in the priority sections later in the report:

HSCP ANNUAL DELIVERY PLAN 2022/23: PROGRESS

Initiative	Strategic Plan Priority	Strategic Plan Commitment	National Outcome
Initiatives Successfully Completed By End 2022/23:			
Develop an HSCP Public Health Strategy and refresh objectives for Public Health Improvement Team	Empowering People	Reduce inequality and inequity of outcomes	1, 2, 3, 4, 5, 6, 7, 9
Redesign of HSCP website	Empowering People	Improving information and communication	1, 2, 3, 4, 5, 6, 7, 9
Increase uptake of support at a distance	Empowering People	Improve Personalisation	1, 2, 3, 4, 5, 6, 7, 9
Learning Disability: service review, action plan and implementation	Empowering Communities	Modernising day services	1, 2, 3, 4, 5, 6, 9

Initiative	Strategic Plan Priority	Strategic Plan Commitment	National Outcome
Develop a Social Support for Older People Strategy	Empowering Communities	Modernising day services	1, 2, 3, 4, 5, 6, 9
Refresh HSCP Locality Plans	Empowering Communities	Building local integrated teams	1, 2, 3, 4, 5, 6, 9
Identify a staff base in the West locality	Empowering Communities	Building local integrated teams	1, 2, 3, 4, 5, 6, 9
Review and redefine operational approaches to community-led support	Empowering Communities	Building informal support options	1, 2, 3, 4, 5, 6, 9
Prioritise Public Protection	Delivering our Key Social Work Public Protection Statutory Duties	Prioritising public protection	4, 5, 7
Delivery of Year 2 of Children's House Project	Supporting Families and Carers	Strengthen corporate parenting	1, 2, 3, 4, 5, 6, 7
Review and update HSCP Carers Strategy	Supporting Families and Carers	Supporting carers with their own needs and in their caring role	1, 2, 3, 4, 5, 6, 7
Implementation of "The Promise"	Supporting Families and Carers	Implementing The Promise for children and young people	1, 2, 3, 4, 5, 6, 7
Review current model of Post Diagnostic Support delivery	Improving Mental Health and Recovery	Improve post-diagnostic support for people with dementia	1, 2, 3, 4, 5, 6, 7
Implement the Children and Young People's Mental Health and Wellbeing Framework	Improving Mental Health and Recovery	Improve mental health support for children and young people	1, 2, 3, 4, 5, 6, 7
Review accommodation arrangements in line with Scottish Government guidance and alongside Health Board and Council policies	Post Pandemic Renewal	Understanding and responding to the impact of the pandemic	1, 4, 5, 8, 9
Develop and implement an organisational	Post Pandemic Renewal	Understanding and responding to the	1, 4, 5, 8, 9

Initiative	Strategic Plan Priority	Strategic Plan Commitment	National Outcome
development plan in support of staff orientation back to buildings		impact of the pandemic	
Address the backlog in unpaid work services, as alternative to custodial sentences	Post Pandemic Renewal	Understanding and responding to the impact of the pandemic	1, 4, 5, 8, 9
Review mainstream Covid-19 testing procedures and implement in line with requirements.	Post Pandemic Renewal	Understanding and responding to the impact of the pandemic	1, 4, 5, 8, 9
Refresh and streamline Personal Protective Equipment (PPE) arrangements	Post Pandemic Renewal	Understanding and responding to the impact of the pandemic	1, 4, 5, 8, 9
Develop and implement a Joint Commissioning Plan for Unscheduled Care	Maximising Operational Integration	Right Care Right Place: urgent and unscheduled health and social care redesign	3, 4, 7, 8, 9
Deliver a range of measures to support staff wellbeing.	Workforce and Organisational Development	Supporting the wellbeing of the health and social care workforce	3, 4, 7, 8, 9
Develop an Annual Delivery Plan for 2022/23	Medium Terms Financial and Strategic Planning	Balancing investment and disinvestment	1, 2, 3, 4, 5, 6, 7, 8, 9
Review the engagement framework in support of collaborative approaches with third and independent sector providers	Collaborative Commissioning	Co-designing solutions with the third and independent sectors	1, 2, 3, 4, 5, 6, 7, 8, 9
Develop and implement an HSCP Property Strategy	Infrastructure and Technology	Modernising health and social care facilities	2, 5, 7, 9

Initiatives with longer term timescales that were on track at end of 2022/23:			
Conclude implementation of the Primary Care Improvement Plan Memorandum of Understanding (2)	Collaborative Commissioning	Supporting Primary Care Improvement	1, 2, 3, 4, 5, 6, 7, 8, 9
Initiatives with longer term timescales that were delayed at end of 2022/23:			
Develop a compassionate communities model in East Dunbartonshire	Empowering Communities	Building informal support options	1, 2, 3, 4, 5, 6, 9
Review of Community Occupational Therapy and Reablement services across the HSCP	Prevention and Early Intervention	Extending rehabilitation and re-ablement	1, 2, 4, 5, 6, 9
Review of commissioned mental health and alcohol and drugs services. Develop action plan for reshaping of services	Improving Mental Health and Recovery	Improving adult mental health and alcohol and drugs recovery	1, 2, 3, 4, 5, 6, 7
Implement the recommendations from the Public Dental Service review Programme Board	Workforce and Organisational Development	Redesigning the Public Dental Service to support the right care is being delivered in the right place at the right time	1, 2, 3, 4, 5, 6, 7, 8, 9
Review HSCP organisational structures	Medium Term Financial and Strategic Planning	Maximising available resources	1, 2, 3, 4, 5, 6, 7, 8, 9
Implement 22/23 Digital Action Plan	Infrastructure and Technology	Maximising the potential of digital solutions	1, 2, 3, 4, 5, 6, 7, 8, 9

PERFORMANCE MANAGEMENT FRAMEWORK

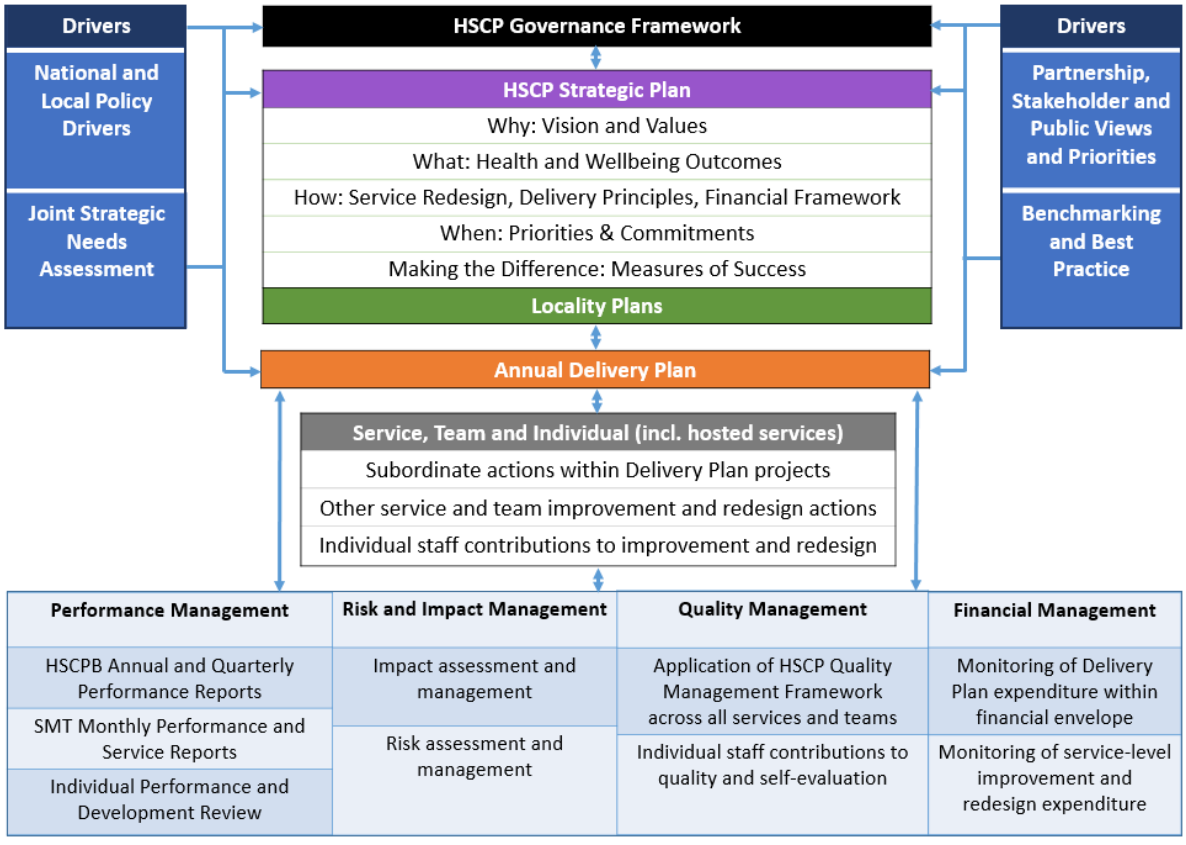
The HSCP has a Performance Management Framework in place that sets out how it measures, monitors and continuously seeks to improve what it does. This is designed to ensure confidence at all levels that it knows how well it is performing, that it knows what should improve and how, and that it knows the impact of any such improvements. The Performance Management Framework also sets out in detail its approach to monitoring and measuring success, including the production of this Annual Performance Report.

The HSCP's Performance Management Framework provides the overarching statement on how the HSCP ensures scrutiny, self-evaluation and reporting in three main areas:

- The fulfilment of the HSCP Strategic Plan, which is a high level statement of our 3-year strategic priorities and enablers;
- Operational improvement, which should be a continuous process of balancing effectiveness, efficiency and economy, and;
- Quality management, which should involve applying scrutiny and evaluation to ensure that our core services are delivering the best possible experiences and outcomes.

The document sets out the HSCP's obligations with respect to Best Value, its systematic approach to continuous improvement (including organisational alignment, often called the "*golden thread*") and its associated governance arrangements. The diagram at **Fig 1** (below) is designed to illustrate the relationships between the Strategic Plan, the Annual Delivery Plan, other subordinate strategies and plans and the reporting of impact and outcomes:

Fig 1: Improvement Planning and Organisational Alignment



A Framework for Community Health and Social Care Integrated Services

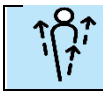
In November 2019, the Scottish Government published A Framework for Community Health and Social Care Integrated Services[2] which was designed to inform the development of local transformation plans, drawing on what has been found to be effective through impact evaluation. We used this document to support the preparation of our Strategic Plan 2022-25. It inspired the Strategic Plan's structure that distinguishes strategic priorities from strategic enablers, it provided a checklist for consideration when setting out our programme of action and it provided a foundation of evidence-based approaches to improving service user, informal carer and organisational outcomes. The progress set out in this Annual Performance Report therefore aligns itself strongly with the provisions within the Framework.

[2] a-framework-for-community-health-and-social-care-integrated-services-07-november-2019.pdf (hscscotland.scot)

Part 2. How Well Are We Achieving Our Priorities?

This section of the Annual Performance Report sets out our progress and performance towards the achievement of the priorities set out in our HSCP Strategic Plan. It also demonstrates our progress towards the delivery of the National Health and Wellbeing Outcomes, which are cross-referenced at **Annex 1**.

Under each priority, the report summarises the key highlights and provides more detail on improvements and developments made in each area. A selection of performance information then follows, firstly the national core integration and ministerial indicators (where these apply to the priorities) and then other national and local measures that are used by the HSCP to measure performance. Notes on methodology relating to the performance measures and indicators are set out at **Annex 5**.



Empowering People

Our Highlights

Adoption of a range of digital solutions to support self-management.	A refreshed Public Health Strategy developed and approved.
New Public Protection website launched, providing more intuitive and accessible information and advice.	Adults with Incapacity Procedures updated and supported with joint training.

Our Progress

Objectives for 2022/25	Progress in 2022/23
Commitment: Improving Personalisation	
Embed and further develop digital solutions, to support self-management (Redesign).	There has been an increase in the technological and digital options available to support self-management and provide support at a distance. These have included: • Ask Sara (online equipment ordering for service users); • Remote diabetic monitoring; • Remote Blood Pressure monitoring; • Electronic Medicines Management (EMAR) piloted within homecare; • Techni-Care project delivery (self-monitoring, self-management of an individual's health status, maximising physical activity); • "Attend Anywhere" video and tele conferencing for Cognitive Behavioural Therapy consultations

Objectives for 2022/25	Progress in 2022/23
	and use by Community and Primary Care teams; • The successful use of "Mind of My Own" app by looked after children to self-report how they are feeling; • The trial of "SOL Connect" to provide support to people living in their own homes remotely. • Progress towards analogue to digital transition for Telecare / Community Alarms, in preparation for the switchover in 2024. Work with the Scottish Government to support a local digital maturity assessment to inform our action plan, has not materialised as planned. The HSCP is now looking to participate in a national programme to reflect our readiness and capabilities to take forward the digital agenda.
Further develop person centred, rights-based, outcome focused approaches (Improvement).	In response to the Mental Welfare commission Report "Authority to Discharge" and its recommendations, the HSCP developed and fully implemented an action plan during 2022/23. Our Adults with Incapacity Procedures were reviewed jointly with legal services and updated to reflect additional safeguards and considerations relating to 'deprivation of liberty'. Leadership sessions and revised training sessions were delivered and rolled out to all relevant HSCP staff. Further work to embed these updated procedures is planned for 2023/24 involving other staff groups including clinical team leads. Social Work has established a Creative and Innovative Directory of Support Packages that describes individualised approaches to meeting people's personal outcomes that are a bit different from the norm. This Directory is then available for colleagues to generate creative approaches and to share good practice.
Commitment: Reducing inequality and inequity of outcomes	
Further reduce inequality of health outcomes and embed fairness, equity and consistency in service provision (Improvement).	A new post of HSCP Communications, Engagement and Equalities Officer has been approved, for deployment during 2023/24.

Objectives for 2022/25	Progress in 2022/23
	A review of HSCP compliance with the Public Sector Equality Duty was completed during 2023/24 with an action plan in place to advance our position. Based on the National Priorities, a refreshed Public Health Strategy has been draft concluded to facilitate further coproduction and sign-off for implementation.
Commitment: Improving information and communication	
Improve service information and public communication systems, advice, reflecting specific communication needs and preferences (Improvement).	In 2022/23, a new Public Protection website was launched, which makes information more accessible and user-friendly. The HSCP's general website content has been reviewed and updated in preparation for its move to a new platform within its hosted site in East Dunbartonshire Councils website. This should make the information more accessible and intuitive.

Our Performance

➢ **National Integration Indicators Used To Measure This Priority:**

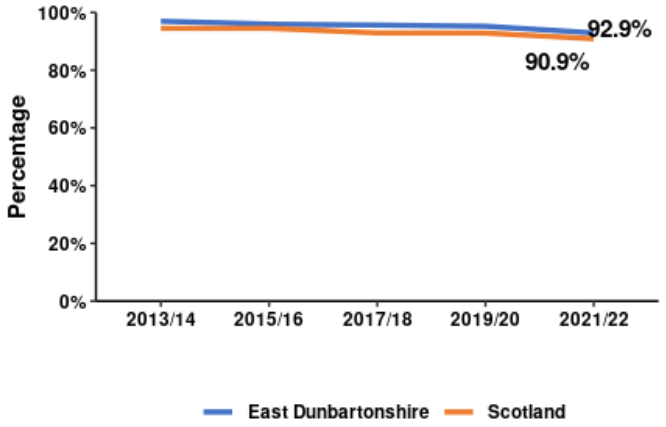
This section provides the HSCP's performance against national core integration indicators (Notes on methodology at Annex 5):

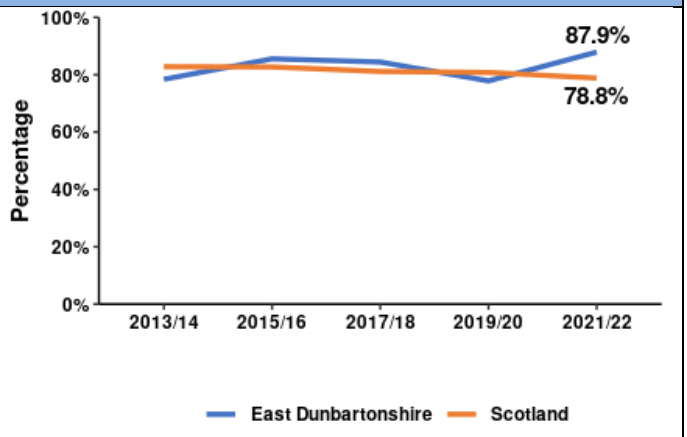
RAG KEY

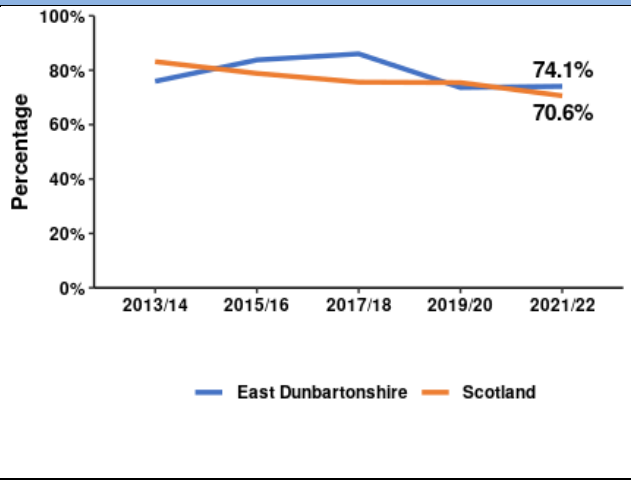
Positive performance improved in 2022/23

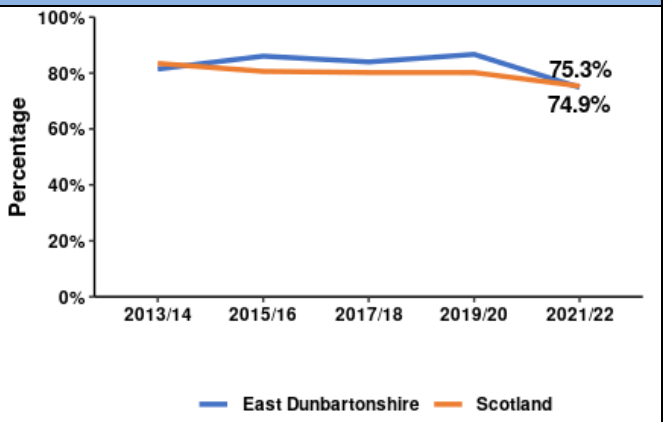
Performance steady (within 5% change in either direction). Arrow direction denotes improving/declining performance

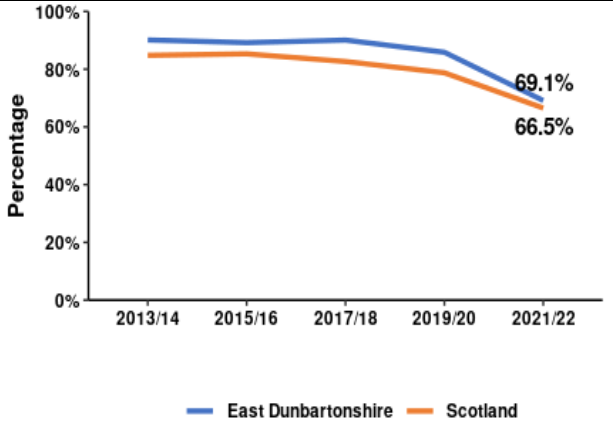
Performance declined in 2022/23

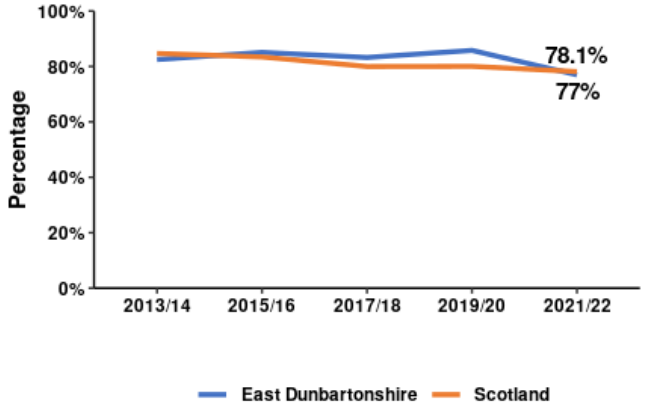
Indicator, Rating and Rank	Performance Trend
1) Percentage of adults able to look after their health very well or quite well (National Outcome 1) (Objective: increase)	
National ranking (biennial): 7 ⇩	Comparison with Previous Survey: ⇩	

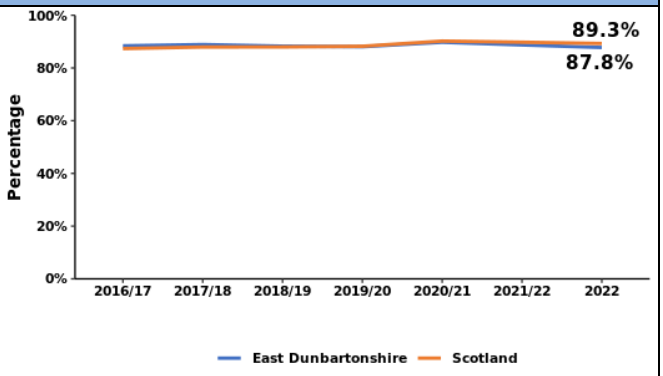
Indicator, Rating and Rank	Performance Trend
2) Percentage of adults supported at home who agree that they are supported to live as independently as possible (National Outcome 2) (Objective: increase)	
National ranking (biennial): 3 ⇧	Comparison with previous survey: ✓	

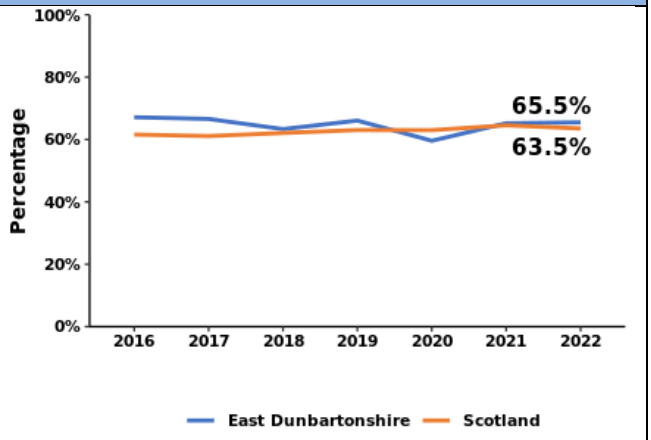
Indicator, Rating and Rank	Performance Trend
3) Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided (National Outcome 2, 3) (Objective: increase)	
National ranking (biennial): 9 ⇧	Comparison with previous survey: ⇧	

Indicator, Rating and Rank	Performance Trend
5) Total percentage of adults receiving any care or support who rated it as excellent or good (National Outcome 3) (Objective: increase)	
National ranking (biennial): 21 ⬇	Comparison with previous survey: ⬇

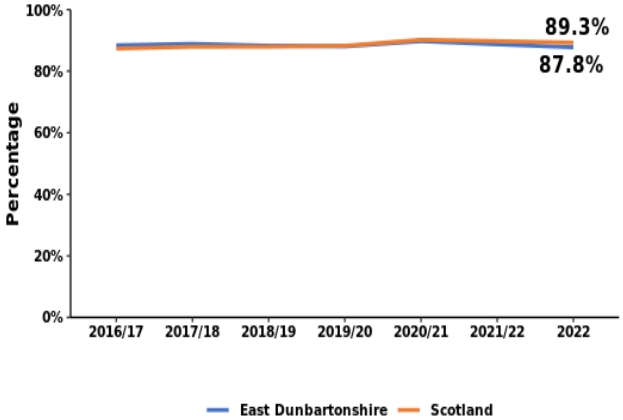
Indicator, Rating and Rank	Performance Trend
6) Percentage of people with positive experience of the care provided by their GP Practice (National Outcome 3) (Objective: increase)	
National ranking (biennial): 13 ⬇	Comparison with previous survey: ⬇

Indicator, Rating and Rank	Performance Trend
7) Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life (National Outcome 4) (Objective: increase)	
National ranking (biennial): 20 ⬇	Comparison with previous survey: ⬇

Indicator, Rating and Rank		Performance Trend
15) Proportion of last 6 months of life spent at home or in a community setting (National Outcome 2,3,9) (Objective: increase)		
National ranking: 29 ⇩	Comparison with Previous Year: ⇩	

Indicator, Rating and Rank		Performance Trend
18) Percentage of adults with intensive care needs receiving care at home (National Outcome 2) (Objective: increase)		
National ranking: 13 ⇧	Comparison with Previous Year: ⇧	

This section provides the HSCP's performance against Scottish Government Ministerial Strategic Group (MSG) indicators:

Indicator	Performance Trend
6. Last 6 months of life spent at home or in a community setting – (% of population) (National Outcomes 2,3,9) (Objective: increase)	
⇩ (Performance broadly in line with Scottish average)	

Other National and Local Indicators of Performance & Quality:

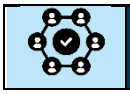
RAG KEY

On or above target

Within agreed variance of target

Below target

PI Title	2022/23			Note
	Status	Value	Target	
Empowering People				
Percentage of people 65+ indicating satisfaction with their social interaction opportunities		95%	95%	Local performance indicator based on a sample of 50 case reviews analysed each quarter.
Percentage of service users satisfied with their involvement in the design of their care packages		96%	95%	Local performance indicator based on a sample of 50 case reviews analysed each quarter.
Number of homecare hours per 1,000 population aged 65+		511	389	Balance of Care. Based on 2022/23 Quarter 4 census period. Aim = to maximise in comparison to support in institutional settings.
Percentage of adults in receipt of social work / social care services who have had their personal outcomes fully or partially met		100%	100%	As a minimum, outcomes should reduce risks from a substantial to a moderate level, but the arranging of informal support may additionally contribute to improving quality of life. Aim = to maximise
Smoking quits at 12 weeks post quit in the 40% most deprived areas		19	21	Service facing difficulties due to stock shortages of Varenicline and other Nicotine Replacement Therapies. Data based on 2022 calendar year data. Aim = to maximise.



Empowering Communities

Our Highlights

Opening of the new purpose-built Allander Day Service for adults with learning and intellectual disabilities.	The HSCP Social Support Strategy for Older People 2023-28 was developed and approved.
Co-location of services continues, to ensure locally responsive, collaborative and accessible services.	Updated community asset map for people with mental health issues.

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Building informal support options	
Work with communities to develop a network of assets and informal supports, to complement formal, statutory support options (Redesign).	The HSCP has sought to develop and implement a model of community led support locally based on best practice, which seeks to reduce waiting lists and divert needs to alternative effective service options. A series of community drop-in sessions have been piloted to support healthy ageing and independent living. The programme is currently being evaluated to consider development of future delivery options. The HSCP and its partners have also refreshed an Asset Map, which is an interactive tool to support people to find local groups and facilities for their own and others' health and wellbeing. The map is populated by community members and local partners. The HSCP aimed to develop and implement a delivery plan for No One Dies Alone (NODA) within East Dunbartonshire. The start of this project was delayed due to funding issues which was resolved in December 2022, when work commenced. This project will continue to be delivered in 2023/24. The HSCP Older People Local Area Co-ordination team has undertaken excellent work with local people to develop new informal social support groups during 2023/24 (see Part 6).

Commitment: Building local integrated teams	
Develop local, co-located services with integrated multi-disciplinary teams to improve services and reduce our carbon footprint (Redesign).	During 2022/23, the co-location of health and social work children and families staff was successfully established, resulting in improved communication, collaboration and relationship building. Locality Planning has now been re-established within the HSCP and will continue to operate though re-established arrangements and supported by the updated locality need and demand profiles. Localities will aim to deliver improved outcomes for local people via collaboration and partnership action and the development and implementation of 2023/24 Locality Plans. The multidisciplinary locality practitioner collaboratives in community health and care services continue to work well to improve outcomes for people and communities. Scope has been identified to expand this model to other care groups. Premises within Milngavie have been identified and suitably adapted for the use of HSCP staff within the West locality, which supports local integrated working. Further work is underway to continue to embed the aspirations of full co-location and integrated working.
Commitment: Modernising day services	
Redesign day services for older people and adults with learning disabilities, to create a wider range of informal and formal support options (Redesign).	March 2023 saw the opening of the new purpose-built Allander Day Service for adults with learning and intellectual disabilities. This new space is co-located with the new Allander Leisure Centre, which offers reciprocal access arrangements, progressive activity-based therapies and extensive accessible resources. The new centre is founded on the principles of a community based approach to service delivery. New initiatives have been developed to support employment / employability, community participation and volunteering established to enhance personalised support options and to promote choice, community integration and independence. This year we have established two new Local Area Coordinator posts to support employment initiatives for adults affected by learning disability, learning difficulty and autism. In the first year of operation the team has worked with twenty eight adults of whom fourteen are now in paid employment, fifteen in further education and seventeen within volunteer

	placements with a number accessing more than one sector. Across all of the HSCP's day service redesign approaches, there has been a continued focus on developing community-based support alternatives to formal day care with employment opportunities and programmes developed in line with an employability pathway and the continued growth and development of community assets. Following a period of consultation on a new model for the delivery of social support options for older people, the Social Support Strategy for Older People 2023-2028 was developed and approved. The first year of the Strategy involves undertaking activities to commission and develop the agreed day centre model, moving to two rather than three formal centres, and to progress the growth in informal community-based social supports.

Prevention and Early Intervention

Our Highlights

Building greater rehabilitation and reablement into care at home services, to promote independence and reduce over-dependence on services	Continuously improving hospital discharge planning arrangements.
Delivery of Anxiety Management (LIAM) interventions by School Nursing Services.	Extended diversion in Justice Services, to ensure individual needs are met at the earliest opportunity, to enable people to desist from further crime.

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Extending rehabilitation and reablement	
Further develop rehabilitation services and reablement approaches to sustain people for longer in the community (Improvement)	The HSCP has committed to a review of community Occupational Therapy (OT) and Reablement services, to deliver an improved service model which addresses OT waiting times and maximises use of equipment and digital options. The project has been delayed due to progress reviews in services that support reviews, but remains programmed for action in 2023/24. Local rehabilitation services have worked closely with our Care at Home Service during the year to evolve service models focused on personal goals that involve delivering care and support with people rather than for people, where possible. Careful review of care packages has encouraged reablement and reduction in over-reliance on formal care. Weekly multidisciplinary meetings within our Home for Me Service allow for well-managed care and discharge planning resulting in over 85% of individuals requiring no further support at the end of 6-8 weeks.

Commitment: Supporting diversion from prosecution	
Extend the range of options for diversion from prosecution available to the Procurator Fiscal Service to extend ability to address the underlying causes of offending, as an alternative to prosecution (Improvement).	Youth Justice team have had an increase in staff training in AIM3 which is a dynamic assessment model that helps practitioners to assess harmful sexual behaviours. This has supported more diversion reports from practitioners able to manage risks within the community. In 2022/23 the Social Work Justice Team has implemented new diversion guidance and extended diversion to ensure individual needs are met at the earliest opportunity, to enable people to desist from further crime.
Commitment: Improving school nursing services	
Develop School Nursing Services in line with "Transforming Nursing, Midwifery and Health Professions' Roles: The school nursing role" (Improvement).	During 2022/23, the School Nursing Service delivered Lets Introduce Anxiety Management (LIAM) interventions as part of the development of enhanced support options. This was very successful, with a waiting list now in place due to demand.

Our Performance

- **National Integration Indicators Used To Measure This Priority:**

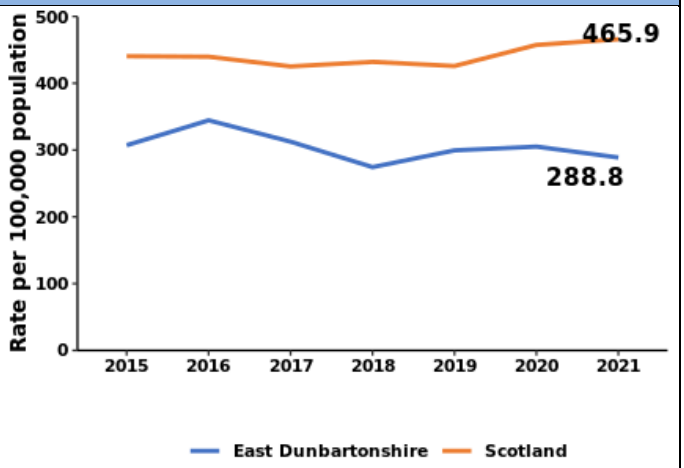
This section provides the HSCP's performance against national core integration indicators:

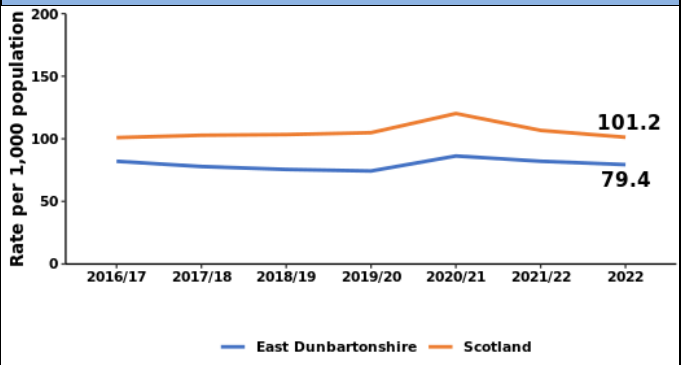
RAG KEY

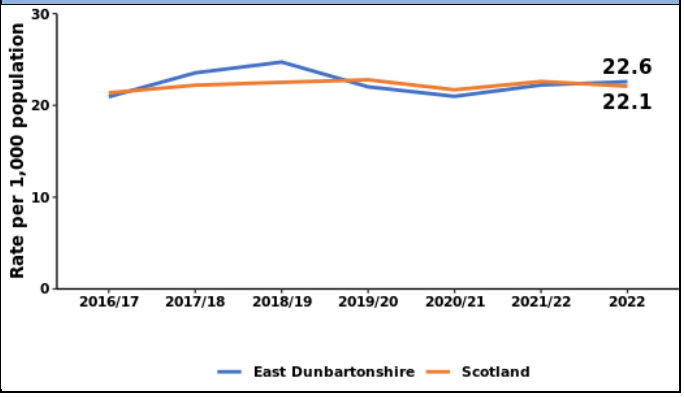
Positive performance improved in 2022/23

Performance steady (within 5% change in either direction). Arrow direction denotes improving/declining performance

Performance declined in 2022/23

Indicator, Rating and Rank		Performance Trend
11) Premature mortality rate for people aged under 75yrs per 100,000 persons (National Outcome 1,5) (Objective: decrease)		
National ranking: 1	Comparison with Previous Year:	

Indicator, Rating and Rank		Performance Trend
14) Readmission to hospital within 28 days (per 1,000 population) (National Outcome 2,4,7,9) (Objective: decrease)		
National ranking: 6	Comparison with Previous Year:	

Indicator, Rating and Rank		Performance Trend
16) Falls rate per 1,000 population aged 65+ (National Outcome 2,4,7,9) (Objective: decrease)		
National ranking: 18	Comparison with Previous Year:	

➢ **Other National and Local Indicators of Performance & Quality:**

RAG KEY

On or above target

Within agreed variance of target

Below target

PI Title	2022/23			Note
	Status	Value	Target	
Prevention & Early Intervention				
% of customers (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery		97.6%	95%	The national standard is to operate within a six week period from assessment to service delivery, which encourages efficiency and minimises delays for service-users. Aim = to maximise.
% of CJSW Reports submitted to court by due date		95%	95%	National Outcomes & Standards (2010) states that the court will receive reports electronically from social work, no later than midday on the day before the court hearing. Aim = to maximise.
The % of individuals beginning a work placement within 7 working days of receiving a Community Payback Order		93%	80%	The criminal justice social work service has responsibility for individuals subject to a Community Payback Order beginning a work placement within 7 days. Aim = to maximise.
% of Court report requests allocated to a Social Worker within 2 Working Days of Receipt		100%	100%	National Outcomes & Standards (2010) places responsibility on the criminal justice service to provide an allocated criminal justice worker within 24 hours of the Court imposing a community sentence. Aim = to maximise.

Delivering our Key Social Work Public Protection Statutory Duties

Our Highlights

Increased delivery of Moving Forward Making Changes treatment programme for sex offenders, to reduce risk to the public.	Promotion of the 'Safe and Together' model which is designed to support victims of domestic violence and keep children safe and together with the protective parent.
Updating and implementing the new Child Protection Guidelines.	The implementation of the Violence and Sex Offenders register (VISOR) and associated procedures.

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Prioritising public protection	
Ensure the highest quality standards in identifying and responding to actual and potential social work public protection concerns (Improvement).	East Dunbartonshire HSCP ensures the highest quality standards in identifying and responding to actual and potential social work public protection concerns through the implementation this year of: • 'Safe and Together' model which is designed to support victims of domestic violence and keep children safe and together with the protective parent; • The implementation of the Violence and Sex Offenders register (VISOR) and associated procedures; • Updating and implementing the new Child Protection Guidelines; • Establishment of the Public Protection Leadership Group; • Increased delivery of Moving Forward Making Changes treatment programme for sex offenders, to reduce risk to the public;

Our Performance

➢ **National Integration Indicators Used To Measure This Priority:**

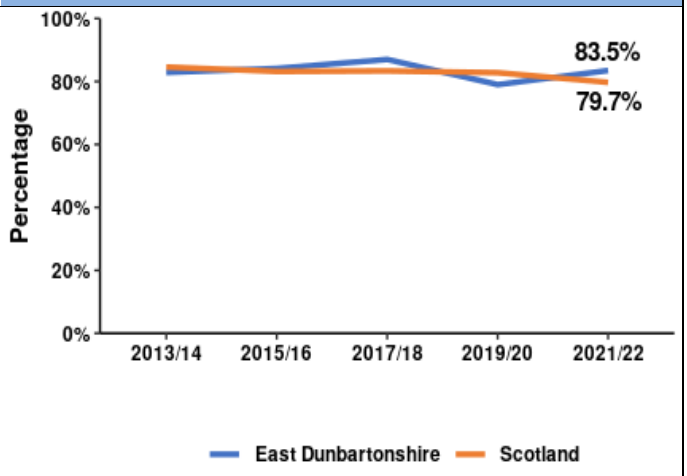
This section provides the HSCP's performance against national core integration indicators:

RAG KEY

Positive performance improved in 2022/23

Performance steady (within 5% change in either direction). Arrow direction denotes improving/declining performance

Performance declined in 2022/23

Indicator, Rating and Rank		Performance Trend
9) Percentage of adults supported at home who agreed they felt safe (National Outcome 7) (Objective: increase)		
National ranking: 8	Comparison with Previous Year:	

➢ **Other National and Local Indicators of Performance & Quality:**

RAG KEY

On or above target

Within agreed variance of target

Below target

PI Title	2022/23			Note
	Status	Value	Target	
Public Protection				
% of first Child Protection review case conferences taking place within 3 months of registration		100%	95%	Local standard and timescales set by East Dunbartonshire Child Protection Committee. Aim = to maximise
% of Adult Protection cases where the required timescales have been met		94%	92%	This indicator measures the speed with which sequential Adult Support and Protection actions are taken against timescales laid out in local social work procedures. Aim = to maximise

PI Title	2022/23			Note
	Status	Value	Target	
% of initial Child Protection Planning Meetings taking place within target timescale	⚠	88%	90%	National targets have been changed during 2022/23 from 21 to 28 days. Target was achieved in three quarters out of four. A very small number of delays (<5) occurred in the April to June period that also caused the overall annual target to be missed. All were rescheduled to enable partner agency and parental attendance. Aim = to maximise
Percentage of first Review Child Protection Planning Meetings taking place within 6 months of registration	✓	100%	95%	Local standard and timescales set by East Dunbartonshire Child Protection Committee. Aim = to maximise

Supporting Families and Carers

Our Highlights

HSCP has reviewed, consulted on and updated its Carers Strategy for 2023-26, with supporting action plan.	The Promise Steering Group has implemented its action plan designed to improve outcomes for looked after children.
The HSCP Health Visiting Team received UNICEF Gold 4 Year Revalidation in 2022/23.	Delivery of Year 2 of the Children's House Project has been completed, designed to improve the outcomes for care experienced young people moving on from care placements

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Supporting carers with their own needs and in their caring role	
Recognise better the contribution of informal carers and families in keeping people safe and supporting them to continue to care if that is their choice (Improvement).	East Dunbartonshire HSCP has consulted, reviewed and updated its Carers Strategy, which will be presented for approval to the HSCP Board in June 2023. This new strategy has been developed with the full involvement of carers, third sector partners and wider stakeholders. Our new Carers Strategy reflects the aspirations of the new national strategy but locates itself as an expression of local needs and priorities within East Dunbartonshire. When reviewing and updating the existing Adult Carer Support Plan, it was concluded that it didn't fully capture personal outcomes. So the HSCP worked in partnership with Carers Link and a small group of Social Work practitioners to update the Adult Carers Support Plan, to more fully record personal outcomes. The group also developed a new Review document designed to report on the extent to which carers' personal outcomes were being achieved, both informal and formal.

Commitment: Implementing The Promise for children and young people	
Ensure that every care experienced child grows up loved, safe and respected, able to realise their full potential (Improvement).	The Promise Steering Group has implemented its action plan designed to improve outcomes for looked after children. This ensures that East Dunbartonshire HSCP is compliant with The Promise and its key principles are being embedded: (i) listening to children and young people, (ii) relationships, (iii) quality of care, (iv) sibling contact. The HSCP Health Visiting Team received UNICEF Gold 4 Year Revalidation in 2022/23. This award reflects standards designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support their health and development. However, ongoing resourcing issues in 2022/23 affected the Health Visiting team from fully implementing the Universal Health Visiting Pathway.
Commitment: Strengthening corporate parenting	
Strengthen corporate parenting, to improve longer term outcomes for care experienced young people, by community planning partners working collectively (Improvement).	Delivery of Year 2 of Children's House Project: The purpose of the house project is to improve outcomes for Care Experienced Young People moving on from care placements. There was a 100% success rate this year with 7 young people moving into their new homes. This was underpinned by strengthened links with the Council's Housing Services to increase appropriate housing offers for care experienced young people. Other work in support of corporate parenting during 2022/23 included: • Joint working with Police Scotland to develop increased awareness of the difficulties and challenges care experienced young people face; • Enhanced links were developed during the year with Woman's Aid, as domestic violence is a particular area of focused work for our care experienced young people; • Care experienced young people attended Education Additional Support Needs Leadership Forum and gave presentation on the challenges they face; • Recognition at the HSCP and Health Board Award Ceremonies of care experienced young people's contribution through their Champs' Board

Our Performance

➢ **National Integration Indicators Used To Measure This Priority:**

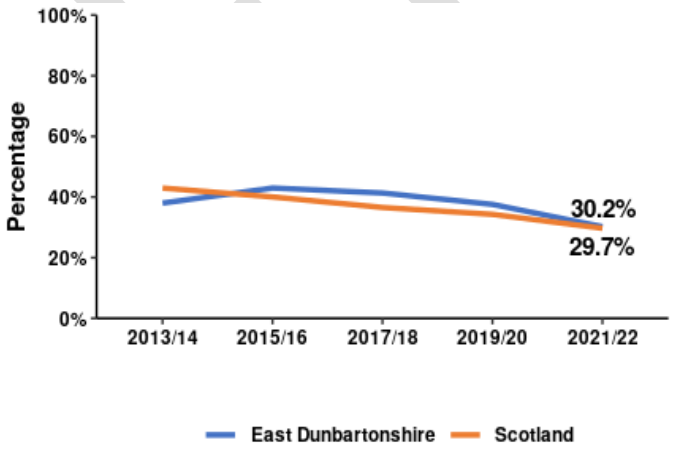
This section provides the HSCP's performance against national core integration indicators:

RAG KEY

Positive performance improved in 2022/23

Performance steady (within 5% change in either direction). Arrow direction denotes improving/declining performance

Performance declined in 2022/23

Indicator, Rating and Rank		Performance Trend
8) Total combined percentage of carers who feel supported to continue in their caring role (National Outcome 6) (Objective: increase)		
National ranking: 16	Comparison with Previous Year:	

➢ **Other National and Local Indicators of Performance & Quality:**

RAG KEY

On or above target

Within agreed variance of target

Below target

PI Title	2022/23			Note
	Status	Value	Target	
Supporting Families & Carers				
Percentage of child care Integrated Comprehensive Assessments (ICA) for Scottish Children's Reporter Administration (SCRA) completed within target timescales (20 days), as per national target		92%	75%	This is a national target that is reported to SCRA and Scottish Government in accordance with time intervals monitoring. Aim = to maximise
Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated		87%	100%	National performance indicator. Subject to the impact of small numbers. Off target due to a small number of reviews (<5) outwith timescale, all to accommodate attendance by key personnel. Aim = to maximise
Balance of Care for looked after children: percentage of children being looked after in the Community		83%	89%	National performance indicator. Work continues to redress the balance of care by reviewing out of authority placements and continuing the Foster Carer recruitment campaign. Aim = to maximise
Percentage of children receiving 27-30 months assessment		96.6%	85%	This indicator relates to early identification of children with additional developmental needs and can then be referred to specialist services. Aim = to maximise

Improving Mental Health and Recovery

Our Highlights

A wide range of improvements were achieved during 2022/23 to improve mental health services and support for children and young people.	Implementation of Medication Assisted Treatment (MAT) Standards, which promote safe, accessible and consistently high quality treatment for those affected by problematic drug use.
Agreement with the Mental Health Network and Scottish Drugs Foundation to work on a collaborative basis on local service user engagement	Highly successful joint working between the Community Mental Health Team and Alcohol and Drug Recovery Service on joint protocols and joint training initiatives

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Improving adult mental health and alcohol and drugs recovery	
Redesign services for adult mental health and alcohol and drugs services to develop a recovery focussed approach (Redesign).	The HSCP is reviewing the commissioned Mental Health and Alcohol & Drugs recovery services to develop enhanced, holistic recovery focused services across adult mental health and alcohol and drugs recovery. The HSCP has been unsuccessful in recruiting a Project Lead, which has delayed progress with this initiative. However, initial consultation and engagement sessions and Provider Forum led to agreement from Healthcare Improvement Scotland to support plans to take forward a Collaborative Commissioning model. Agreement was also reached with Mental Health Network and Scottish Drugs Foundation to work on a collaborative basis on local service user engagement. As part of our Drug Death Action Plan a focus of work has been to enhance joint working between the Community Mental Health Team and Alcohol and Drug Recovery Service. Joint protocols have been reviewed and updated and a series of joint training initiatives developed on trauma and substance misuse, motivational interviewing, children affected by substance misuse and 'Staying Alive'. Extensive work has been undertaken during 2022/23 to implement Medication Assisted Treatment (MAT) standards, which ensure safe, accessible and consistently high-quality treatment for those affected

Objectives for 2022-25	Progress in 2022/23
	by problematic drug use, to help reduce drug deaths and other harms and promote recovery The development of a new Mental Health Strategy commenced in 2022/23.
Commitment: Improving mental health support for children and young people	
The provision of faster, more responsive support for children and young people with mental health challenges (Improvement).	A wide range of actions were undertaken during 2022/23 to improve mental health services and support for children and young people, including: • Implementation of the Children's Mental Health and wellbeing framework; • Improvements to Tier 1 and Tier 2 mental health and wellbeing services for children, young people and families, by developing a Compassionate Distress Response Service and the extension of school counselling and nurture approaches in schools; • Extension of Lifelink counselling to those aged 16+ who are no longer in Education or care experienced. • Children and Adolescent Mental Health Services (CAMHS) improved its performance against waiting times targets during 2022/23. By the final quarter of 2022/23, 88% of children waiting for treatment in East Dunbartonshire had been waiting less than 18 weeks. This is below the 90% referral to treatment (RTT) target but an improvement from the start of the year where only 37% met the target. The service plans for further workforce expansion, in line with Scottish Government recommendations.
Commitment: Improving post-diagnostic support for people with dementia	
Increase the capacity of the post diagnostic support service (Improvement).	The model for delivering Post Diagnostic Support has been reviewed and the service has been brought wholly in-house and additional hours added to the structure. It is expected that these changes will bring better performance in relation to people being seen within 12 weeks from their diagnosis.

Our Performance

- **National and Local Indicators of Performance & Quality:**

RAG KEY

On or above target

Within agreed variance of target

Below target

PI Title	2022/23			Note
	Status	Value	Target	
Improving Mental Health & Recovery				
Percentage of people waiting less than 18 weeks to start treatment for psychological therapies		98.6%	90%	This includes the Community, Primary and Older People's Mental Health Teams. The service has delivered above target during 2022/23. Aim = to maximise.
Total number of Alcohol Brief Interventions delivered during the year		332	487	The delivery of ABIs has been below target since the onset of the pandemic. Recovery plans are in place including maximising digital technology and rebuilding capacity within GP surgeries. Aim = to maximise.
Percentage of Young People seen or otherwise discharged from the CAMHS waiting list who had experienced a wait of less than 18 weeks		88%	90%	Based on Q4 census period. The CAMHS service has substantially increased compliance with this standard, from 37% in quarter 1, to just short of the national referral to treatment target. Aim = to maximise.
Percentage of People Waiting less than 3 weeks for Drug & Alcohol Treatment		89.1%	90%	Due to routine delays with data finalisation by Public Health Scotland, the figures here are for 2022 full calendar year. Performance is very marginally below 90% but within variance of 2%
Percentage of people newly diagnosed with dementia receiving Post Diagnostic Support (PDS)		0%	90%	In the early part of 2021/22, the service was operating almost at target levels, but became severely impacted by

PI Title	2022/23			Note
	Status	Value	Target	
				staffing issues that have persisted throughout 2022/23. The service has now moved over to a new operating model which should address performance issues.

Post Pandemic Renewal

Our Highlights

Extensive impact assessment work undertaken to evaluate consequence of the pandemic on health and social care needs and complexity, to inform revised service models and approaches.	Successful phased approach to supporting staff safely back to the workplace, operating to a hybrid working pattern and in line with national guidance
Successful local clearing of the backlog of Community Payback Orders that had been suspended nationally in successive periods during lockdown.	The HSCP Care Homes Support Team, working closely with local care homes, to ensure excellence in care and support for people living in this setting.

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Understanding and responding to the impact of the pandemic	
Understand the impact of the pandemic on the health and wellbeing of our population (including those living in care homes), the responses necessary to meet these needs and resource requirements (Redesign).	<u>Workforce</u> Risk assessments and the review of guidance in relation to physical distancing and mask wearing continued to be undertaken throughout the year in line with the changing guidance from the Scottish Government. Guidance within buildings has been aligned to a blended working approach where staff work both at home and in the workplace. This continued to be reviewed and changes to location of teams within building were put in place when necessary, to ensure maximum opportunities for integrated working. An Organisational Development plan was put in place to support staff returning to building based working arrangements with continued communication with staff throughout 2022/23. Staff are now working to respective partner blended working policies. <u>Community Payback Orders</u> During 2020-22, work placements as an alternative to custodial services were suspended by the Scottish Government during two extended periods due to Covid-19 public health constraints. This consequently

Objectives for 2022-25	Progress in 2022/23
	led to a backlog in those with Community Payback Orders. The Community Justice Team put mechanisms in place to address the unpaid work services backlog and ensuring those sentenced are able to complete their hours without breaching any order. The backlog was successfully cleared by quarter 3 of 2022/23. <u>Covid-19 Testing</u> Operational processes for mainstream Covid-19 testing were clarified and implemented. Resourcing was agreed and testing processes in line with current Scottish Government requirements were mainstreamed via the HSCP Covid-19 Hub. <u>Personal Protective Equipment</u> Consolidated arrangements to maintain support to PPE distribution to support the ongoing delivery of front facing services in line with guidance was organised through the PPE Hub. <u>Care Homes Support Team</u> We have continued to develop our integrated Care Homes Support Team, working closely with local care homes, to ensure excellence in care and support for people living in this setting. <u>Analysis of Impact</u> With the support of Public Health Scotland, the HSCP has undertaken a range of impact analyses to help understand better the short, medium and longer term impact of the pandemic on people's health and social care needs, to support planning and service redesign. Increasing complexity and volume of care needs are evident across most services. This indicates a growing need for more sophisticated methods of measuring frailty and complexity and the relative impacts of different (and new) service models.

Our Performance

- **National and Local Indicators of Performance & Quality:**

RAG KEY

On or above target

Within agreed variance of target

Below target

PI Title	2022/23			Note
	Status	Value	Target	
Post Pandemic Renewal				
Reduction of Covid-19 backlog of Unpaid Work Orders (Outstanding Hours)		5,578 hours	5,578 hours	Backlog of Unpaid Work Orders due to the suspension of service during Covid-19 has been cleared within timescale.

Maximising Operational Integration

Our Highlights

The 2022/23 actions within the Joint Commissioning Plan for Unscheduled Care were successfully implemented, based on collaborative and innovative working practices.	Integrated quality management was further developed across the partnership, with enhanced oversight through clinical and care governance.
The HSCP evaluated its Adults with Incapacity practice. This led to an integrated action plan that is now being implemented across the HSCP.	The HSCP's Vulnerable Pregnancy Process was reviewed and updated during 2022/23, leading to better information sharing and collaboration with Education Services and GPs.

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Right Care Right Place: urgent and unscheduled health and social care redesign	
Improve patient experience, safety, clinical outcomes, and organisational efficiency in responding to and managing urgent health care needs and preventing unnecessary hospital care (Redesign).	The 2022/23 actions within the Joint Commissioning Plan for unscheduled care were successfully implemented and included: • CAPA (Care About Physical Activity) established and embedded within Support to Care Homes Team • Development of a network for Activity Co-ordinators within each Care Home to provide support, share ideas and embed principles of CAPA. • Participation in GGC wide Home First Response Huddles • Development of a framework to support Frailty Practitioner competencies • Recruitment of a Frailty Practitioner Participation in the GGC Discharge Without Delay programme • Implementation of extended core hours in our Adult Community Nursing (District Nursing) service; • Primary Care Advanced Nurse Practitioner service responding to urgent care and home visiting needs in support of General Practice;

Objectives for 2022-25	Progress in 2022/23
	• Growth of the District Nurse Advanced Nurse Practitioner (DNANP) capacity; • Increased capacity in the Hospital Assessment Team, who have dealt with a 30% increase in referrals in the last year. Hospital delayed discharge performance has fluctuated with significant challenges around placement to care homes in line with choice and affordability issues, and in meeting care at home demand in some areas. The HSCP's Vulnerable Pregnancy Process was updated during 2022/23. The aim of this approach is to undertake holistic, person centred assessments for vulnerable pregnant women and unborn babies that will identify and minimise risk. Particular improvements have been made to information sharing and collaboration with Education Services and GPs.
Commitment: Developing integrated quality management arrangements	
Further develop robust, quality-driven clinical and care governance arrangements that reflect the National Health and Social Care Standards and the Partnership's Quality Management Framework (Improvement).	The HSCP's Quality Management Framework was refreshed to reflect the impact of Covid-19 and a more robust connection to the Clinical & Care Governance Group was established. A new governance post was established and filled, to support the implementation of the HSCP Quality Management Framework. A new Self-Assessment Module was developed and piloted, that aims to strengthen team capacity for quality management and improvement action. This approach has been successful and will be rolled out to all teams and services during 2023/24, as part of the wider Performance Management Framework. The HSCP undertook a detailed self-evaluation of its practice with respect to Adults with Incapacity legislation and standards in 2022/23. The findings and analysis highlighted strengths in assessment and risk assessment, engagement with carers and families, application of legislation and appropriate use of powers.

Objectives for 2022-25	Progress in 2022/23
	Areas for improvement identified were in relation to improving recording, consistent advocacy involvement, and establishing powers more proactively. An Improvement Action Plan is now taking forward these findings. The development of enhanced quality management has also been extended within Care at Home services and with new audit tools applied to Adult Community Nursing Services.

Our Performance

➢ **National Integration Indicators Used To Measure This Priority:**

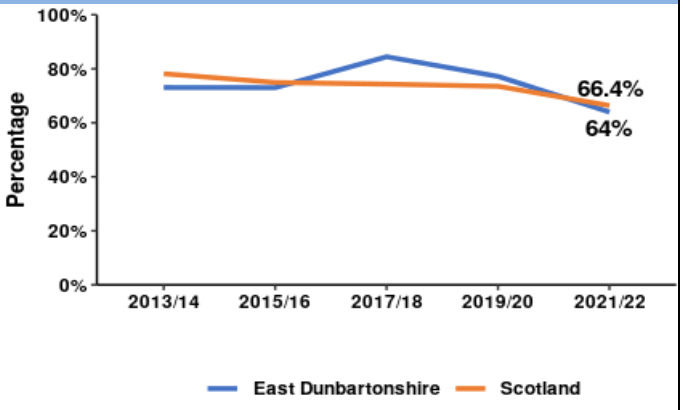
This section provides the HSCP's performance against national core integration indicators:

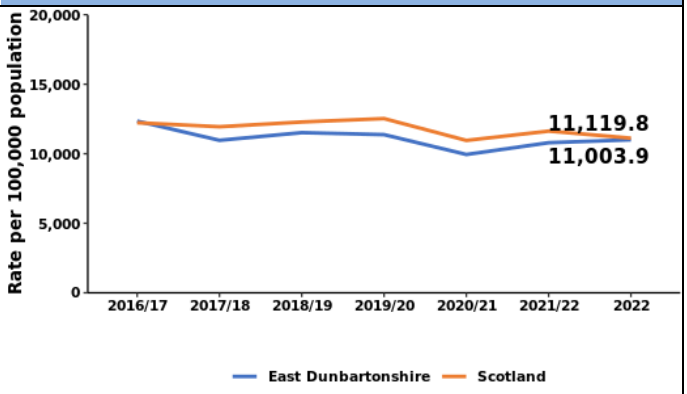
RAG KEY

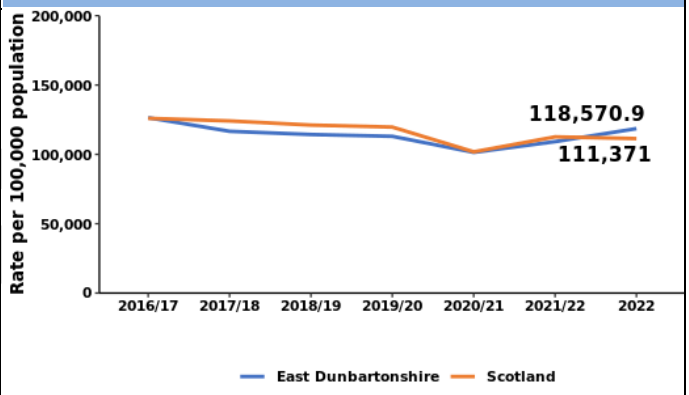
Positive performance improved in 2022/23

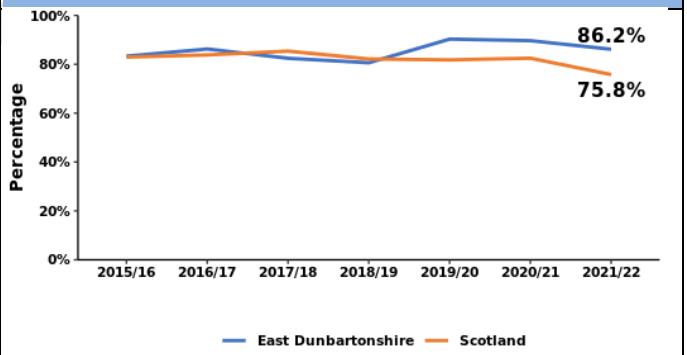
Performance steady (within 5% change in either direction). Arrow direction denotes improving/declining performance

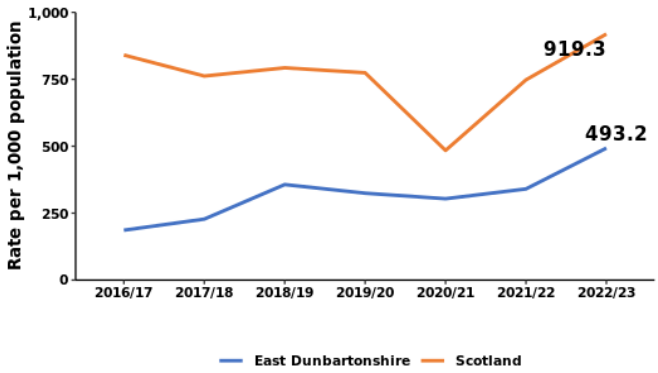
Performance declined in 2022/23

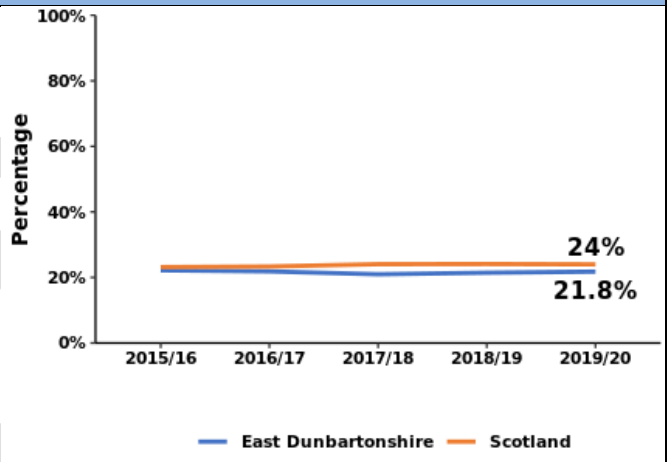
Indicator, Rating and Rank		Performance Trend
4) Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated (National Outcome 3, 9) (Objective: increase)		
National ranking: 21	Comparison with Previous Year:	

Indicator, Rating and Rank		Performance Trend
12) Emergency admission rate (per 100,000 population) (National Outcome 1,2,4,5) (Objective: decrease)		
National ranking: 14 ↓	Comparison with Previous Year: ↓	

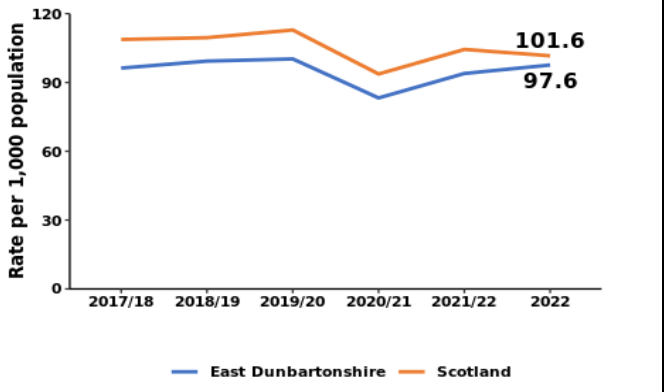
Indicator, Rating and Rank		Performance Trend
13) Emergency bed day rate (per 100,000 population) (National Outcome 2,4,7) (Objective: decrease)		
National ranking: 19 ↓	Comparison with Previous Year: ↓	

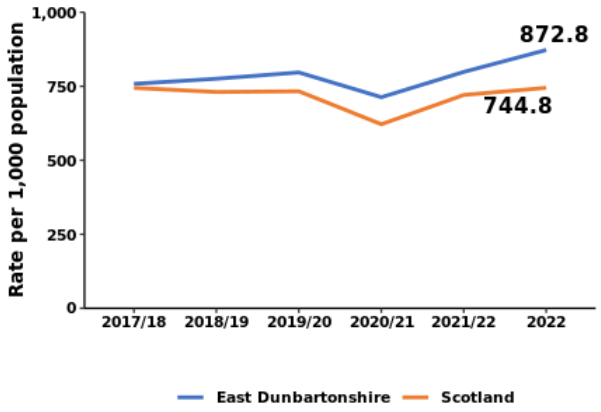
Indicator, Rating and Rank		Performance Trend
17) Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (National Outcome 3,4,7) (Objective: increase)		
National ranking: 4 ↑	Comparison with Previous Year: ↓	

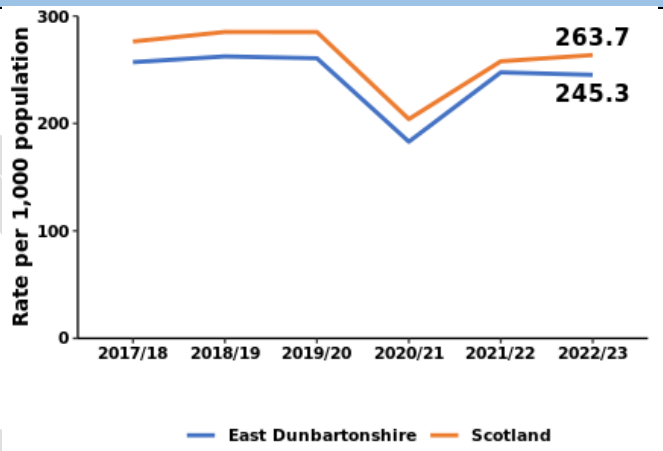
Indicator, Rating and Rank		Performance Trend
19) Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) (National Outcome 2,3,4,9) (Objective: decrease)		
National ranking: 8 	Comparison with Previous Year: 	

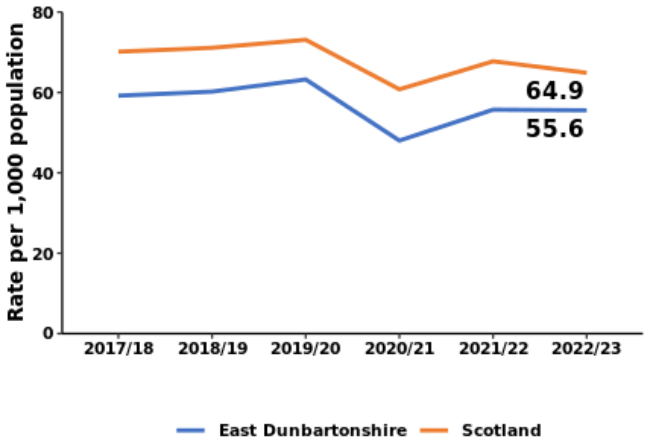
Indicator, Rating and Rank		Performance Trend
20) Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (National Outcome 2,4,7,9) (Objective: decrease)		
National ranking: 8 	Comparison with Previous Year: 	

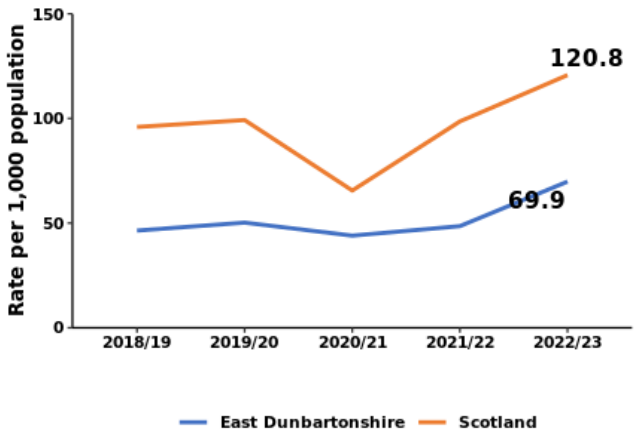
This section provides the HSCP's performance against Scottish Government Ministerial Strategic Group (MSG) indicators

Indicator and Rating	Performance Trend
1. Unplanned admissions – rate per 1000 population (National Outcomes 1,2,3,4) (Objective: decrease)	
 (Performance ahead of Scottish average)	

Indicator	Performance Trend
2. Unplanned bed days - rate per 1000 population (National Outcomes 2,4,7) (Objective: decrease)	
⬇ (Performance behind Scottish average)	

Indicator	Performance Trend
3. A&E attendances - rate per 1000 population (National Outcomes 1,2,9) (Objective: decrease)	
⬆ (Performance ahead of Scottish average)	

Indicator	Performance Trend
4. Admissions from A&E – rate per 1000 population (National Outcomes 1,2,3,4) (Objective: decrease)	
⬆ (Performance ahead of Scottish average)	

Indicator	Performance Trend
5. Delayed discharge bed days - rate per 1000 population (National Outcomes 2,3,4,9) (Objective: decrease)	
⬇ (Performance ahead of Scottish average)	

Part 3. How Well Are We Developing Our Enablers?

This section of the Annual Performance Report sets out our progress towards the achievement of the enablers that underpin the priorities set out in our HSCP Strategic Plan and the associated national health and Wellbeing Outcomes

Workforce & Organisational Development

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Supporting the wellbeing of the health and social care workforce	
Respond to the pressures across all staff, independent contractors, commissioned services, partners and stakeholders due to the impact of the pandemic, with wellbeing support prioritised (Redesign).	A range of measures have been developed and put in place to support staff wellbeing including: • Participation in 'Sunflower' campaign • Promotion of Active Staff activities • Circulation of advice on financial wellbeing Distribution of staff thank you packs • Establishment of MS Teams page for the sharing of information and resources • Individual relaxation sessions • Provision of snacks and drinks for staff to address well-being and cost of living concerns • Development of activity calendars • Delivery of a series of workshops offered to all HSCP staff by our Community Mental Health Team. The sessions aimed to develop skills in self-compassion to promote wellbeing, and to learn new skills to help manage stress.
Commitment: Equipping the workforce and workplace during and after the pandemic	
Ensure that the workforce and the workplace is prepared and equipped to respond to the impact of the pandemic (Redesign).	During 2022/23, significant additional investment was made in core community health and social care services, and in adult social work. Capacity has improved across many areas of the HSCP functions, but persistent difficulties in recruiting to Social Worker, Mental Health Officer, Health Visiting and Social Care posts continues to present challenges. These challenges have impacted negatively on our capacity to respond to the level and complexity of presenting need.

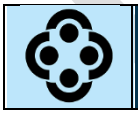
Objectives for 2022-25	Progress in 2022/23
Commitment: Redesigning the Public Dental Service	
Redesign the Public Dental Service by implementing a new service delivery model (Redesign).	The redesign of the Public Dental Service to support the right care being delivered in the right place at the right time was significantly impacted by the pandemic and its impact on the services it provides. The recommendations have been reviewed in light of the changes that have been made to the Public Dental Service as a result of the pandemic and these recommendations will be implemented in 2023/24.
Commitment: Implementing a skills framework for supporting children's mental health and wellbeing	
Support the improvement of children's mental health and wellbeing, by implementing a national workforce knowledge and skills framework (Improvement).	The HSCP successfully completed Year 2 of the workforce knowledge and skills framework, notably establishing a Compassionate Distress Response Service and extending Lifelink Counselling.

Medium Term Financial & Strategic Planning

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Maximising available resources	
Maximise available resources through efficiency, collaboration and integrated working (Improvement).	The HSCP was able to manage service delivery within the budget set for 2022/23 in delivery of our strategic priorities. This included reporting on and maximising the funding available for specific priorities including the Primary Care Improvement Plan, Mental Health Action 15, Annual Delivery Plan, Mental Health Rapid Response (MHRRS) service and Adult Winter Planning. The HSCP aimed to increase adult social work capacity in line with the Scottish Government funding allocation and implement a revised operating model which is fit for purpose and aligned to the strategic priorities of the HSCP. Not all posts were filled as planned, due to resourcing issues within partner bodies to support job evaluation and recruitment. Work continue to progress these roles.

Objectives for 2022-25	Progress in 2022/23
Commitment: Balancing investment and disinvestment	
Balance investment and disinvestment to deliver HSCP priorities within the medium term financial plan (Improvement).	The IJB was able to set a balanced budget for 2023/24 in March which included a savings programme under written by general reserves to smooth in the delivery of key areas of disinvestment. Annual Delivery Plans are now developed each year to support the delivery of the HSCPs Strategic Plan priorities. These are underpinned by Head of Service Plans and Team Plans. The overarching planning, performance governance arrangements supporting these mechanisms are set out in a new HSCP Performance Management Framework. Successful redesign during 2022/23 in areas that aim to reduce overdependence on formal support, in support of more informal, rehabilitative and re-abling services demonstrate the work that the HSCP is doing to rebalance overall investment to deliver improved outcomes. This can also be demonstrated with the work undertaken to localise services to add value through improved integration and collaboration.
Commitment: Delivering financial sustainability	
Ensure longer term sustainability of services within available resources (Redesign)	The financial planning assumptions were updated for the next 5 years with work progressing to identify areas of service redesign which will deliver a balanced budget position for the HSCP going forward.



Collaborative Commissioning and Whole System Working

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Co-designing solutions with the third and independent sectors	
Build collaborative commissioning through the development of improved efficiency, co-designed and co-produced solutions and better outcomes in collaboration with third and independent sector providers (Redesign).	Collaborative commissioning approaches were introduced during 2022/23 in the areas of mental health services and alcohol and drugs services. This now provides a foundation for delivering this approach across other care groups and service areas.

Objectives for 2022-25	Progress in 2022/23
	A review of the engagement framework used to support the HSCPs collaborative approach with the third and independent sector was undertaken and a new model has been designed, approved and implemented.
Commitment: Supporting primary care improvement	
Support primary care improvement and multi-disciplinary working through development in line with the new General Medical Services Contract Memorandum of Understanding (Improvement).	During 2022/23, the HSCP has continued with the implementation of the Primary Care Improvement Plan Memorandum of Understanding (2). Significant progress has been made. The HSCP is on track to complete a level of implementation deliverable within the current financial budget and with the limitations of accommodation and recruitment challenges.

Infrastructure & Technology

Our Progress in 2022/23

Objectives for 2022-25	Progress in 2022/23
Commitment: Modernising health and social care facilities	
Progress towards the development of appropriate, modern facilities that enable co-location of team members and services as well as alignment with GP Practices (Redesign).	The HSCP has development a Property Strategy during 2022/23 which reflects and delivers on the priorities to support delivery of Primary Care Improvement Plan, wider HSCP property requirements and maximises opportunities related to hybrid working: An accommodation review progressed during 2022/23 with an expansion of space within Milngavie Enterprise Centre for office based staff previously located within Milngavie Clinic. This increases the opportunity to modernise clinical and therapeutic space close to local communities. Upgrades within the clinic have been completed during the year with more planned. A similar programme is underway within the East Locality, with shop-front premises secured in the Bishopbriggs area to convert into primary care clinical space. A review of the Woodlands Centre clinic and Kirkintilloch Health and Care Centre is also

Objectives for 2022-25	Progress in 2022/23
	progressing with design plans developed to maximise clinical and therapeutic space within these buildings. Options are being reviewed to further expand clinical and drop-in space within the West Locality. A Health Board wide property evaluation during 2022/23 gave strong support to progressing an integrated health and social care solution within the West Locality; a business case will be developed and taken forward over the next year.
Commitment: Maximising the potential of digital solutions	
The delivery of a comprehensive Digital Health and Social Care Action Plan that maximises the potential of digital solutions, whilst ensuring equality of access for everyone (Redesign).	The HSCP aims to implement its 2022/23 Digital Action Plan by 2024, which seeks to maximise experience of remote technology for a digitally enabled workforce, implement Analogue to Digital Telecare Transformation. Work towards Digital Maturity Assessment with the Scottish Government was not finalised due to delays within the Scottish Government and the loss of key information to inform the assessment. The HSCP is now participating in a national digital assessment of HSCPs. A number of local digital projects have concluded in the year, including "Ask Sara" which provides impartial advice about supportive equipment.

Part 4. Locality Planning

The HSCP established two Locality Planning Groups during 2015/16 to support the understanding, planning and delivery of services around communities within these localities. These locality areas relate to natural communities. They consist of:

- The east of East Dunbartonshire (Bishopbriggs, Torrance, Lenzie, Lennoxtown, and Kirkintilloch).
- The west of East Dunbartonshire (Bearsden and Milngavie).

The Locality Groups have brought together a range of stakeholders including GPs, social workers and social care professionals, community health professionals, carers and service users to facilitate an active role in, and to provide leadership for local planning of service provision.

Three Primary Care Clusters exist in Kirkintilloch and the Villages, Bishopbriggs and Auchinairn, and Bearsden and Milngavie. Most community health, social work and social care services are organised into either locality or cluster teams.

Locality Planning Groups: 2022/23 Update

The continued response to the pandemic had an impact on the impetus and delivery of the locality planning groups. Due to operational pressures, both groups were stood down for 2021/22 and 2022/23.

During this interim period, the HSCP has reviewed the leadership, membership, purpose and governance of locality planning within the HSCP, developing a revised model that ensures a closer link between locality needs, resources and assets.

The operational Locality Practitioner Collaborative model has continued to grow and develop in line with the increasing development of locality-based services and has now been implemented across the authority.

Core membership of the Locality Practitioner Collaboratives meets weekly and consists of senior practitioners from the East and West Social Work Teams, Community Occupational Therapy and Sensory Impairment Service, Community Rehabilitation Teams, Adult Community Nursing, Older People's Mental Health Service and in-house Care at Home, with extended membership from Clinical and Primary Care Pharmacy Services, Adult Mental Health and Podiatry services.

The purpose of this weekly group is to discuss complex adult cases and utilise a Multi-Disciplinary Team approach involving collective knowledge, expertise and resources to improving outcomes for individuals and carers. This approach has shown that using a collective approach to supporting people with complex needs at home has enabled more to remain in their preferred place of care, with the right input to meet their needs. Feedback from the services involved has also been positive.

Building on the success of this approach, a Community Health and Care Services Locality Operational Leads Group was to be established in December 2022 with membership consisting of Team Leaders and Managers from the aforementioned teams meeting monthly. This arrangement has been designed to work alongside the establishment of an Extended Locality Collaborative, with wider membership from Children and Families, Adult Mental Health, Learning Disabilities, Public Health Improvement, Primary care and the Alcohol and Drugs Recovery Service which will meet quarterly. Due to the prolonged and particularly intensive winter pressure period, the establishment of these new collaborative groups was deferred until April 2023.

The Locality Planning Group meetings are also scheduled to re-launch in April/May 2023 where agreement will be reached on their future priorities and areas of focus. Budget has been set aside for both locality groups to facilitate small projects and direct engagement.

Part 5. Hosted Services

Background and Context

The integration of services in a Health and Social Care Partnership involves a legal process whereby functions and services are delegated by the Council and Health Board to a separate governance body called an Integration Joint Board (IJB). In East Dunbartonshire, we call this our Health and Social Care Partnership Board. There are a range of services that by statute *must* be delegated to IJBs and there are additional functions and services that *may* be delegated.

For most services that are delegated to IJBs, these are arranged on a local area basis, so that each local IJB will oversee their strategy and operation as they are arranged and delivered for the area in which the IJB operates. There are six IJBs operating across the NHS Greater Glasgow and Clyde area, so that means that most services are split up into six divisions, one for each IJB. But some services cannot be easily split up, either because it would fragment the services or economies of scale would be lost. In these circumstances, it is often agreed that one IJB will "host" a service on behalf of some or all of the IJBs across the NHS Greater Glasgow and Clyde area.

East Dunbartonshire HSCP Board hosts two functions on behalf of the family of IJBs in the NHS Greater Glasgow and Clyde area: Specialist Children's Services and Oral Health Services. These services are described in more detail below, with a summary of their achievements during 2022/23 and their planned priorities in the year ahead.

Specialist Children's Services (SCS) provide services to children and young people aged 0-18 with various long term, life limiting illness and disorders as well as mental health problems and difficulties. The total 0-18 year old population across the NHS Greater Glasgow and Clyde area is in excess of 215,000. In SCS, there are two overarching services: Child and Adolescent Mental Health Services (CAMHS) and Specialist Community Paediatrics Teams (SCPT), with our new Neurodevelopmental (ND) Service currently being piloted prior to NHS Greater Glasgow and Clyde Board-wide roll out.

SCS has a large workforce based throughout the NHS Greater Glasgow and Clyde area. Some of these staff work within the local communities such as health centres, in hospitals and inpatient units, schools – mainstream and additional support for learning schools and within the patient's home and we have many office bases throughout the NHS Greater Glasgow and Clyde area.

Across Scotland, there is a tiered approach to mental health services in the public sector. GIRFEC principles underpin service delivery in each tier and these are built into service specifications. Tier 1 mental health support is delivered locally and as part of universal services such as Health Visiting and Education. Tier 2 covers mild mental health presentations and is targeted towards those who need it. These services are usually delivered by voluntary and community organisations and offer short term interventions. Tier 3 community CAMHS services are targeted at children and young people with moderate to severe mental health needs who require assessment, intervention and management which is more specialist than that which can be provide by universal services. Tier 4 CAMHS services focus on highly specialist services operating on a GGC level with small numbers of children who require specialist care. GGC CAMHS also host the regional child and adolescent psychiatric in-patient unit at Skye House, and one national service, the national children's psychiatric in-patient unit for under 12s at the Royal Hospital for Children.

Areas of Development and Progress during 2022/23

Over the last year, development and improvement work has predominantly focused on phase 1 of the Mental Health Recovery and Renewal plan, amongst other local run initiatives designed to improve services within SCS. Some highlights include:

- Implementation of the national CAMHS specification across Tier 3 and 4. CAMHS have been developing services towards each of the 7 national standards and the service is working towards auditing and reporting on these to evidence successful implementation.
- The expansion of some community CAMH services from an upper age limit of 18, up to 25 for specific targeted groups, most particularly care experienced young people. This development has also been put in place for our learning disabilities pathway with staff recruited to carry out this work.
- The clearance of waiting list backlogs for CAMHS. By the end of 2022/23, 91.9% of children waiting for treatment had been waiting less than 18 weeks. This exceeds the 90% RTT target and is an improvement from the start of the year where only 60.4% met the target. Similarly, by the end of 2022/23, only two children were waiting over 40 weeks which is a reduction from 117 children at the start of the year.

Other work has been ongoing within phase 2 of the Mental Health Recovery and Renewal plan including the initial planning of a regional adolescent intensive psychiatric care unit, the improvement of CAMHS national data and the development of eating disorder services.

Areas for Focus during 2023/24

As part of the annual performance report and actions for the coming year, a series of development points linked to phase 2 of the Mental Health Recovery and Renewal plan will be important, alongside the ongoing effort for faster, more responsive support for children and young people.

We will continue to aim to meet the 18 week referral to treatment target to ensure children and young people are waiting less than 18 weeks. We will continue to focus on reducing the numbers waiting the longest. While the target has been met at the

end of 2022/23 at a Health Board level, there are challenges in sustaining that performance linked to a combination of ongoing recruitment challenges and the need to balance offering first appointments to young people newly referred, with offering further follow up appointments to those already being seen. CAMHS will therefore aim to achieve and sustain this by the mid-point of 2023/24 with the longest waits being targeted each month to further reduce the length of waits. The workforce plan will be reviewed to focus on professional groups able to increase case holding capacity to create a larger core of nursing and psychology staff.

Alongside the implementation of the national CAMHS specification, the national children and young people's Neurodevelopmental Specification will also be implemented throughout this year. This will create a third umbrella service across SCS, linking very closely with CAMHS and SCPT. The Neurodevelopmental Specification, along with clinical guidelines, a clinical competency framework and a demand and capacity model are all being developed for implementation. These are currently being piloted in two locality areas with the aim to roll out across NHS Greater Glasgow and Clyde, throughout the year.

SCS are working with Scottish Government, GGC eHealth and Public Health Scotland on the development of the Child, Adolescent and Psychological Therapies National Dataset (CAPTND), linking to all NHS Boards across Scotland. The aim is to improve the quantity and quality of monthly data submissions, alongside the improvement of data in general to support reporting on the national specifications. This work is underway and initial monitoring of improvements will be reported.

Oral Health Directorate

The Oral Health Directorate (OHD) is hosted within East Dunbartonshire Health and Social Care Partnership and has responsibility and accountability for Primary Care Dental services within NHS Greater Glasgow and Clyde (NHSGGC) Health Board. The responsibility and accountability for Secondary Care Dental services sits with the Regional Services Directorate, part of the Acute Sector of NHSGGC.

The OHD structure incorporates:

- General Dental Services including Greater Glasgow & Clyde Emergency Dental Service
- Public Dental Service
- Oral Health Improvement
- Secondary Care Dental Services
- Dental Public Health

General Dental Services (GDS)

The role of the OHD General Dental Services administration team is to provide a comprehensive administrative support service to 800 General Dental Practitioners in Greater Glasgow and Clyde in accordance with The National Health Services (General Dental Services) (Scotland) Regulations 2010. The department acts as an enabling function providing practitioners with the necessary support and expertise

associated with their terms and conditions obligations. The department supports the organisation by ensuring that its statutory responsibilities are fulfilled in relation to this group of NHS independent contractors.

Public Dental Service (PDS)

The PDS service operates on a board-wide basis across 28 sites and provides comprehensive dental care and oral health education to priority group patients, including those with additional support needs, adult and paediatric learning disabilities, medically compromised and children who are unable to be seen routinely by GDS (these will include higher levels of treatment complexity and behavioural factors). Treatment is provided in clinics, schools and nurseries, care homes, outpatient daycentres, hospital settings, domiciliary visits, prisons and undergraduate outreach clinics.

Oral Health Improvement

Incorporating strategic and organisational leadership to reduce oral health inequalities, including fulfilling NHSGGC responsibilities in relation to the Oral Health Improvement Plan (2018), delivery of national Oral Health Programmes (such as Childsmile and Caring for Smiles), local oral health strategy and for oral health improvement requirements and ambitions across other programmes in NHSGGC.

Secondary Care Dental (SCD) Service

SCD services also known as Hospital Dental services are the main referral centre for specialist dental services for NHSGGC and the West of Scotland. SCD services accept patients on referral from medical and dental practitioners as well as tertiary referrals from other areas/specialties, including Emergency Dental Treatment Centre (EDTC) and the Out of Hours (OOH) service. Patients can be treated in outpatient clinics or, depending on the treatment required, patients are admitted as inpatients or day cases. Treatment is carried out in the Glasgow Dental Hospital (outpatients) as well as many hospital sites (inpatients/day cases) within the Acute Sector of NHSGGC.

Dental Public Health

Dental Public Health is the speciality of dentistry that deals with the prevention of oral disease, promotion of oral health and improvement of quality of life through the organised and collective efforts of society. Dental Public Health practitioners also have roles in health protection related to dentistry and provide strategic input to the management of healthcare services. The NHSGGC Consultant in Dental Public Health sits within the OHD and works alongside colleagues in the Public Health Directorate and Health Improvement in the Health Board and HSCP's.

Areas of Development and Progress during 2022/23

Over the last year development and improvement work has predominantly focused on recovery of primary and secondary care dental services. Some highlights include:

- Resurrection of the Public Dental Service Review post pandemic and the creation of short life working groups to re-align the recommendations of the review in a post Covid era.
- Revalidation of Paediatric General Anaesthetic (GA) waiting lists to respond to waiting times challenges and deflect as may patients as possible who are awaiting GA to other appropriate modalities of care and treatment.
- Through non-recurring Winter Preparedness Funding (WPF) the PDS was able to increase access to routine dental care for patients within GGC. The funding was used to support access to emergency and urgent dental care and support patients who were not able to register with a dentist. A highlight was the PDS's ability to respond to significant access issues within Inverclyde by creating an Access Centre. Furthermore, an occasional care clinic was set up to deliver emergency and routine dental services for patients referred by the EDTC and OOH clinics who could not access NHS dental care through their local general dental practitioner.
- The OHD stated a robust case and worked closely with Scottish Government to have Inverclyde (under the remote and rural label) included on the list of areas eligible to apply for financial incentives through the Scottish Dental Access Initiative. The initiative allows eligible practices/practitioners within the Inverclyde area to apply for the grant.

Areas for Focus during 2023/24

As part of the annual performance report for the coming year and in response expected changes within Dental Services in Scotland it is important for the OHD to focus on supporting access to NHS dentistry within Greater Glasgow and Clyde. We aim to scope and implement access initiatives throughout primary care oral health services. The key challenge is the awaited outcome of the Dental Reform process and the proposed Determination 1 of the Statement of Dental Remuneration.

Flexible implementation of the recommendations from the Public Dental Service review Programme Board are a key focus for 2023/24 with the creation of a work programme and key work streams alongside the appointment of a Programme Manager to support implementation within agreed timescales. Consideration needs to be given to the outcome of the review of the Statement of Dental Remuneration and the impact of Determination 1 on PDS services; this is expected in October 2023 and may result in changes or additionality to the recommendations in order to be responsive to PDS needs and protect its core services.

The creation and implementation of an OHD wide Communication and Engagement Strategy is a primary focus for the coming year. The initial focus will be establishing and capturing the OHD "audience" which spans both Primary and Secondary Care settings. The creation of a rolling communications programme and action plan that is meaningful to our audience and key stakeholders via social media and other mediums. The intention that by the end of the year the strategy will be embedded as business as usual.

Part 6. Other Achievements and Good Practice Highlights

Each year we report on a wide range of achievements that have been delivered across the HSCP, many of which represent new and innovative ways of working. Managers and staff demonstrate good and improving practice in their day to day work and we feel it is important to showcase these:

Care About Physical Activity (CAPA):

Allied Health Professionals – Support to Care Homes

Care Home residents now have access to care and treatment when required by a Physiotherapist, Occupational Therapist or Senior Rehabilitation Worker, to support residents who have been discharged from hospital and who need support to improve their function or mobility, to remain as independent as possible as per the recommendations in the Scottish Government's Care About Physical Activity Agenda.

Care About Physical Activity Projects

Two projects have been initiated by the CAPA team in line with the National Improvement Programme for Physical Activity Projects within two local Care Homes. Each project aimed to improve the amount of physical activities offered to residents and support Care Home Staff in delivering activities based on the resident's interests and needs. Both have been a success and have encouraged residents to be more active, particularly male residents who had not previously been showing an interest in taking part in activities. These activities support the reduction and prevention of falls and improves the mental health of residents.

A new Care Home Activity Coordinators Peer Support Group has also been set up to enable Care Home staff to share ideas about what has worked well within their Care Homes in relation to increasing the physical activity of residents.

Falls Reduction

The CAPA team have been delivering awareness raising and training sessions to Care Home staff about the Falls Pathway. This approach supports good decision after a resident has fallen and provides staff with professional advice about alternatives to hospital attendance and potential admission.

UNICEF Baby Friendly Gold Award

The UNICEF UK Baby Friendly Initiative enables public services to better support families with feeding and developing close and loving relationships, so that all babies get the best possible start in life. The Health Visiting Service were awarded a UNICEF Baby Friendly gold award in November 2022.

District Nursing Service

Extension of Core Hours

After consultation and a test of change, the District Nursing Service implemented a new working-hours model in September 2023 to provide core services to patients between 08:30 and 22:00, 7 days a week. This new model has shown significant improvements in patient experience, particularly for palliative care, with timely responses to unplanned visits, better continuity of visits and improved communication across the service.

Quality Assurance

A new Quality Assurance audit has been implemented within the District Nursing service. This monthly audit includes in-depth exploration of nursing clinical records and shadowing to include qualitative and quantitative outcomes. Since June 2022, all three District Nursing teams have achieved a consistent Gold rating which is 90% compliance and over and demonstrates a high standard of care across the whole service.

Children's Mental Health and Emotional Wellbeing

During the pandemic the numbers of children and young people seeking support for anxiety and eating disorders increased significantly. In response, our Delivering for Children and Young People Partnership (DCYPP) prioritised improvements in this area. The aim has been to improve early access to mental health, wellbeing and emotional support that is fit for purpose, at the right time and in the right place. New funding has been used to develop local pilot projects, including a Compassionate Distress Response Service (aged 16-26) and additional counselling provided by LifeLink to support home schooled children and young people 16+ who are not in school. This service specifically targeted young people referred for support to the Children & Young People Mental Health Services (CAMHS).

Wayfinder – Peer Navigator for Justice Clients

Working in collaboration with the Alcohol and Drug Partnership and the Community Justice Partnership, Justice Social Work services secured funding from the Drugs Death Task Force, to commission a Peer Navigator post to enhance justice clients' ability to access alcohol and drugs services with a view to improving outcomes and reducing drug deaths.

The Peer Navigator has lived expertise and uses relationship-based practice to develop supportive and meaningful relationships with clients, many of whom are often difficult to engage. This service is aimed at men subject to community-based disposals and those returning to the community after custodial sentences.

Since coming into post the navigator has supported 15 clients to positive destinations.

Connect-ED

Connect-ED was an initiative piloted during 2022/23 to promote healthy aging and independence. It delivered a range of health and wellbeing information and support from the HSCP, the Council and local third sector services.

During the 6-month programme, 59 people were supported on issues including Power of Attorney and wills advice, provided by our Age Scotland partner. Others were provided with information on social clubs, walking groups and enquired about volunteering opportunities. It is also notable that all organisations who took part in the programme reported increased referrals and established new networks.

Mind of My Own App

The child care Integrated Comprehensive Assessment (ICA) cannot be completed and authorised for the Scottish Children's Reporter if the Child/Parents view is not recorded. In response to this, the Children and Families team have introduced the Mind of My Own App, which enables children and young people to communicate their views, experiences and feelings to a trusted adult in a safe digital space. This supports practitioner in understanding the child or young person, enables them to respond quickly to them and evidences their views.

Income Maximisation

In 2022 the Health Improvement Team devised and developed a digital QR code to support the Income Maximisation service. The service can now receive service user referrals directly from the new digital pathway incorporating a quicker self-referral route, streamlining the process and making the service more accessible for a wider range of individuals.

East Dunbartonshire Improving the Cancer Journey

This service, in partnership with Macmillan Cancer Support has been running for 16 months and helps people to get the support they need, whether that's physical, emotional, practical, medical or financial. In 2022 the service entered into partnership with Low Moss Prison to offer the service to those who live or work within the prison environment. This partnership is being cited as an area of good practice by both the Scottish Prison Service and The Scottish Government.

Children and Young People's Mental Health

The School Nursing service continues to support the increasing number of children and young people seeking support for mental health and wellbeing. Through training and development, the team have upskilled staff to support children and young people with complex health needs and/or emotional health and wellbeing needs. All school nurses provide Lets Introduce Anxiety Management (LIAM) intervention to 8-18 years.

Access to Advanced Practitioner – Festive Holiday Cover

Advanced Nurse Practitioner access was arranged over the 4 public holidays during the festive period to give advanced support to four care homes that were in a Covid-19 outbreak at the time as well as support to patients in their own home. Within the care homes, this resulted in 21 calls to NHS24 or GP Out of Hours being avoided as well as 12 potential hospital admissions being avoided. For those patients at home, 6 potential hospital admissions and 10 calls to GP Out of Hours were avoided.

Perinatal Mental Health Services

The Enjoy Your Baby Group has been expanded to included fathers and partners as well as mothers. It is an evidence-based programme for the management of stress, anxiety and depression for parents experiencing mild to moderate mental health challenges, during this period. The programme promotes early intervention, reducing the risk of deterioration using a recovery-based model of person-centered care, taking account of the parent's needs and that of their infant, partner and family.

Care Home Support Team

Anticipatory Care Planning (ACPs)

The Care Home Liaison nurses are promoting the importance of Anticipatory Care Planning for care home residents which is a plan for how and where they would like to be cared in the future and identifies what personal outcomes are important to that individual. This information is available on a shared electronic system accessed by the ambulance service, GPs and health staff working within community and Acute services. Anticipatory Care Plans enable a meaningful conversation with residents about preferred place of care and contribute to the reduction of unscheduled admissions and the facilitation of successful and timely discharge from hospital. Education has been provided to the whole team and to the community social work teams.

Project Milkshake

The Dietitian, in conjunction with the Care Home Dietetic team (Health Board wide), started a pilot project during 2022/23, Project Milkshake, within one East Dunbartonshire care home that promotes the use of milkshakes and a 'Food First' approach for residents experiencing weight loss.

Relatives Forum

In collaboration with Carers Link, a Relatives Forum has been established for relatives of care home residents with an emphasis on mutual support. Topics that have or will be covered include food, fluid and nutrition, bereavement, finances, meaningful / physical activities, life story work, palliative care and anticipatory care planning.

Community Mental Health Team

Attention Deficit Hyperactivity Disorder (ADHD)

During 2022/23 a new ADHD assessment clinic was established on a Saturday to enable people to attend out with working or school hours. This is proving popular with clinic attendance rates at 100%.

Public Dental Service

The Public Dental Service set up additional clinics in 2022/23 to tackle issues relating to reduced access to dental services experienced since the Covid-19 pandemic, in particular in General Dental Services. A Paediatric clinic has been set up to assess and treat children who have been unable to access routine dental care within General Dental Practice. A service for frail elderly patients has been established for patients who require routine domiciliary care but do not need input from the Special Care Dental Team. An occasional clinic has also been established to offer a single course of treatment for unregistered patients who required a course of dental care to secure oral health but were unable to register with a General Dental Practice due to ongoing access issues.

"Make it Work"

Having a job is considered to be one of the main positive influences on an individual's ability to not reoffend. It not only improves their prospects of securing appropriate accommodation, healthcare, and more secure finances, but it can provide them with new peer groups, and help build their resilience and a positive self-image.

In collaboration with the Local Employability Partnership (LEP) the Community Justice team have introduced the 'Make it Work' East Dunbartonshire employability project for people in contact with the Justice system.

A dedicated employment advisor has been employed and 21 people started on the first year of the programme in 2022/23, with 14 gaining a qualification necessary for ongoing employment and 9 people starting employment.

Electronic Medical Administration Record (eMAR)

eMAR is an electronic medical records software which is an alternative to the paper-based Medical Administration (MAR) sheets used for managing medication administration. The HSCP Care at Home team are currently piloting eMAR through their scheduling system, with a small number of clients who are receiving prescribed creams in conjunction with the District Nursing Service. This enables the Care at Home Carers to apply the prescribed cream based on the scheduling and dosages entered by the District Nurses. The hope is that the eMAR system can be rolled out to a great number of customers for a wider number of prescribed medications in the future.

Home & Mobile Health Monitoring for Self-Management

Blood Pressure Monitoring

Blood pressure monitors have been distributed across 6 GP Practices involved in the rollout of the self-management of blood pressure monitoring. 176 patients so far are monitoring their blood pressure at home preventing repeat visits to their GP practice.

Community Treatment and Care Service (CTAC) - Vitamin B12 Injections

Patients have fed back to the CTAC team that for some of them, having to attend regular clinic appointments for their Vitamin B12 injections was negatively impacting on their life due to the time it took to attend appointments. This feedback led the team to introduce a test of change for interested patients which focused on developing training resources to support and educate willing participants to self-administer vitamin B12 injections. The pilot was launched successfully in March 23 with 16 service users now self-managing their condition. A further 30 service users have expressed an interest in undertaking the training to allow them to self-manage their condition.

Rehabilitation

Home For Me

The Home For Me service is a continuously developing joint service between the Community Rehabilitation Team and the Care at Home service. These services work jointly to provide a short period of rehabilitation and reablement to promote independence and reduce the need for an ongoing care package. The majority of service users have had a recent hospital admission and a change in their functional abilities.

This collaborative way of working allows individuals to receive care when required, whilst receiving rehabilitation, setting patient centered goals and reducing their reliance on services. The service has also been used to prevent admission to hospital where a short term packages of care has been put in place to support someone at home during a period of ill health. Currently the service manages to support 93% of individuals back to full independence. Customer feedback has been very positive.

Frailty Practitioners

East Dunbartonshire HSCP now has 2 Frailty Practitioner posts within the Community Rehab Team as part of a wider NHS Greater Glasgow & Clyde response to the issue of frailty across the Health Board area. The Frailty Practitioners provide a comprehensive assessment of individuals identified as living with frailty within the community.

Work has also commenced with 2 GP practices to identify individuals in the community who would benefit from a comprehensive assessment within their own home. They will then receive advice for self-management of any issues they may have been having, sign-posting to any supports they may need and/or a referral to any professional services they may require.

"Apna Ghar"

Apna Ghar is a new group within the Bearsden area for women from ethnic minority backgrounds. The group offers a friendly, welcoming environment, encouraging friendship and peer support.

The Older People Local Area Co-ordination Service worked in partnership with the volunteers and organiser for the group, East Dunbartonshire Voluntary Action (EDVA), the public and the Council to establish the group, secure accommodation, develop the group's constitution and membership, and support funding applications. The group now operates independently with minimal ongoing assistance from the Local Area Co-ordination Team.

Alcohol and Drugs Recovery Service

EAST DUNBARTONSHIRE ALCOHOL AND DRUG PARTNERSHIP

The Alcohol and Drugs Recovery Service has developed a new Standard Operating Procedure that the Scottish Government are utilising as an example of good practice and sharing with other Alcohol and Drug Partnership areas.

AskSARA is a self-help website which gives impartial expert advice and information on products and equipment to help make daily living easier for older and disabled people. The HSCP continues to promote and raise awareness of the AskSARA service. There has been a 33% increase in activity from last year.

Engagement with Place Communities

During the past year, the HSCP has been working in partnership with our community planning partners to consult with the communities in Lennoxtown, Hillhead and Harestanes, Twechar and Auchinairn. The consultation was undertaken to inform the new Locality Plans which will drive work in those areas and will replace the previous Place plans.

During the consultation, the Public Health Improvement Team engaged with approximately 420 people to find out what support they need as we work through and out of the pandemic and how we can help empower communities to support themselves in a true community-led approach.

This partnership approach has helped build and maintain stronger relationships between partners in East Dunbartonshire, share resources and skills and lead to a more joined up and community-led approach.

Income Maximisation

Over the past 5 years the Income Maximisation Service has generated a total of £3,898,000 of income which has directly benefited East Dunbartonshire residents. This service which is managed by the Public Health Improvement Team (HIT), supports the HSCPs ambition to mitigate poverty and increase health & wellbeing outcomes across East Dunbartonshire. In 2022 the HIT added a digital QR code to support referral to the income maximisation service. This has helped to streamline and simplifying the referral process, reducing barriers and widening its reach.

Trauma Informed Practice

A number of the teams across the HSCP have invested significantly in embedding trauma informed practice during 2022/23, recognising where people are affected by trauma and adversity, and better able to respond in ways that prevent further harm and support recovery. Staff training has been rolled out and work has begun to improve clinical spaces to appear more user friendly with framed pictures, furnishings and softer lighting. Noise outside rooms has also reduced by minimising staff use of the corridors. In November 2022 we appointed a Trauma Informed Coordinator to progress this work and support the Aces and Trauma Collaborative.

Joint Learning Disability Services

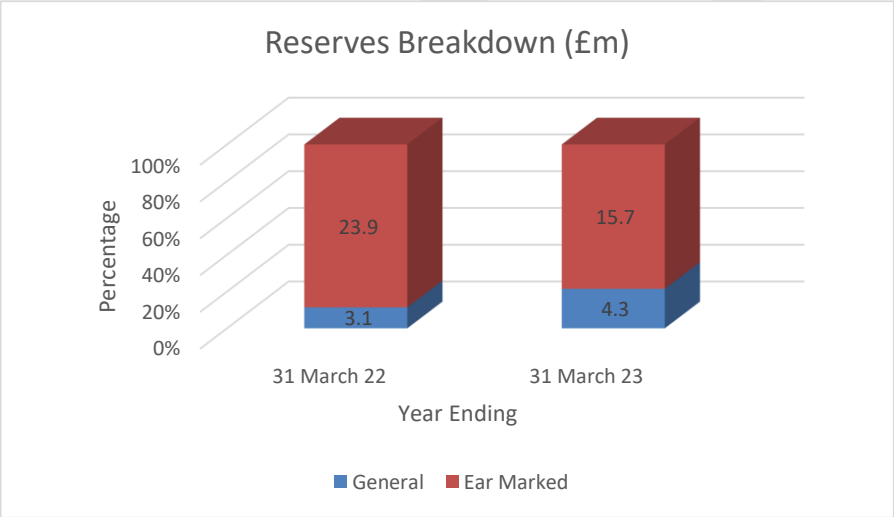
In line with Scotland's National Dementia Strategy, the team has been contributing towards the development of dementia support for people with learning disabilities. We have contributed towards the development of a new care plan guidance resource for Post Diagnostic Support. We have also been involved in the development and delivery of a dementia training programme, in line with the 'Promoting Excellence' framework, which is being rolled out across NHS GG&C Learning Disability Services.

Part 7. Financial Performance

Financial Performance 2022/23

The partnership's financial performance is presented in the Annual Accounts. The Comprehensive Income and Expenditure Statement (CIES) describes expenditure and income by care group across the IJB and shows an over spend of £6.928m against the partnership funding available for 2022/23. Adjusting this position for in year movements in reserves provides an underlying positive variance on budget of £4.387m for 2022/23 which represents operational service delivery for the year and has been reported throughout the year to the IJB through regular revenue monitoring updates.

This has reduced the overall reserves position for the HSCP from a balance of £26.990m at the year ending 31 March 2022 to that of a balance of £20.062m as at year ending 31 March 2023. The reserves can be broken down as follows:



The CIES includes £2.930m of expenditure related to the impact from Covid-19. The costs incurred during 2022/23 are set out in the table below.

Additional Covid-19 Costs - HSCP	2022-23 Revenue Total
Flu Vaccination & Covid-19 Vaccination (FVCV)	**181,186**
Additional Staff Costs (Contracted staff)	**239,379**
Additional Staff Costs (Non-contracted staff)	**57,374**
Additional Equipment and Maintenance	**513**
Additional PPE	**30,321**
Additional Capacity in Community	**140,547**
Children and Family Services	**895,242**
Covid-19 Financial Support for Adult Social Care Providers	**1,167,495**
Additional FHS Contractor Costs	**72,322**
Digital & IT costs	**4,086**
Loss of Income	**141,237**
Total Covid Costs - HSCP - All	**2,929,701**

Costs were covered through HSCP earmarked reserves, held for this specific purpose. The balance of reserves of £7.034m was returned to SG in the financial year to be redistributed across the sector to meet current Covid-19 priorities. The mechanism by which the funds were returned resulted in the contribution from NHSGG&C being reduced by this amount.

Financial Outturn Position 2022/23

The budget for East Dunbartonshire HSCP was approved by the IJB on the 24th March 2022.This provided a total net budget for the year of £199.034m (including £38.514m related to the set aside budget). This included £0.449m of agreed savings to be delivered through efficiencies, service redesign and transformation to deliver a balanced budget for the year and moving forward into future years.

There have been a number of adjustments to the budget since the HSCP Board in March 2022 which has increased the annual budget for 22/23 to £208.479m. These adjustments relate mainly to non-recurring funding from SG specific to the dental health bundle, family health services, PCIP, ADP and the pay award for NHS and social work staff. This is netted off against the reduction in the NHS contribution related to the return of Covid funding in year.

The partnership's financial performance across care groups is represented below:

Care Group Analysis	Annual Budget 2022/23 £000	Annual Expenditure 2022/23 £000	Year End Variance £000
Strategic & Resources	4,615	4,465	149
Older People & Adult Community Services	52,188	48,793	3,395
Physical Disability	5,314	5,093	221
Learning Disability	22,859	23,142	(283)
Mental Health	4,363	4,501	(138)
Addictions	1,916	1,307	609
Planning & Health Improvement	618	552	66
Childrens Services	15,632	14,930	702
Criminal Justice Services	416	455	(39)
Other Non Social Work Services	1,258	950	308
Family Health Services	33,220	33,218	2
Prescribing	21,095	22,027	(932)
Oral Health Services	11,713	12,738	(1,025)
Set Aside	40,306	40,306	0
Covid Expenditure	(7,034)	2,930	(9,964)
Net Expenditure	208,479	215,407	(6,928)

A breakdown of the projected underspend against the allocation from each partner agency is set out in the table below:

Partner Agency	Annual Budget 2022/23 £000	Actual Expenditure 2022/23 £000	Year End Variance 22/23 £000
East Dunbartonshire Council	71,437	77,737	(6,301)
NHS GG&C	137,042	137,670	(628)
TOTAL	208,479	215,407	(6,928)

The main reasons for the variances to budget for the HSCP during the year are set out below:

- **Mental Health, Learning Disability, Addiction Services, Health Improvement (£0.255m under spend) -** the overall variance relates to pressures in relation to increased taxi provision (as opposed to use of fleet transport) to support SW service users to access services, loss of income from charging due to numbers attending day services and in receipt of non-residential services not resuming to pre covid levels. This is offset by the numbers of care packages not resuming to pre covid levels anticipated at the time of setting the Budget for 2022/23, vacancies, ongoing recruitment and retention issues across nursing and psychology posts within MH and LD health services.

- **Community Health and Care Services – Older People / Physical Disability (underspend of £3.616m) –** there continued to be reduced levels of care home placements, supported living packages and care at home services purchased from the external market from that assumed at the time of setting the budget, due to the continuing impacts of Covid-19. Numbers are continuing to recover to more normalised levels. This mitigates pressures within the in-house care at home service and pressures in relation to equipment to support people to remain at home along with additional adult winter planning funding to increase capacity in this area. SG funding was made available in year for Adult winter planning which was not fully spent in year due to ongoing recruitment challenges in filling posts. This will be taken to earmarked reserves.

  This also includes the refund of monies of £1.1m related to charges for continuing care beds within Fourhills Care Home dating back to 1st April 2019 (£0.3m related to 19/20, £0.4m related to 20/21 and £0.4m related to 21/22).

- **Children and Criminal Justice Services (underspend of £0.663m) –** there continued to be recruitment and retention challenges across Children's services for the year. There was also reductions in external fostering and residential childcare placements as children move onto positive destinations. There continue to be pressures in relation to Unaccompanied Asylum Seeking Children (USAC) where placements within in house provision is at capacity and will require the purchase of externally purchased placements to accommodate these children.

- **Housing Aids and Adaptations and Care of Gardens (underspend of £0.308m) -** there are a number of other budgets delegated to the HSCP related to private sector housing grants, care of gardens and fleet provision. These services are .delivered within the Council through the Place, Neighbourhood and Corporate Assets Directorate – there has been a continuing underspend in relation to fleet recharges related to a downturn in transport provision needed as a consequence of Covid and a reduction in services requiring this type of transport. This is compounded by underspends across the care and repair service and private sector housing grants.

- **Prescribing (overspend of £0.932m) -** pressures in relation to price and volume increases across a range of medicines have been reported throughout the financial year which has resulted in an adverse variance in this area. A number of initiatives are in development to target the volume and types of prescriptions dispensed such as script-switch, review of use of formulary vs non formulary, waste reduction, repeat prescription practices. Prices across the market will continue due to global factors outwith the control of the HSCP, however use of alternative medicines will form part of the programme of initiatives being rolled out across East Dunbartonshire and more widely across GG&C.

- **Oral Health (overspend of £1.025m) -** the overspend relates to expenditure incurred in year on temporary staffing to address winter pressures and ventilation and equipment purchases in support of recovery of services following the pandemic to be funded from earmarked reserves set aside for this purpose. This was offset by some delays in filling vacancies during the year.

- **Covid Expenditure (overspend of £9.964m) –** there was expenditure related to Covid-19 during the year of £2.930m and the return of un-used reserves to SG of £7.034m. This expenditure will be met entirely from HSCP earmarked reserves held for this purpose.

Partnership Reserves

As at the 1 April 2022, the HSCP had a general (contingency) reserves balance of £3.1m. The surplus on operational service delivery generated during 2022/23 (£4.387m) will allow the HSCP to further that reserve in line with the HSCP Reserves Policy. This will provide the HSCP with some financial sustainability into future years and an ability to manage in year unplanned events and afford a contingency to manage budget pressures without the need to resort to additional partner contributions as a means of delivering a balanced budget.

The performance of the budget during 2022/23 supports the HSCP in the enhancement of a reserve to support the redesign of accommodation by a further £1m. This will increase the reserve already available to £3m to support the HSCP in delivery of its strategic priorities, primarily related to the delivery of the primary care improvement programme, moving services currently delivered within acute settings to local communities, such as Phlebotomy, and additional space to accommodate increased staffing capacity in response to Adult Winter Planning monies, adult

social work capacity funding. In addition it will facilitate the creation of a digital redesign programme of £0.5m in response to the outcome of a national digital maturity assessment and the work already underway as a result of the Covid-19 pandemic where resort to digital platforms moved forward significantly and needs ongoing investment to maintain and develop further. At its meeting in March 2023, the IJB approved the use of an element of contingency reserves to create a smoothing reserve to underwrite the delivery of the savings programme for 2023/24 of £0.594m and also to enhance the prescribing reserve by £1m to mitigate anticipated pressures related to increased price and volume demands during 2023/24. This provides a remaining balance on general reserves of £4.371m.

IJB's are empowered under the Public Bodies (Joint Working) Scotland Act 2014 (section 13) to hold reserves and recommends the development of a reserves policy and reserves strategy. A Reserves policy was approved by the IJB on the 11 August 2016. This provides for a prudent reserve of 2% of net expenditure (less Set Aside) which equates to approximately £3.8m for the partnership. The level of general reserves is in line with this prudent level and provides the partnership with a contingency to manage any unexpected in year pressures moving into future years of financial uncertainty.

While contingency reserves have increased during 2022/23, there has been a net reduction in the level of earmarked reserves from £23.912m to £15.691m with the application of reserves in year to deliver on specific strategic priorities. During 2022/23, the HSCP used £12.891m of its earmarked reserves. In the main this related to the application of £2.930m towards Covid-19 expenditure incurred in year, the return of £7.034m to SG of the balance of Covid reserves as well as the use of reserves to support expenditure related to the delivery of PCIP, Action 15 and Oral Health priorities. There were some additions to earmarked reserves in year of £1.576m (related primarily to ADP, Adult Winter Support Funding and Community Link workers) along with the creation / enhancement of earmarked reserves as set out above totalling ££3.094m provides for an overall net reduction in earmarked reserves for the year of £8.221m. This will leave a balance on earmarked reserves of £15.691m.

The total level of partnership reserves is now £20.062m.

Financial Planning

In setting the budget for 2023/24, the partnership had a funding gap of £3.894m following an analysis of cost pressures set against the funding available to support health and social care expenditure in East Dunbartonshire, this is set out in the table below:

	Delegated SW Functions (£m)	Delegated NHS Functions (£m)	Total HSCP (£m)
Recurring Budget 2022/23 (excl. Set aside)	69.918	92.118	162.036
SCS Budgets transferred to ED HSCP		30.074	30.074
Set Aside		38.382	38.382
Total Recurring Budget 2022/23	69.918	160.574	230.492
Financial Pressures - 23/24	6.724	1.640	8.364
2023/24 Budget Requirement	76.642	162.214	238.856
2023/24 Financial Settlement / Budget 2023-24	73.226	161.736	234.962
Financial Challenge 23/24	3.416	0.478	3.894
Savings Plan 23/24	(3.396)	(0.498)	(3.894)
Residual Financial Gap 23/24	**0.020**	**(0.020)**	**(0.000)**

Savings plans of £0.3894m were identified to mitigate the financial pressures which delivered a balanced budget position moving into 2023/24. There are a number of significant financial risks to the HSCP moving into 2023/24 with uncertainty on the funding to support pay uplifts for Social Work staff, pressures in relation to prescribing expected to continue into the new financial year, pressures on contractual spend for Social Work care providers with funding only available to support the SLW element and risks to the delivery of the savings programme in full. This has necessitated the need to enhance prescribing reserves and to create a smoothing reserve to underwrite and phase in elements of the savings plan during 2023/24 with full delivery expected in future financial years.

The HSCP has a Medium Term Financial Strategy for the period 2023 – 2028 which outlines the financial outlook over the next 5 years and provides a framework which will support the HSCP to remain financially sustainable. It forms an integral part of the HSCP's Strategic Plan, highlighting how the HSCP medium term financial planning principles will support the delivery of the HSCP's strategic priorities.

There are a number of key opportunities and challenges for the HSCP at a national and local level. The most significant being the Review of Adult Social Care, elements of which have now been reflected in the new programme for government. This may see significant investment across a range of areas including the development of a National Care Services on an equal footing to the National Health Service, expansion of support for lower-level needs and preventive community support, increasing support to unpaid carers and sums paid for free personal care.

The HSCP has particular demographic challenges.

The longer term impacts of the pandemic (Covid-19) are yet to be fully assessed and the impact of this on the delivery of health and social care services.

The Financial Challenge

The Medium Term Financial Strategy (MTFS) for the HSCP provides a number of cost pressures with levels of funding not matching the full extent of these pressures requiring a landscape of identifying cost savings through a programme of transformation and service redesign. The MTFS was updated as part of the Budget Setting for 2023/24 in March 2023.

The main areas for consideration within the MTFS for the HSCP are:-

- The medium term financial outlook for the IJB provides a number of cost pressures with levels of funding not matching the full extent of these pressures requiring a landscape of identifying cost savings through a programme of transformation and service redesign.
- The IJB is planning for a range of scenarios ranging from best to poor outcomes in terms of assumptions around cost increases and future funding settlements. This will require the identification of £17.2m to £38.4m of savings (previously £11.5m to £21.8m) with the most likely scenario being a financial gap of £17.2m over the next five years.
- This will extend to £42.3m (previously £28.9m) over the next 10 years, however this becomes a more uncertain picture as the future environment within which IJBs operate can vary greatly over a longer period of time.
- Based on the projected income and expenditure figures the IJB will require to achieve savings between £4.1m and £4.5m (previously £0.5m and £3.0m) each year from 2023/24s onwards.

The aim of the medium term financial strategy is to set out how the HSCP would take action to address this financial challenge across the key areas detailed below:

Key areas identified to close the financial gap

Delivering Services Differently through Transformation and Service Redesign

- Development of a programme for Transformation and service redesign which focuses on identifying and implementing opportunities to redesign services using alternative models of care in line with the ambitions of the HSCP Strategic Plan.

Strategic Commissioning

- Ensuring that the services purchased from the external market reflect the needs of the local population, deliver good quality support and align to the strategic priorities of the HSCP.

Shifting the Balance of Care

- Progressing work around the un-scheduled care commissioning plan to address a shift in the balance of care away from hospital based services to services delivered within the community.

Prevention and Early Intervention

- Through the promotion of good health and wellbeing, self-management of long term conditions and intervening at an early stage to prevent escalation to more formal care settings.

Demand Management

- Implementing a programme focussed on managing demand and eligibility for services which enable demographic pressures to be delivered without increasing capacity. This is an area of focus through the Review of Adult Social Care.

Part 8. Inspection and Regulation

Joint Inspections

On 26 September 2022 the Care Inspectorate wrote to the East Dunbartonshire Community Planning Partnership to advise that the Care Inspectorate, Education Scotland, Her Majesty's Inspectorate of Constabulary in Scotland and Healthcare Improvement Scotland would undertake a joint inspection of services for children at risk of harm in East Dunbartonshire.

The remit of these joint inspections is to consider the effectiveness of services for children and young people up to the age of 18 at risk of harm. The inspections look at the differences Community Planning Partnerships are making to the lives of children and young people at risk of harm and their families.

The active phase of the inspection took place between October 2022 and February 2023 and the inspection report was published 18 April 2023. The report can be accessed on the Care Inspectorate's publications web page[3].

The inspection report highlights areas of good practice and areas for further development and concludes on an assessment grading for a single quality indicator 2.1, from the inspection framework, 'impact on children and young people'. The inspection report has graded the services in East Dunbartonshire as 'Good'. An evaluation of good is applied where performance shows important strengths which clearly outweigh any areas for improvement. The strengths will have been assessed as having a significant positive impact on children and young people's experiences and outcomes.

The report highlighted the following strengths and areas of good practice:

- Many children and young people said that they got the right help to make and keep loving relationships with those they cared about. We saw how some were being supported to maintain relationships with brothers and sisters, as well as with parents.
- Support for children's wellbeing, planning of care and provision of good nurturing relationships was rated as good or better in regulated care inspections.
- Almost all children and young people told us they felt safe where they lived all or most of the time. Asylum seeking young people felt well supported, safe and helped to maintain cultural links. Interpreters were provided for individual children or parents.
- Young people were being listened to about what mattered to them, felt involved and were aware of their rights. Many children and young people had the opportunity to develop consistent and enduring relationships with key staff.

[3] Joint inspections of services for children and young people (careinspectorate.com)

- Children and young people had been directly engaged in service developments such as the House project. In other examples, including record keeping, they were influencing changes in practice.
- Staff we spoke with demonstrated a child-centred approach to providing services to improve the wellbeing of children and young people.
- Statutory and voluntary agencies were working well together to provide practical support for children, young people and their families. A range of services from pre-birth to teenage, provided early and effective intervention in response to emerging concerns.
- Children and young people had benefitted from their safety and wellbeing having been a key priority for leaders throughout the Covid-19 pandemic.
- The scrutiny partners concluded that they were confident that partners in East Dunbartonshire have the capacity to make changes to service delivery in the areas that require improvement. This was based on the following factors:
- Evidence of strong partnership working, and staff and leaders being committed to improving outcomes for children, young people and families.
- High levels of confidence from staff in their knowledge and abilities, supported by evidence from records reading.
- Similar levels of support from staff about their leaders' ability to continue to drive change and make improvements.
- Well-developed management information and self-evaluation practice capable of identifying areas for improvement and further action.
- Collaborative inter-agency practice, including the role of the third sector, providing services to children at risk of harm and their families.
- Recent commitments to changes in practice, including the introduction of the Safe and Together model, and an emphasis on trauma informed practice.
- The partnership's own self-evaluation had already identified many of the areas for improvement found by the inspection team, which showed that they knew themselves well and had a solid foundation to make improvements.

Scope for improvement was identified in awareness and consistent availability of advocacy services, further opportunities for the voices of children who were, or had been, at risk of harm to inform strategic planning, scope to improve the quality of chronologies, waiting times for access to specialist CAMHS services and scope to further develop analysis of impact and outcomes for children and their families.

An action plan has been developed in response and will be overseen by the Delivering for Children and Young People group on behalf of the Community Planning Partnership.

Service Inspections

Detail on Care Inspectorate evaluation grades relating to directly provided and arranged services is set out at **Annex 2.**

ANNEX 1: National Outcomes and Local Strategic Priorities & Enablers

The relationship between the National Health and Wellbeing Outcomes and the East Dunbartonshire HSCP Strategic Priorities and Enablers are set out in the chart below. The linkages shown are the ones that are most direct, but there may be other less direct associations:

National Outcome		East Dunbartonshire HSCP Strategic Priorities							
		Empowering People	**Empowering Communities**	**Prevention and Early Intervention**	**Public Protection**	**Supporting Families and Carers**	**Improving Mental Health and Recovery**	**Post Pandemic Renewal**	**Maximising Operational Integration**
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	X	X	X		X	X	X	
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	X	X	X		X	X		
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	X	X			X	X		X
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	X	X	X	X	X	X	X	X
5	Health and social care services contribute to	X	X	X	X	X	X	X	

National Outcome		East Dunbartonshire HSCP Strategic Priorities							
		Empowering People	Empowering Communities	Prevention and Early Intervention	Public Protection	Supporting Families and Carers	Improving Mental Health and Recovery	Post Pandemic Renewal	Maximising Operational Integration
	reducing health inequalities.								
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	X	X	X		X	X		
7	People who use health and social care services are safe from harm.	X			X	X	X		X
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.							X	X
9	Resources are used effectively and efficiently in the provision of health and social care services.	X	X	X				X	X

National Outcome		East Dunbartonshire HSCP Strategic Enablers			
		Workforce & Organisational Development	Medium Term Financial & Strategic Planning	Collaborative Commissioning	Infrastructure & Technology
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	X	X	X	
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	X	X	X	X
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	X	X	X	
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	X	X	X	
5	Health and social care services contribute to reducing health inequalities.	X	X	X	X
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	X	X	X	
7	People who use health and social care services are safe from harm.	X	X	X	X
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	X	X	X	
9	Resources are used effectively and efficiently in the provision of health and social care services.	X	X	X	X

ANNEX 2: CARE INSPECTORATE EVALUATIONS – LOCAL SERVICES

The Care Inspectorate is the national regulator for care services in Scotland. The Care Inspectorate inspects services and evaluates the quality of care they deliver in pursuance of the National Care Standards. They support improvement in individual services and across the care sector nationally.

The Care Inspectorate will award grades for certain 'quality themes' that they have assessed. These 'quality themes' cover the main areas of a service's work. How well the service performs in these areas will indicate how good the service is. One or more themes will be assessed, depending on the type of service and its performance history. A grade is given to each of the quality themes assessed using a six point grading scale, which works in this way:

Grade 6 – Excellent	Grade 3 – Adequate
Grade 5 – Very good	Grade 2 – Weak
Grade 4 – Good	Grade 1 – Unsatisfactory

The functions delegated to the HSCP Board include a statutory obligation to provide or arrange services to meet assessed care needs. The HSCP Board "directs" the Council to provide or arrange these services on its behalf. Some of these services are delivered directly by the Council and others are purchased from the third and independent sectors. It is important that the quality of the services we directly provide and those purchased are both of the highest quality. The Partnership works to improve its own services through direct management and operational oversight. Purchased services are subject to detailed specification and contract monitoring by the Partnership's Commissioning Team. The grades of the services delivered by the Council and those purchased by the Partnership are set out below. The grades below are the most recent assessed by the Care Inspectorate for services based in East Dunbartonshire. Inspection reports can be found at on the Care Inspectorate website.

The Care Inspectorate now applies the National Care Standards. These have introduced new quality themes which will eventually apply to all registered services. The Care Inspectorate has begun applying these new quality themes.

The tables below have therefore separated out registered services by the framework of quality themes that were used as the basis of the inspections:

NEW INSPECTION MODEL:

Service	Wellbeing (previously Care & Support)	Leadership (previously Management & Leadership)	Staffing	Setting (previously Environment)	Care Planning (new Category)
HSCP / Council In-house Services					
Ferndale Care Home for Children & Young People	5	Not Assessed	Not Assessed	Not Assessed	6
Ferndale Outreach for Children & Young People	5	Not Assessed	Not Assessed	Not Assessed	6
John Street House	5	4	Not Assessed	Not Assessed	Not Assessed
Homecare Service *Addendum: May 2023 service graded 5 in all categories (except Setting which was not inspected)*	5	4	5	Not Assessed	3
Commissioned - Supported Accommodation					
Cornerstone Community Care	5	5	Not Assessed	Not Assessed	Not Assessed
Living Ambitions (Group registration covers Glasgow North & West Services)	3	3	Not Assessed	Not Assessed	Not Assessed

Independent Care Homes					
Abbotsford House	How good is our care and support during COVID-19 pandemic - 4				
Antonine House	How good is our care and support during COVID-19 pandemic - 4				
Ashfield	5	4	Not Assessed	Not Assessed	Not assessed
Birdston Care Home	4	4	Not Assessed	Not Assessed	Not Assessed
Boclair Care Home	Registered August 2022, not been inspected				
Buchanan House	3	3	3	4	4
Buchanan Lodge	4	4	4	4	4
Buttercup House	5	Not Assessed	Not Assessed	Not Assessed	4
Campsie View	3	4	Not Assessed	Not Assessed	Not Assessed
Lillyburn	5	5	Not Assessed	Not Assessed	5
Mavisbank	Not Assessed	Not assessed	4	Not Assessed	4
Milngavie Manor	4	4	Not Assessed	Not Assessed	Not Assessed
Mugdock	5	5	5	Not assessed	Not assessed
Springvale	4	4	4	4	4
Westerton	4	4	4	4	4
Whitefield Lodge	Not Assessed	Not assessed	3	Not Assessed	Not assessed
Commissioned – Care at Home Services					
Blue Bird Care	4	4	4	Not Assessed	Not assessed
Cornerstone	5	5	Not Assessed	Not Assessed	Not Assessed

Hands-On Homecare	Not Assessed	3	3	Not Assessed	Not Assessed

PREVIOUS INSPECTION MODEL:

Service	Care and Support	Environment	Staffing	Management and Leadership
HSCP / Council In-house Services				
Milan Day Service	5	Not Assessed	5	Not Assessed
Allander Resource Centre (previously Kelvinbank Day Service	5	Not Assessed	5	Not Assessed
Meiklehill & Pineview	5	Not Assessed	Not Assessed	5
Fostering Service	5	Not Assessed	5	4
Adoption Service	4	Not Assessed	5	4
Community Support Team for Children and Families	5	Not Assessed	Not Assessed	6
Commissioned - Supported Accommodation				
Key Housing Association – Key Community Supports – Clyde Coast (Group registration covers Milngavie, Kirkintilloch, Clydebank, Alexandria & Dalmuir)	5	Not Assessed	Not Assessed	5
Orems Care Services	4	Not Assessed	4	Not Assessed
Quarriers (Phase 3)	4	Not Assessed	4	Not Assessed
Quarriers (Phase 2)	4	Not Assessed	4	4
Quarriers (Phase 1)	5	Not Assessed	Not Assessed	5

Service	Care and Support	Environment	Staffing	Management and Leadership
Real Life Options East Dunbartonshire Service	5	Not Assessed	5	Not Assessed
The Richmond Fellowship East & West Dunbartonshire Support Living Services	5	Not Assessed	Not Assessed	5
Commissioned – Care at Home Services				
Delight Supported Living	5	Not Assessed	5	Not Assessed
Extended Personal Care	4	Not Assessed	4	Not Assessed
Home Instead	5	Not Assessed	Not Assessed	4
The Richmond Fellowship – East and West Dunbartonshire	5	Not Assessed	Not Assessed	5

ANNEX 3: COMPARATIVE INCOME & EXPENDITURE 2015/16 – 2022/23

Objective Analysis	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
Strategic / resources	3,743	3,044	2,568	3,042	3,205	3,648
Addictions	1,692	1,351	1,369	1,285	1,360	1,253
Older people	47,551	42,664	38,644	39,410	36,916	34,531
Learning disability	23,380	20,479	19,333	19,580	18,559	18,068
Physical disability	5,093	5,005	4,880	4,067	4,042	4,003
Mental health	6,057	5,520	5,378	5,155	5,129	5,349
Adult services						
Children & families	14,930	14,795	14,262	14,277	13,514	13,056
Criminal justice	455	346	162	211	258	226
Other - non sw	984	810	741	817	946	1,198
Community health services						
Oral health	12,738	10,786	9,820	9,835	9,899	9,632
Family health services	33,218	31,314	29,822	27,678	25,848	24,724
Prescribing	22,027	19,936	19,178	19,484	19,072	19,473
Covid-19	2,930	6,245	7,215			
Operational costs	304	289	282	270	246	234
Cost of Services Managed By East Dunbartonshire HSCP	175,101	162,584	145,111	145,111	138,995	135,394

Set Aside for Delegated Services provided to Acute Services	40,306	35,982	36,975	32,247	*27,471*	17,381
Total Cost of Services to East Dunbartonshire HSCP	215,407	198,566	190,629	177,358	166,466	152,775
NHS Greater Glasgow & Clyde	(137,042)	(149,959)	(144,950)	(120,508)	(111,583)	(99,721)
East Dunbartonshire Council	(71,437)	(62,753)	(57,719)	(55,760)	(52,690)	(51,910)
Taxation & Non Specific grant Income	(208,479)	(212,712)	(202,669)	(176,268)	(164,273)	(151,631)
(Surplus) or deficit on Provision of Services	6,928	(14,146)	(12,040)	1,090	2,193	1,144
Movement in Reserves	6,928	(14,146)	(12,040)	1,090	2,193	1,144

General Reserves	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**
Movement in General Reserves only	(1,293)	(1.143)	(1,935)	41	916	1,703
Balance on Reserves	(4,371)	(3,078)	(1,935)	0	(41)	(957)

ANNEX 4: ACHIEVEMENT OF BEST VALUE

Best Value Audit June 2023 – HSCP Evaluation		
1.	Who do you consider to be accountable for securing Best Value in the IJB	Integration Joint Board Integration Joint Board Performance, Audit & Risk Committee HSCP Chief Officer HSCP Chief Finance & Resources Officer Senior Management Team HSCP Leadership Group and Forum Parent Organisations around support services, assets and all staff who are involved in commissioning and procurement. All staff involved in the prescription of packages of care, drugs and drugs (acting in line with agreed policies etc.)
2.	How do you receive assurance that the services supporting the delivery of strategic plans are securing Best Value	Performance management reporting on a quarterly basis to IJB. Explicit links between financial and service planning through Annual Service Delivery Planning, HOS plans, Service Plans to ensure a golden thread that links back to our over-arching Strategic Plan. Scrutiny of delivery through our Annual Delivery Plan Board and SMT with regular updates and scrutiny to PAR Committee on key priorities. Application of HSCP Performance Reporting and Quality Management Frameworks Monthly Performance Reports Annual Performance Report Audit and Inspection Reports Integration Joint Board Meetings – consideration of wide range of reports in furtherance of strategic planning priorities. Engagement with Finance leads from partner organisations Performance, Audit & Risk Committee scrutiny Clinical & Care Governance Group Strategic Planning Group Senior Management Team scrutiny (HSCP) Service specific Leadership Groups and operational management supervision Corporate Management Teams of the Health Board and Council Service specific performance updates to SMT on a regular basis. Operational Performance Review: scrutiny by CEOs of Council and Health Board

Best Value Audit June 2023 – HSCP Evaluation		
		Housing, Health & Social Care Forum Business Improvement Planning (BIP) and How Good is our Service (HGIOS) reports to Council, including Local Government Benchmarking Framework analysis. HSCP Commissioning Strategy and Market Facilitation Plan The IJB also places reliance on the controls and procedures of our partner organisations in terms of Best Value delivery.
3.	Do you consider there to be a sufficient buy-in to the IJB's longer term vision from partner officers and members	Yes, the IJB has approved a Medium Term Financial Strategy 2022 - 2027 setting out the financial outlook, challenges and strategy for managing the medium term financial landscape. This is reviewed annually. This is aligned to its Strategic Plan which clearly sets out the direction of travel with work underway to develop and engage on the next iteration of the Strategic Plan. The IJB has good joint working arrangements in place and has benefited from ongoing support, within the resources available, in support of service redesign, from members and officers within our partner organisations over the past 12 months in order to deliver the IJBs longer term vision. Engagement with partner agency finance leads to focus on budget performance, financial planning in support of delivery of strategic priorities. Bi Annual OPR meetings with partner agency Chief Executives to focus on performance and good practice and any support required to progress initiatives. (frequency impacted through Covid-19 response / recovery and to be re-established)
4.	How is value for money demonstrated in the decisions made by the IJB	Monthly budget reports and scrutiny at service level and regular budget meetings with managers across the HSCP. IJB development sessions Chief Finance & Resources Officer Budget Monitoring Reports to the IJB Review of current commissioning arrangements across the HSCP to ensure compliance with Procurement rules through Parent Organisation processes in support of service delivery. All IJB papers carry a section that clearly outlines the financial implications of each proposal as well as other implications in terms of legal, procurement, HR, equality and diversity and linkage to the IJBs strategic objectives. The IJB engages in healthy debate and discussions around any proposed investment decisions and savings proposals, many of which are supported by additional IJB development sessions.

Best Value Audit June 2023 – HSCP Evaluation		
		In addition IJB directions to the Health Board and Council require them to deliver our services in line with our strategic priorities and Best Value principles – 'Optimise efficiency, effectiveness and flexibility'. This has been enhanced in light of the final strategic guidance on directions with regular oversight and monitoring of delivery through PAR Committee and IJB.
5.	Do you consider there to be a culture of continuous improvement?	The HSCP has an overarching Quality Management Framework that establishes a cultural and operational commitment to continuous improvement. This is being implemented across the HSCP with a Governance post now in place to provide effective oversight and monitoring of consistent quality aspects set out within the framework. Focus on self-evaluation work as a means for identifying improvement and preparation for strategic inspections. The HSCP Clinical & Care Governance Group provides strategic leadership in developing a culture of continuous improvement with representation across all professional disciplines and operational service groups with a focus on improving the quality of services delivered throughout the partnership. There is a range of activity in this area: • A number of HSCP service areas now have service improvement plans in place and a focused approach to quality/continuous improvement (QI). Examples of these improvements are captured and reported through the Clinical & Care Governance Group and reported to the IJB. • The Public Service User and Carers group has been involved in developing improvement activity on areas highlighted through engagement events. • In addition, a number of service reviews and redesign work strands are underway/or planned to maximise effectiveness, resources and improve the patient/service users journey across East Dunbartonshire. • The HSCP Annual Delivery Plan is focussed on proactively developing our health and social care services in line with national direction and statutory requirements; optimising the opportunities joint and integrated working offers; and ensuring any service redesign is informed by a strategic planning and commissioning approach (subject to regular IJB reports). • Lessons learned through Covid-19 response has escalated a number of areas of improvement e.g. through maximising use of digital, virtual meetings, focus on aspects of quality improvement through enhanced support to care home sector.

Best Value Audit June 2023 – HSCP Evaluation		
		• HSCP Organisational Development and Training, Learning and Education resources support services in undertaking improvement activity. • A wide range of stakeholder consultation and engagement exercises, to evaluate the quality of customer experience and outcomes. • Regular service audits, both internal and arm's length. • An extensive range of self-evaluation activity, for example case-file assessment against quality standards. • There are opportunities for teams to be involved in Quality Improvement development, which includes ongoing support and coaching for their improvement activity through our organisational development lead. • Workforce planning and OD/service improvement (SI) activity is planned, monitored and evaluated through our Human Resources and Organisational Development leads. • A Quality and Improvement Framework has been developed to support continuous improvement within the in-house Care at Home Service.
6.	Have there been any service reviews undertaken since establishment – have improvements in services and/or reductions in pressures as a result of joint working?	A robust process for progressing service reviews is in place with support from the Council's transformation team where appropriate. A number of reviews have been undertaken including: • Review of locality management arrangements to support locality working including alignment of contractual arrangements for care at home services. • Review of Learning Disability Services - Whole System Review of services to support individuals with a learning disability including daycare provision and supported accommodation. Overarching Adult Learning Disability Strategy established that sets out redesign priorities. Fair access and resource allocation policy approved and implemented to manage current and future demand on a sustainable basis and to achieve Best Value. LD Day service element concluded in 22/23 with successful move to the Allander Resource Centre as part of a wider community development. Further work will progress on employment opportunities and maximising supports within the community as well as re-patriating individuals in high cost daycare provision out with the area. Work underway to progress improvements and developments across LD in house and commissioned supported accommodation. • Review of Mental Health & Addiction Services through an updated needs assessment with an action plan for

Best Value Audit June 2023 – HSCP Evaluation		
		progression in line with recovery based approach and strategic realignment of commissioned services. • Review of Older People's Daycare and Social Supports model concluded during 22/23 with the development of an updated needs assessment and Older People's Formal and Informal Social Supports and Daycare Strategy. This included the approval of a revised model for the delivery of centre based daycare which will facilitate investment into more community based supports. The HSCP is also participating in a number of reviews in collaboration with NHS GGC such as • Un scheduled Care Review / Commissioning Plan/ Design and Delivery Plan • Mental Health Review and 5 year Strategy • Primary Care Improvement Plan (PCIP) and delivery of the GP contract requirements There are a number of work streams to be progressed through the HSCP Annual Delivery Plans which sets out the transformation activity for the year and the strategic areas of work the HSCP will be progressing during 23/24.
7.	Have identified improvement actions been prioritised in terms of those likely to have the greatest impact.	The oversight for any improvement activity identified through service review, inspection reports, incident reporting or complaints learning is through the Clinical and Care Governance Group. This is reported through the SMT, the Performance, Audit & Risk Committee and the IJB to ensure priority is afforded to progress areas of high risk with scope for most improvement. The Annual Delivery Board has a role to consider and oversee service redesign which will deliver service improvement including robust business cases and progress reporting to ensure effective delivery in line with strategic planning priorities and quality care governance and professional standards.
8.	What steps are taken to ensure that quality of care and service provided is not compromised as a result of cost saving measures.	All savings proposals are subject to a full assessment which includes: • Alignment to Strategic Plan • Alignment to quality care governance and professional standards including risk assessment by Professional Lead • Equalities impact assessed • Risk assessment by responsible Heads of Service and mitigating actions introduced • Stakeholder engagement as appropriate

Best Value Audit June 2023 – HSCP Evaluation		
		Where possible, the HSCP look to take evidence based approaches or tests of change to ensure anticipated benefits are realised and there is no compromise to care.
9.	Is performance information reported to the board of sufficient detail to enable value of money to be assessed	Regular budget and performance monitoring reports to the IJB give oversight of performance against agreed targets with narrative covering rationale, situational analysis and improvement actions for areas where performance is off target. These reports are presented quarterly as well as the detailed Annual Performance Report. Financial performance reported every cycle to IJB. Plans to revise format of performance report to include finance narrative to provide linkages of impact of performance on the partnership financial position. The Annual Service Delivery Plan aligns key priorities for service redesign and transformation to the delivery of efficiency savings which are regularly reported through the Financial monitoring reports to the IJB and regular scrutiny of the transformation plan through the Performance, Audit and risk committee.
10.	How does the IJB ensure that management of resources (finances, workforce etc.) is effective and sustainable	Workforce and Organisational Development plan linked to strategic plan. Oversight through Staff Partnership Forum and reporting through the IJB. Service review process involves staff partnership representation for consideration of workforce issues. Regular budget and performance monitoring reports to the IJB give oversight of this performance. Financial planning updates to the IJB on budget setting for the partnership highlighting areas for service redesign, impact and key risks. Regular review and update on reserves positions as a means of providing contingency to manage any in year unplanned events. All IJB reports contain a section outlining the financial implications of each paper for consideration.

ANNEX 5: NOTES ON PERFORMANCE DATA METHODOLOGY

The Scottish Government operate two sets of indicators to monitor performance across core integration functions. These relate principally to adult health and social care functions:

- Core National Integration Indicators
- Ministerial Strategic Group (MSG Indicators

Notes on Core National Integration Indicators

Indicators 1-9 are reported by a national biennial Health and Social Care Experience Survey that reports every two year. The most recent data for this is 2021/22. East Dunbartonshire had a response rate of 30%, which equates to 2,400 returns, compared to a Scotland response rate of 24%, which equates to 130,000 returns. It is important to note the limitations of the survey due to small numbers, which introduces a margin of error at a local level. Comparison of "performance" using this data should therefore be seen as an approximation.

Please note figures for the years from 2019/20 for indicators 2, 3, 4, 5, 7 and 9 are not directly comparable to figures in previous years due to changes in methodology.

More information on the survey and changes in the methodology are available by clicking here:

Scottish Government Health Care Experience Survey

Indicators 12, 13, 14, 15, 16 and 20

The primary sources of the remaining data for these indicators are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. Annual figures for these indicators are presented by financial year until the most recent reporting year. In accordance with recommendations made by Public Health Scotland (PHS) and communicated to all Health and Social Care Partnerships, the most recent reporting period available is calendar year 2022; this ensures that these indicators are based on the most complete and robust data currently available and acts as a suitable proxy, for comparison purposes.

Indicator 20 presents the cost of emergency admissions as a proportion of total health and social care expenditure. Information for this indicator was previously published up to calendar year 2020 but is now presented to financial year 2019/20 only. PHS have recommended that Integration Authorities do not report information for this indicator beyond 2019/20 within their Annual Performance Reports.

More detail is provided in the Background and Glossary document is available by clicking here:

Public Health Scotland Core Suite of Integration Indicators

Trends and National Rankings

The tables and charts aim to illustrate whether the objective is to increase or decrease the performance value, they show our performance in the reporting year, our performance trend compared to the previous year, our performance trend over the period since the integration of health and social care, our comparative performance over the same period and our "ranking" against the 31 other HSCPs in Scotland (Clackmannanshire & Stirling are a joint HSCP). Regardless of whether the objective is to increase or decrease the performance value, in ranking terms, 1 is always the best performing HSCP and 31 is the least well performing HSCP. With a number of indicators though, HSCPs perform at very similar levels, so trend lines can be very close together and national rankings should be viewed cautiously in situations where very tight clustering of performance levels exist. For these reasons, the tables and charts should be viewed in a balanced way that takes into account these factors.

Ministerial Strategic Group (MSG) – Performance Indicators

This measures provides data and performance status of the HSCP's performance against the Scottish Government's Ministerial Strategic Group's indicators. Performance using a "Red-Amber-Green" (RAG) rating is based upon comparison with the previous year. A chart showing comparative performance against the Scottish average is also provided.

For indicators 1 and 2 annual data are presented by financial year until the latest reporting year. As April 2022 to March 2023 data is not fully complete for all NHS Boards, calendar year figures are shown for 2022 as a proxy for financial year data.

Impact of Coronavirus (COVID-19)

Depending on the stage of the pandemic, COVID-19 may have an impact on trends observed for certain indicators across certain periods, particularly those based on hospital activity information (indicators 12, 13, 14, 15, and 16 and MSG indicators). The "bounce-back" from the Covid-19 related downturn in hospital activity also results in exaggerated single year trends for these indicators.

East Dunbartonshire
Health & Social Care
Partnership

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East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 07.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20th JUNE 2023**
REPORT REFERENCE:	**PERF/200623/07**
CONTACT OFFICER:	**GILLIAN MCCONNACHIE, CHIEF INTERNAL AUDITOR, 0141 574 5642**
SUBJECT TITLE:	**HSCP ANNUAL INTERNAL AUDIT UPDATE AND REPORT 2022/23**

1.0 PURPOSE

1.1 The purpose of this Report is to present the Committee with the Annual Internal Audit Report for 2022/2023. In addition, an update on internal audit work completed in the period since the last Committee and outstanding audit actions is also provided. The Committee is furthermore provided with the internal audit plan for 2023/24.

1.2 The information contained in this report relating to East Dunbartonshire Council or NHSGGC audits has been presented to the Council's Audit & Risk Management Committee (A&RMC) and the NHSGGC Audit & Risk Committee (ARC) as appropriate, where it has received scrutiny. Once noted by these committees, this report provides details on the ongoing audit work, for information, to the H&SCP Performance, Audit & Risk (PAR) Committee and to allow consideration from the perspective of the H&SCP.

2.0 RECOMMENDATIONS

2.1 The Performance, Audit & Risk Committee is asked to:

- Consider the Annual Audit Report for 2022/23, including the Internal Audit Opinion for 2022/23.
- Agree that the opinion on the adequacy and effectiveness of the HSCP's framework of governance, risk management and control be applied in the completion of the HSCP's 2022/23 Financial Statements.
- Consider the contents of the Internal Audit Performance and Outputs Report, the Internal Audit Follow Up Report 2022/23, and the Internal Audit Plan for 2022/23.
- Request the Chief Finance & Resources Officer to submit performance monitoring reports detailing progress against Plan and audit results to future meetings of the Committee.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND / MAIN ISSUES

3.1 East Dunbartonshire Council's (the Council) Internal Audit Team provides an independent and objective assurance service to the HSCP that is guided by an overriding objective of adding value to improve systems, controls and operations. The team provides a systematic and disciplined approach to the evaluation of the internal controls and governance processes in accordance with the Public Sector Internal Audit Standards.

3.2 One of the primary objectives of the Internal Audit team is to provide a high quality and effective internal audit service, which complies with professional best practice, meets the needs of stakeholders and assists the HSCP's Performance, Audit & Risk Committee to effectively discharge its roles and responsibilities. The team's purpose, authority and responsibilities are set out in more detail in the Internal Audit Charter, which has previously been presented to this committee in March 2019. This has been reviewed and refreshed and is attached at *Appendix 5* for information.

3.3 The presence of an effective internal audit team contributes towards, but is not a substitute for, effective control and it is primarily the responsibility of line management to establish internal control so that the activities are conducted in an efficient and well-ordered manner, to ensure that management policies and directives are adhered to and that assets and records are safeguarded.

3.4 Internal Audit activity is planned to enable an independent annual opinion to be provided by the Council's Audit & Risk Manager as the Chief Internal Auditor on the adequacy and effectiveness of internal controls, governance and risk management within the HSCP. For 2022/23, this opinion is included in the Annual Audit Report at *Appendix 1*, which also includes the 'Statement on the Adequacy and Effectiveness of the Internal Control Environment of the HSCP' for the year.

3.5 The annual statement and opinion includes:

- Summary of work supporting the opinion,
- Comparison of work carried out against work planned,
- Performance of the Internal Audit Team,
- Impairments or restriction of scope,
- Conformance with Public Sector Internal Audit Standards, and
- Consideration of any other relevant issues.

3.6 In reaching the opinion of reasonable assurance, Internal Audit note risks raised by Internal Audit in the current and previous years relating to the controls around the contractual status of social work expenditure. This risk does not significantly impair the HSCP's systems of internal control but it will continue to be kept under review, with auditors reviewing compliance with the agreed action as part of an established follow up cycle. Management have agreed an action plan to mitigate this issue and auditors will support ongoing improvements where required as part of the 2023/24 audit programme.

3.7 The statement concludes that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP's internal control systems in the year to 31 March 2023. Two additional documents are attached in support of the annual audit opinion:

- The Internal Audit Follow Up Report at *Appendix 2.* This report covers risks relevant to the HSCP, albeit some risks require input from Council services to address.

- The Internal Audit Performance and Output Monitoring Report is attached at *Appendix 3*.

3.8 The Internal Audit Plan 2023/24 is included at *Appendix 4* to detail planned Internal Audit activity for 2023/24. The Audit and Risk Manager has reviewed and updated the Internal Audit Charter which is attached at *Appendix 5.* This was presented to the Council's Audit & Risk Management Committee for approval on 8th June 2023. The following changes have been made since the previous version:

- Revised wording relating to access to records to reflect that these are now mostly electronic documents.

- Revision of the wording of the team's specific commitments to align more closely to the PSIAS Application Note. This now includes specific bullet points on ethics, information technology and governance processes.

- Removal of the need for physical signatures on the document, with committee approval being sufficient.

- Other minor changes such as job titles.

<u>Update on Outstanding High Risk Issue</u>

3.9 At the last PAR committee members asked for a report to be brought back with further detail on the outstanding high risk. Due to a further follow up report being due at this PAR from the Audit & Risk Manager and following discussions between management and the Audit & Risk Manager it was agreed that further information would be provided in the context of the follow up report. This is attached at *Appendix 2* and provides further detail, context and now importantly includes a revised target date.

3.10 The original finding relating to Social Care Contractual Arrangements was that a large percentage of services, 65%, were operating without a contract. The % has reduced to 34% of services (28% by value). This remains a material figure but represents a large reduction in the associated risk and significant improvement. It also must be considered in the context of the changed environment since 2014.

3.11 Management have provided further context to both the changes in the market and the reasons why regularising contractual arrangements have proved challenging in recent years:

- Legislative changes including Self Directed Support giving users more choice and control over services,

- The advent of Health & Social Care Partnerships has seen a significant increase in community based services for people diagnosed with complex health requirements,

- Throughout the Covid-19 pandemic resources were focused on protecting front line service provision which caused necessary changes to the timelines for other workstreams including contract development,

- Increasing market fragility caused by a combination of: Covid-19 and subsequent focus on recovery and sustainability, the market not being in a position to negotiate or bid for tenders, Brexit, workforce issues (recruitment & retention), increasing Acute pressures and Cost of Living Crisis.

3.12 The current social work market and contracting regime is unrecognisable with that in place in 2014 when the audit action was originally agreed. As is reflected above this is due to factors including the increased sophistication and use of frameworks, the increasingly specialised service provision and the impact of the COVID pandemic. It is also worth noting that the unpredictable nature of social work services and the rapid turnover of users in some services is such that it essentially impossible to reach a point where 100% of services are covered by fully documented contracts, and so there is a requirement to identify a pragmatic tolerance level.

3.13 In the context of the above points, auditors are pleased to note that significant progress has been made towards addressing this risk over the last year. Following a report to Council last year setting out the current and developing challenges in relation to the procurement of social work services, a Market Risk Assessment Matrix was developed to help determine the route to contract using a risk based approach. This is being documented and signed off by the Head of Service for each contract. This will in turn provide a prioritised work plan thereby embedding this work into the business as usual arrangements by 30 September 2023 in Strategic Commissioning, Procurement and Legal Services. It is expected by auditors that the risk will be substantially addressed at this stage, being reduced to an acceptable level and the audit action closed off.

3.14 To support progression of the above, a model contract is being developed by Legal Services and the Strategic Commissioning Team to speed up the process for agreeing contractual terms with providers.

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022 – 2025 Priorities - None.

4.2 Frontline Service to Customers – None.

4.3 Workforce (including any significant resource implications) – None.

4.4 Legal Implications – Legal risks are presented in the body of internal audit reports with reference to relevant legislation where appropriate.

4.5 Financial Implications – Internal Audit reports are presented to improve financial controls and aid the safeguarding of physical and intangible assets.

4.6 Procurement – Where applicable these are referenced in the body of internal audit reports with associated management actions for improvement.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None

4.11 Other – None.

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The Risks are highlighted to management in audit reports. The risks are addressed through agreed action plans, appended to internal audit reports.

6.0 IMPACT

6.1 **STATUTORY DUTY** – None

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The risks identified in the internal audit reports relevant to East Dunbartonshire Council have been highlighted to the Council's Audit & Risk Management Committee.

6.3 **NHS GREATER GLASGOW & CLYDE** – The risks relevant to the NHS Greater Glasgow & Clyde identified in the internal audit reports have been highlighted to the NHSGGC's Audit & Risk Committee.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction required.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** – HSCP Annual Internal Audit Report

8.2 **Appendix 2** – HSCP Follow Up Report

8.3 **Appendix 3** – HSCP Performance and Outputs Report

8.4 **Appendix 4** – HSCP Annual Internal Audit Plan

8.5 **Appendix 5** – Internal Audit Charter

Appendix 1

East Dunbartonshire Council

Internal Audit Services

HSCP Internal Audit Annual Report 2022/23

Gillian McConnachie

Audit & Risk Manager

East Dunbartonshire Council

HSCP Internal Audit Annual Report 2022/23

This HSCP Internal Audit Annual Report is a summary of the internal audit work completed by East Dunbartonshire Council's Internal Audit team for the financial year 2022/23 for East Dunbartonshire Integration Joint Board (IJB). In East Dunbartonshire, the IJB is known as the East Dunbartonshire Health and Social Care Partnership Board (HSCP). The internal audit opinion, following an assessment of the internal audit work and other sources of assurance, is provided at *Appendix 1.1*. The opinion provided concludes on the adequacy and effectiveness of the HSCP's framework of governance, risk management and control. It supports the annual governance statement, which is included in the annual financial accounts. It takes into account the expectations of senior management, the Performance, Audit & Risk (PAR) Committee and other stakeholders. It is supported by sufficient, reliable, relevant and useful information, as referenced in the body of this report. Through utilising such information, Internal Audit demonstrates compliance with relevant Public Sector Internal Audit Standards.

Internal Audit Opinion

The full statement and opinion provided at *Appendix 1.1*, confirms my opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP's internal control systems, governance and risk management systems in the year to 31 March 2023.

In reaching this conclusion, I note a risk raised by Internal Audit in a prior year relating to the controls around Contractual Arrangements for Social Work Commissioned Care. This risk does not, however, significantly impair the HSCP's systems of internal control. Nonetheless, this risk will continue to be kept under review, with auditors monitoring compliance with the agreed action as part of an established follow up cycle and updates being reported to the Performance, Audit & Risk Committee.

The opinion represents a consolidated view, informed by a number of sources and, in bringing these together, considers whether there is evidence that key controls are absent, inadequate or ineffective. The work includes an assessment of any weaknesses identified and whether these, taken independently or with other findings, significantly impair the HSCP's system of internal control. Wider issues relating to the HSCP's corporate governance framework and risk management arrangements have also been considered in providing the opinion.

Auditors take due consideration of risks including fraud risks in preparing the annual audit plan and in approaching individual assignments in order to maximise the assurance that can be provided. However, the level of assurance provided by the Internal Audit Team can never be absolute. This reflects the sample nature of the work carried out, the relative scope and objectives of audit assignments and those explanations offered, and evidence provided by officers. In addition, factors external to the audit process including human error, collusion or management overriding controls create the potential for systems, historically highlighted as being satisfactory, to become exposed to risk or loss.

Summary of Work Supporting the Opinion

The opinion is informed by a number of sources, including the work completed as part of the Annual Internal Audit Plan for the HSCP. The risk of fraud is also considered in each assignment, together with any governance or risk management implications; this allows the HSCP's Chief Internal Auditor to draw sustainable conclusions.

A total of 11 outputs were completed by 31 March 2023 compared to 9 outputs planned – a completion rate of over 100%. A detailed comparison of the work carried out against the Plan and the reasons for the variance is provided in subsequent sections.

The opinion is also informed by Internal Audit's programme of follow up activities, which reviews the extent to which those risks previously identified have been subsequently managed or mitigated. Internal Audit have prepared a follow up report covering risks across the HSCP, as attached at *Appendix 2*. Our consolidated follow up work has identified that a high risk finding of direct relevant to the HSCP remains outstanding, relating to the contractual arrangements for social work expenditure. Auditors have recognised progress made by management towards closing off the high risk relating to Contractual Arrangements for Social Work Commissioned Care action and have asked for this to continue.

Comparison of work carried out against work planned

There were 9 planned HSCP internal audit outputs for the year 2022/23 and 11 outputs were completed by the year-end. Within this figure there was an underlying variation in the type of work completed. Auditors were able to provide additional, unplanned, consultancy work and a further three audits were in progress at the year end. The team has been able to provide assurance over a wide range of areas, including additional Consultancy work mentioned relating to care payments, as detailed in the section below. This, together with other sources of assurance, provides adequate assurance across the activities of the HSCP for the provision of the annual audit opinion.

The 2022/23 annual audit plan included provision for a direct allocation of 103 audit days and planned production of 9 outputs. 99 days were spent in the year on the completion of 11 audits as per the list below, representing an allocation of 96% of planned days in completing 122% of expected outputs. The planned actual days were below planned due to unexpected absence in the team.

Some changes from the original plan were made in the course of the year, in the form of consultancy notes in response to emerging risks and a reprofiling of audits that had originally been planned. The team has been able to provide assurance over a number of areas, as detailed below:

Summary of work completed to support opinion

Regularity

- HSCP Annual Report
- HSCP Governance Statement
- Interim Follow Up of Previous Audit Risks
- Final Follow Up of Previous Audit Risks
- Internal Audit Plan

Reviews

- Use of Directions
- Social Work Charging

- HSCP Governance Arrangements
- Self Directed Support – Overpayment Process
- Meiklehill/John St Controls Advice
- Care Payments interim process advice

Full details on these audits have been provided in the internal audit updates to Committee. Where internal audit have identified risks in the areas reviewed, action plans have been agreed. The agreed actions are logged on the Performance and Risk System, Pentana, and will be followed up on and progress reported back to the Performance, Audit and Risk Management Committee.

Internal Audit Performance Key Performance Indicators (KPIs) for the year are provided in *Table 1* and *Table 2* below.

Table 1 - Analysis of HSCP Internal Outputs by Audit Type 2022/23

Audit Type	Completion Number	Completion %
Systems	4 Completed out of 3 Audits Planned	>100% Complete
Regularity	5 Completed out of 5 Audits Planned	100% Complete
Consultancy	2 Completed out of 1 Audits Planned	>100% Complete
Total	**11 Completed out of 9 Planned**	**>100% Complete**

Table 2 - HSCP Internal Audit Key Performance Indicators 2022/23

Audit Type	Planned	Actual	Status
Percentage of finalised audit outputs against the number anticipated in the Plan	100%	>100%	
Percentage of productive days worked against the target productive days in the Plan.	100%	96%	
Percentage of audit reports issued within 20 days of completion of fieldwork.	95%	100%	

In reviewing the performance of the team, it was noted that all HSCP reports completed were issued within the target of 20 days of fieldwork, giving a compliance rate with this Performance Indicator of 100%, against a target of 95%. The target is set at 95% rather than 100% as, at times, a management decision will be taken to prioritise time critical pieces of work, meaning that a finite number of audits may not be issued in accordance with our internal timescales.

Annual Assurance - A number of documents that collate the work of the Internal Audit team have been produced by the team as part of their responsibility for annual assurance. These are the follow up report, the Annual Internal Audit Report (this document), the drafting of the Annual Governance Statement for inclusion in the accounts and signature by the IJB Chair and Chief Officer. Internal Audit have also reviewed the HSCP's Risk Management arrangements and have concluded that the HSCP has a reasonably well developed risk management maturity. The Risk Management Policy sets out the process and responsibilities for managing risk in the HSCP. The Corporate Risk Register was revised and approved in January 2023 and is reviewed by the Senior Management Team at least twice a year.

Progress against improvement plans

The Internal Audit service takes a 'continuous improvement' approach to our internal audit work. This is reflected in our reports and recommendations made to services and also in the approach to the internal audit work itself, with a focus in making incremental improvements to our work through efficiencies, and/or improved quality. This helps us to improve our quality and adherence to PSIAS, and to focus on the areas of greatest risk and where we are able to add the most value. Improvements over the past year have included a revision of our standard audit report template to simplify and condense the report to allow a focus on key risks.

Impairments or Restriction of Scope

There have been no impairments or restrictions of scope during the course of the year.

Reliance on Other Assurance Providers

The internal audit opinion also includes consideration of the work of other assurance providers, including those reports issued by the HSCP's external auditors, previously Audit Scotland and now Mazars. Furthermore, the work undertaken by the Council's and the NHSGGC's Internal Audit teams are considered, where it may be relevant to the HSCP. The opinion provided by the Council's Audit & Risk Manager on the Council's systems was that of reasonable assurance, whilst highlighting risks raised in particular areas that require to be addressed, including those relating to controls around the contractual status of social care providers. Similarly, Azets have provided an opinion of reasonable assurance on the NHSGGC framework of governance and internal control for 2022/23.

The Internal Audit team have also liaised with the external audit team during the course of the year. This has enabled the team to engage with our external auditors on a range of issues covered within their reports and letters on financial controls, financial statements, annual report and best value arrangements.

The final Audit Scotland Annual Audit Report for 2021/22 included comment on the level of transformational change required to be achieved, long term financial planning and public access to IJB meetings. An action plan was agreed to address these risks.

Progress & Results of the Quality Assurance Improvement Programme

The Internal Audit Team is required to work to a set of rules - PSIAS. These rules apply to all public sector internal auditor teams. It is a requirement of these standards that periodic self-assessments are conducted to evaluate conformance with the Code of Ethics and the PSIAS. Under Section 7 (1) of the Local Authority Accounts (Scotland) Regulations 2014, the council must operate a professional and objective internal auditing service in accordance

with recognised standards and practices in relation to internal auditing. The Council defines such practices as those set out within the PSIAS. A self-assessment against PSIAS was completed by the Audit & Risk Manager in March 2023 and formed part of EDC's Quality Assurance and Improvement Programme for Internal Audit for 2022/23. This review included a review of the Internal Audit Charter which is attached as a separate item at *Appendix 5*.

In addition to the self-assessment, an external assessment was completed of the Internal Audit function in 2018, in order to meet the PSIAS requirement for an external assessment at least once every five years. It was found that, in the opinion of the qualified, independent assessor, the Internal Audit team fully conforms to twelve of the standards and generally conformed to the other standard (Independence and Objectivity). However, due to changes in the organisational structure since this review was completed, the Audit & Risk Manager has not had responsibility for Health & Safety or Corporate Performance & Research since 2018. The organisational structure in place since that date ensures the Audit & Risk Manager's organisational independence. Furthermore, the actions identified by the external assessor in 2018 and by the self-assessment carried out in 2018 have been implemented. A further external assessment is planned for later in 2023.

Internal Audit have also issued questionnaires on completion of each audit assignment, providing an opportunity for the auditee to provide feedback on the planning process, communication and the quality of the internal audit report. All audit files are reviewed by the Audit & Risk Manager to ensure high standards are maintained and to encourage a continuous improvement approach by the team.

Statement of Conformance with Public Sector Internal Audit Standards

Internal Audit is required to comply with PSIAS. This is assessed herewith by the Audit & Risk Manager.

The Audit & Risk Manager deems the Internal Audit service to fully conform with PSIAS.

Other Issues

I am aware of no other material issues that require to be reported at this time.

Appendix 1.1

STATEMENT ON THE ADEQUACY AND EFFECTIVENESS OF THE INTERNAL CONTROL ENVIRONMENT OF THE HSCP FOR 2022/23.

To the Members of the Health and Social Care Partnership Board's Performance, Audit & Risk Committee, the Chief Officer and the Chief Finance & Resources Officer of the HSCP

As the appointed Chief Internal Auditor of the HSCP, I am pleased to present my annual statement on the adequacy and effectiveness of the internal control system of the HSCP for the year ended 31 March 2023 to the PAR Committee.

Respective Responsibilities of Management and the Internal Audit Team in Relation to Governance, Risk Management and Internal Control

It is the responsibility of the HSCP's senior management to establish appropriate and sound systems of governance, risk management and internal control to monitor the continuing effectiveness of those systems. It is the responsibility of the Chief Internal Auditor to provide an annual overall assessment of the robustness of governance, risk management and internal control.

The HSCP's Framework of Governance, Risk Management and Internal Controls

The main objectives of the HSCP's framework of governance, risk management and internal controls are to ensure that resources are directed in accordance with agreed plans, policies and priorities and to ensure that there is sound decision−making and clear accountability for the use of those resources in order to achieve the desired outcomes for service users and communities.

This includes ensuring that appropriate internal controls and risk management arrangements are in place in order to effectively manage issues which might impact on the delivery of HSCP services, the achievement of corporate and service objectives and public confidence in the HSCP. The HSCP also requires effective internal controls and risk management arrangements to protect its assets, to maintain effective stewardship of public funds, to ensure good corporate governance, to ensure compliance with statutory requirements and to ensure it continues to deliver best value.

Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. Accordingly, the HSCP is continually seeking to improve the effectiveness of its systems of governance, risk management and internal controls.

The Work of the Internal Audit Team

Internal audit services were provided by East Dunbartonshire Council Internal Audit Team. The EDC Internal Audit Team objectively examines, evaluates and reports on the adequacy of internal controls as a contribution to the proper, economic, efficient and effective use of the HSCP's resources.

The Internal Audit Team has undertaken a programme of work in the year, with some of the work differing from that originally planned as a result of emerging risks and a reprofiling of audits that had originally been planned. The work undertaken has been carried out in consultation with the Corporate Management Team and key stakeholders, to understand the key risks facing the HSCP.

All Internal Audit reports identifying system weaknesses, risks and/or non-compliance with expected controls are brought to the attention of senior management and significant findings presented to the Performance, Audit and Risk Committee. Audit reports and action plans provide insight into the risks identified and include an agreed narrative highlighting the intended course of action, including the timescales involved to mitigate and manage the risk. It is management's responsibility to ensure that proper consideration is given to internal audit reports and that appropriate action is taken on those risks identified.

The Internal Audit team are required to ensure that appropriate arrangements are made to determine whether action has been taken on agreed reports or, where appropriate, that management has understood and assumed the risk of not taking action. Significant matters (including non-compliance with audit recommendations) arising from internal audit work are reported to the Performance, Audit & Risk Committee and the Senior Management Team.

In 2022/23, one high risk issue remained in progress from a previous year relating to the contractual status of social work expenditure. Management have reported progress towards mitigation of this issue and a revised target date and Auditors will monitor compliance with the agreed actions as part of a six monthly cycle. Updates will be reported to the Performance, Audit & Risk Committee.

Impairments or Restriction of Scope

There have been no impairments or restrictions of scope during the course of the year.

Basis of Opinion

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

- The HSCP internal audit work completed by the EDC Internal Audit Team during the year to 31 March 2023 and material findings since the year end;
- The audit work undertaken by the Internal Audit Team in previous years;
- The assessment of the Annual Governance Statements Internal Checklist relating to 2022/23 as completed by the Chief Officer;
- The assessment of audit risk to internal and financial controls determined during the preparation of the annual Internal Audit Plan;
- Reports issued by the HSCP's external auditors and other review agencies,
- Work undertaken by the partners' internal auditors; and
- My own knowledge of the HSCP's governance, risk management and performance management arrangements.

Opinion

It is my opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP's internal control system in the year to 31 March 2023.

Gillian McConnachie CA
Chief Internal Auditor, HSCP
Audit & Risk Manager
East Dunbartonshire Council
20 June 2023

Appendix 2

East Dunbartonshire Council
Internal Audit Services

HSCP Internal Audit

Follow Up Report

2022/23

Gillian McConnachie

Audit & Risk Manager

June 2023

1 INTRODUCTION

1.1 The 2022/23 Internal Audit Plan included provision for the follow up and evaluation of risks identified in all previously issued Internal Audit reports.

1.2 This final follow up report demonstrates the HSCP's ongoing commitment to maintaining compliance with the Public Sector Internal Audit Standards. These require that the Audit & Risk Manager, as the Chief Audit Executive, *'establish a process to monitor and follow up management actions to ensure that they have been effectively implemented or that senior management have accepted the risk of not taking action'*. As part of this process, the following areas have also been considered:

- Where issues have been noted as part of the follow up process the Audit & Risk Manager may consider revising the initial overall audit opinion,
- The results of monitoring management actions may be used to inform the risk based planning of future audit work; and,
- The review extends to all aspects of audit work including consulting engagements.

2 SCOPE and OBJECTIVES

2.1 The scope of the audit is to review those risks identified in prior audit work and establish, through a combination of testing, corroboration and interview, whether the agreed control measures have been adequately implemented, and the associated risks addressed.

2.2 The objective of the review is to provide assurance to key stakeholders that management actions have been effectively implemented. Where this is not the case, auditors will establish the reasons for non-compliance, including consideration of the extent to which senior management have accepted the risk of inaction.

2.3 The purpose of this follow up report is as follows:-

- Provide a summary of outstanding audit reports at *Table 2* at the end of this report.
- Detail areas where significant progress has been made since the last follow up report; and
- Inform the Annual Internal Audit Report and opinion.

3 METHODOLOGY

3.1 Auditors have evaluated the extent to which management have mitigated individual risks allocated to them. Where risks have been fully managed and closed off by management, auditors have sought to validate a sample of these actions and ensure that they mitigate the risk, with a focus on risks that were classified as 'High'. Where there has been substantial progress in closing off a report that had identified a number of issues, Auditors may schedule a separate follow up review to allow time to consider these issues in detail. This may be

beneficial when the original report was issued some time ago and when there have been significant changes in the system controls.

4 FINDINGS - ALL RISKS DUE FOR COMPLETION

4.1 *Table 1* provides a summary of the 6 individual risks and improvement actions of relevance to the HSCP that were outstanding for implementation as of June 2023, by risk rating. The risk rating (High/Medium/Low) answers the question, '*in internal audit's professional opinion, what is the risk that the issue identified could impair the achievement of the system's objectives*?'

Table 1 - Individual Audit Report Action Points by Risk Rating

Risk rating	Total Per Original Reports[1]	Completed Actions	Outstanding
High	1	-	**1**
Medium	17	15	**2**
Low	3	-	**3**
Total	21	15	**6**

1 There were 21 issues raised in the original reports and 15 issues have since been closed.

4.2 Progress has been made in the past year in addressing audit actions, the total of 6 outstanding risks representing an increase on the previously reported figure of 3, although the number of High outstanding risks has remained the same at 1.

4.3 Whilst acknowledging the significant and ongoing work and the continued pressures on services, auditors ask for continued prioritised focus in closing off the remaining outstanding High risk issue relating to the Contractual Status of Social Work expenditure. HSCP management will require input from the Strategic Commissioning Team, the Council's Legal Services and Corporate Procurement teams to complete this action. Auditors have noted the changed commissioning environment since this issue was first raised, the progress to date and are pleased to see a revised target date associated with closing this action. Further detail is provided in *Table 2*.

5 CONCLUSION

5.1 Our consolidated follow up work has identified that 6 risks identified by audit remain outstanding across the HSCP. There has been a small increase in the total number of outstanding risks from 3 to 6 whilst the outstanding high risks, has remained constant at 1. Auditors have recognised progress made by management towards closing off the high risk relating to Contractual Arrangements for Social Work Commissioned Services action, and have asked for this to continue.

5.2 Responding to the requirement of the Public Sector Internal Audit Standards, the Audit & Risk Manager has not revised any opinions previously reported to members. All residual issues will be considered in the 2023/24 follow up work

and will inform future audit focus, including the specification of the 2024/25 internal audit plan.

Table 2 – List of Outstanding Audit Reports

The table below details the number of issues raised in the original Internal Audit reports, the number now closed and the total number of issues remaining open.

Report Name	Original issues	Closed	Remaining Risk			Total Open	Comments	Revised Target Date	Primary Executive Officer/ Senior Officer
			High	Med	Low				
Social Work Contract Monitoring 2014	10	9	**1**	-	-	**1**	The original finding relating to Social Care Contractual Arrangements was that a large percentage of services, 65%, were operating without a contract. The % has reduced to 34% of services. This remains a material figure but represents a large reduction in the associated risk and significant improvement. It also must be considered in the context of the changed environment since 2014. The current social work market and contracting regime is unrecognisable with that in place in 2014. This is due to factors including the increased sophistication and use of frameworks, the increasingly specialised service provision and the impact of the COVID pandemic. It is also worth noting that the unpredictable nature of social work services and the rapid turnover of users in some services is such that it essentially impossible to reach a point where 100% of services are covered by fully documented contracts, and so there is a requirement to identify a pragmatic tolerance level. Following a report to Council last year setting out the current and developing challenges in relation to the procurement of social work services, a Market Risk Assessment Matrix was developed to help determine the route to contract using a risk based approach. This is being documented and signed off by the Head of Service for each contract. This will in turn provide a prioritised work plan thereby embedding this work into the business as usual arrangements by 30 Sep 23 in Strategic Commissioning, Procurement and Legal Services. To support progression of the above, a model contract is being developed by Legal Services and the Strategic Commissioning Team to speed up the process for agreeing contractual terms with providers.	30 Sep 23	Organisational Transformation

Report Name	Original issues	Closed	Remaining Risk High	Med	Low	Total Open	Comments	Revised Target Date	Primary Executive Officer/ Senior Officer
HSCP Governance Arrangements 2022	4	-	-	1	3	4	Actions in progress relate to the completeness of declarations of interest, risk management, whistleblowing arrangements and a self-assessment of its Performance, Audit and Risk Committee.	30 September 2023	Chief Finance & Resources Officer HSCP
HSCP Financial Outturn and Key Controls 2020	7	6	-	**1**	-	1	The outstanding risk relates to data cleansing of the service register. From the Carefirst Steering Group a short life working group has been established to take this forward with the HSCP's Chief Finance and Resources Officer being the lead. The Strategic Commissioning Team are reviewing the service register in sections, with Supported Accommodation being first. The various elements that require amendments have been passed to the Carefirst Team. Following this Supported Living, then Residential data will be reviewed and updated. Any changes that can be facilitated through the Council will be progressed but any more fundamental changes to the Carefirst set up which requires input from the software providers OLM will not be progressed at this time given the move to implement a change in the system as the top priority regarding Carefirst.	31 December 2023	HSCP Chief Finance & Resources Officer
Total	**21**	**15**	**1**	**2**	**3**	**6**			

Appendix 3

HSCP

Internal Audit Performance and Output Monitoring

March to May 2023

Gillian McConnachie

Audit & Risk Manager

Internal Audit Outputs March 2023

In the period of March 2023, the Internal Audit Team finalised and reported on the areas as shown in *Table 1* below. The table represents a continuation and completion of the reporting on the Internal Audit work for 2022/23, with Outputs 1 to 8 having previously been completed and reported to Committee.

Table 1 – Analysis of Internal Audit Outputs March 2023

	Audit Area and Title	Areas Noted	High Risk	Medium Risk	Low Risk
	Systems				
9	Self Directed Support – Overpayments Process	**2**	-	2	-
	Consultancy				
10	Meiklehill/John St Controls Advice	**-**	-	-	-
	Regularity				
11	Internal Audit Plan 2023/24	**-**	-	-	-

Three outputs were completed in the period, representing a final year end cumulative achievement of 11 outputs or 122% completion of the 9 outputs planned for the year 2022/23, at 100% through the year. In delivering these outputs, 96% of the resources in the Plan for the year have been allocated.

The work completed in the year supports the provision of the year end audit opinion which informs the Annual Governance Statement in the accounts.

System Audits

Self Directed Support (SDS)- Overpayments Process

The 2022/23 Internal Audit Plan included provision for a systems-based audit in support of our annual audit opinion to examine SDS Overpayments with a particular focus on the timely identification and collection of overpaid monies.

Where individuals have been assessed as having eligible social care needs, SDS provides them with a choice of options on how their care arrangements are delivered. A Direct Payment (DP) is one of four options, where their SDS monies are paid directly to them to purchase support themselves. DPs provide the individual with control on how and when support is provided, in line with their assessed needs.

Individuals are accountable for the DP they receive, with their contract clearly setting out the responsibilities for ensuring the appropriate use of these monies. The contract also states that during the course of financial audits which are carried out by the Council, the Council can ask for the repayment of any monies which have either accumulated or not been used for the intended purposes. Those responsibilities are also fully discussed with individuals during the assessment and support planning process.

Overpayment of DPs can occur for various reasons and the DP audits, which are scheduled according to risk classifications, may identify issues. Once an overpayment is identified, an

invoice is issued to the individual via the Council's Ash Debtors system. Thereafter, any unpaid accounts are subject to the Debtors follow-up process.

Auditors concluded that the key controls around the administration of Self-Directed Support (SDS) overpayments are generally reasonable but should be subject to further improvement actions to further enhance assurances within the area.

A risk has been identified relating to the timely transferring of Direct Payment (DP) cases to another option of service delivery where a lack of engagement from individuals prevented their scheduled DP audit from taking place. A review of the Social Work processes regarding timeframes for cancellation of the DP is being taken forward in order to improve controls in this area.

The Medium Risk audit findings specifically relate to the following:

- Auditors noted two cases where individuals failed to provide information for their DP audits, where they continued to receive payments for up to two years before their DPs were ended. It was noted that Senior Management were involved in detailed reviews of these exceptional cases.

  Whilst the SDS Operational Procedures provide timescales for reminders where no information is forthcoming for the direct payment audits, and to notify individuals that this could result in their DP being withdrawn, the procedures do not state a clear timeframe for ending the DP under such circumstances.

- In such cases as the ones mentioned above, where a decision is made to continue with the DP, despite lack of engagement in providing evidence of spend, auditors would expect a formal process to exist. Auditors noted Senior Management were involved in the decisions and this was documented on Carefirst.

  As a point for improvement, the process should include the requirement for documentation to be completed, which not only sets out the circumstances and reason for the decision, but also the financial implications, risks and a timeframe for reviewing the continuation of the DP. The decision should be signed off by Senior Management.

Draft procedures have now been reviewed in response to audit findings, and a new written process developed where individuals fail to engage with audit requirements. These procedures establish specific timescales attached to each step in the process, with clear written guidance in relation to recording and reporting arrangements, and associated responsibilities.

Documentation is being additionally prepared setting out reasons for decisions to continue DPs despite lack of engagement, financial implications, risks and review timetable. Procedure requires to be signed off by HSCP SMT and briefings to relevant Team Managers completed. A target date of 30 June 2023 has been set.

Consultancy Reviews

Meiklehill Housing Support Service - Proposal to Amend Petty Cash Process

John Street House is an East Dunbartonshire Council care home for a small number of adults with learning disabilities and mental health difficulties. Management at John Street House also have responsibility for the housing support service at Meiklehill, Kirkintilloch,

which provides a service to adults with learning difficulties in their own homes, and Pineview, Canniesburn, a house which has the capacity to support three people.

In circumstances such as adults with incapacity, a member of their family may be appointed as a financial and welfare guardian. Auditors were advised by the John Street Unit Manager that is normal practice in Care at Home and Housing Support Services for families in these circumstances to provide small sums of money for personal expenses. The cash is used for shopping, haircuts, day services attendance and any other appropriate expenditure for the needs of the individual.

John Street management operate an imprest petty cash float for various purposes, with a sub imprest cash float of £210 held at Meiklehill. The Meiklehill sub imprest is used to meet the personal expenses of the resident, with an imprest reconciliation being carried out approximately every two weeks by Finance staff.

Proposal

Internal Auditors were approached by the Social Work Revenue Accountant, on behalf of the Unit Manager of John Street House, to provide advice on a proposal to remove the sub imprest petty cash from Meiklehill. The intention is to use monies directly provided by the individual's family, thereby removing the need for the sub imprest.

It is proposed that the current procedure at Meiklehill is replaced by a procedure of residents' families paying cash directly to the unit. This would have the advantage of freeing up time currently taken by John Street staff handling the cash and of Finance staff completing the monthly reconciliation.

Controls

The controls proposed would mirror the procedures in place at Pineview, Canniesburn. The families would be provided with handwritten receipts for any cash that they pay to the unit. Auditors provided advice that Management should also ensure that a detailed log of all monies received and spent continues to be maintained, with receipts retained as back-up. Additionally, someone independent of the process at Meiklehill should carry out regular reconciliations of these monies. Monies should be kept in a secure location, with access to the cash restricted.

Risk Management

Provided that the controls as proposed above are implemented, Auditors have not identified any additional risks associated with the proposed revised process at Meiklehill. The proposed arrangement has the advantage of requiring the resident's family to provide the cash upfront to cover any expenditure, rather than the current process whereby a petty cash sub-imprest is used by staff to meet expenses, then reclaimed from the family.

Conclusion

The proposed process is not likely to increase the risks associated with handling cash, provided the controls are properly implemented. The proposal should simplify the process and create a small efficiency in terms of staff time. Auditors are therefore comfortable with the proposal.

Regularity

Internal Audit Plan 2023/24

The Performance, Audit and Risk Committee received a verbal update on the areas of focus for the 2023/24 Internal Audit Plan at its last meeting. The Plan is included at Appendix 4 for review and approval.

Internal Audit Outputs April to May 2023

In the months of April to May 2023, the Internal Audit Team finalised and reported on the year end governance requirements as shown in *Table 2* below. These are summarised as follows:

In relation to the period since the last monitoring report, Auditors highlight the following:

Table 2 – Analysis of Internal Audit Outputs April to May 2023

	Audit Area and Title	Areas Noted	High Risk	Medium Risk	Low Risk
	Regularity				
1	Annual Governance Statements	**-**	-	-	-
2	Annual Audit Report	**-**	-	-	-
3	Internal Audit Follow Up Report	**-**	-	-	-

Regularity

Annual Governance Statements – these were drafted for review and inclusion in the HSCP's financial statements.

Annual Audit Report – This report is presented to the first Performance, Audit & Risk Management Committee following the financial year end. The Council's Audit & Risk Manager, as the Chief Internal Auditor of the HSCP, has concluded that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP's governance, risk management and control systems in place for the financial year ended 31 March 2023. This opinion is based on the Internal Audit Team's work for the year and other sources of assurance as is detailed at *Appendix 1*.

Internal Audit Follow Up Report – This report is presented at *Appendix 2* and supports the Annual Audit Report and opinion referred to above. The total number of risks outstanding has reduced. There has been a small increase in the total number of outstanding risks from 3 to 6 whilst the outstanding high risks, has remained constant at 1. Auditors have recognised progress made by management towards closing off the high risk relating to Contractual Arrangements for Social Work Commissioned Care action, and have asked for this to continue.

Three outputs were completed in April and May 2023, representing 30% completion of the 10 outputs planned for the year, at 17% through the year.

Work also continues on specific audit areas, as audits underway at the year end are progressed. Furthermore, work has commenced on the audits on the 2023/24 audit plan.

EAST DUNBARTONSHIRE COUNCIL INTERNAL AUDIT PROGRESS

Work on the Council's internal audit plan has continued and completed, with assurance being provided over a number of areas. No high risks of relevant to the HSCP have been identified in the year.

The Council's Internal Audit Plan has been substantially completed, with the Audit & Risk Manager concluding that, based on the Internal Audit Team's work for the year and other sources of assurance, reasonable assurance can be placed upon the adequacy and effectiveness of the Council's governance, risk management and control systems in place for the financial year ended 31 March 2023. Work has also commenced on the Council's 2023/24 internal audit plan of work.

NHSGGC INTERNAL AUDIT PROGRESS

The March 2023 report by Azets provided assurance over a number of areas:

- Financial Systems Health Check (Payroll)
- Sustainability and Value Programme
- Capital/Estates Planning – Neurological Science Project
- Waiting List Management

These areas were all assessed as Minor improvement required, with no Grade 4 recommendations raised (very high risk exposure). One Grade 3 high risk exposure was identified in the area of Payroll – an action plan has been agreed to resolve this.

The NHSGGC's internal auditors Azets have provided an opinion of reasonable assurance over the governance and internal control frameworks in place in 2022/23 to achieve objectives in an effective and efficient manner. Work has started on the NHSGCC internal audit plan for 2023/24.

Appendix 4

East Dunbartonshire Council
Internal Audit Services

HSCP Internal Audit Plan
2023/24

Gillian McConnachie
Audit & Risk Manager
East Dunbartonshire Council

Internal Audit Plan 2023/24

Background

The Annual Internal Audit Plan is prepared on an annual basis, detailing the HSCP Internal Audit work planned for year ahead. Planning the work is important to demonstrate that Internal Audit is proactive and that the activities are targeted to areas of risk and need. The Plan also has to be flexible so that Internal Audit can react to events that might happen during the course of the year.

The Annual Internal Audit Plan is prepared and presented to the Performance, Audit & Risk Committee to allow review and approval of the planned Internal Audit activity for the year ahead.

Plan

The plan for 2023/24 is expected to provide adequate evidence relating to the HSCP's systems to enable the Council's Audit & Risk Manager to provide a year end opinion. This will be closely monitored and the Performance, Audit & Risk Committee will be kept informed of any change in the situation, with resources and expected outturn monitored as the year progresses. However, when determining the focus of the Internal Audit Team the following principles apply:

- The internal audit team will remain flexible and responsive to emerging risks and requests for assurance over new processes,
- The higher priority audits per *Table 1* will remain top priority for completion; and,
- Service demands, Key Officer availability and the skills mix of the individual members of the internal audit team will also be considered when scheduling audits.

Planning Process

The Plan reflects not only our understanding of systems and controls but also the HSCP's goals, the national context and current economic climate. Using this understanding the Audit & Risk Manager discussed potential areas of focus with Senior Management. The following alternative sources of assurance are also considered at the planning stage: external reports on the HSCP, the HSCP's performance, the risk registers, how the HSCP manages its risks and where improvements are required. For the most part 'need' equates to 'risk' but consideration is also given to other aspects such as Internal Audit's reporting history, expected future HSCP changes and local demographics.

Having worked through all of the above, Internal Audit have a considerable amount of information and potential areas for review. Internal Audit cannot cover all areas of risk and we need to make sure what we plan to do is manageable and balanced.

The Plan for 2023/24 includes 10 areas of need to be reported on. This is one more than the 9 outputs that was planned for 2022/23, due to a decrease in the average planned days per audit. Audit days are assigned in the Plan to each assignment, based on an assessment of the relative risks of the audits planned and the expected complexities involved in undertaking the audit work. The work has been planned to enable us to draw conclusions on the HSCP.

Internal Audit Plan – Working to a Standard

The above summary is based on the provisions within the Public Sector Internal Audit Standards (PSIAS). The work of the Internal Audit Team is aligned to these provisions, which are also reflected in the Internal Audit Manual. For the 2023/24 financial year, the following standards have been applied with respect to Internal Audit Planning.

The Internal Audit Plan (Public Sector Internal Audit Standard 2010)

The Plan for 2023/24 is based on a documented risk assessment process. The process uses the HSCP's existing Risk Registers, the expectations of stakeholders and input from Senior Officers whilst considering the HSCP Performance Management Framework and outcomes.

The HSCP's risk management framework is well established, with auditors placing reliance on the actions being taken to manage key risks, as well as using the corporate risk register as a source for identifying areas of potential audit activity.

The Plan takes into account the requirement to produce an annual audit opinion. This opinion is delivered through the statement on the adequacy and effectiveness of the HSCP's framework of governance, risk management and internal controls. This statement is used to inform the governance statement included in the annual accounts.

The Plan is linked to the internal audit mission statement, charter and strategy, ensuring that activities are consistent with existing direction, organisational objectives and priorities.

The Internal Audit team also provides consultancy work on the basis that these assignments improve management of risks, add value and improve the HSCP's operations. Provision for the completion of one consultancy note is included in the planned activities for the year.

Audit Resources (PSIAS Standard 2030)

The Audit & Risk Manager can confirm that, in her opinion, the planned resources are appropriate and sufficient and will be effectively deployed to provide the required assurances to stakeholders.

PSIAS provides further definitions of each of the above requirements with appropriate reference to the mix of knowledge, skills and other competencies needed to perform the Plan. Sufficient refers to the quantity of resources needed to accomplish the Plan. Resources are effectively deployed when they are used in a way that optimises the achievement of the approved Plan.

The Plan is developed to ensure that staff availability, qualifications, experiences and skills are sufficient and appropriate. The process is supported by the Council's Performance Development Review (PDR) framework providing an ongoing mechanism to assess the effectiveness of staff in their roles and supporting future developments through training. The Audit & Risk Manager continually reviews the available resources to ensure that the Plan continues to be achievable. The impact of uncertain or unanticipated resource changes may need to be reported to Members where this affects the ability of the team to deliver the plan.

All auditors in the team have, or are working towards, an accounting, risk management or internal audit qualification. When one of our stakeholders reads an Internal Audit Report they can be assured that is has been prepared with due recognition of the all the best practices, ethics and professional responsibilities, as is required.

Staff training and coaching are being used to good effect to aid in delivery of the Plan. In addition, the budgeted allocation for administrative time has been reviewed to ensure that the application of resources continues to be reasonable.

Policies and Procedures (PSIAS 2040)

The Internal Audit Manual serves as the Internal Audit Team's policies and procedures. The Internal Audit Manual is aligned to the provisions of the Public Sector Internal Audit Standards and, in complying with the manual, the team are demonstrating compliance with the standards.

The Manual is reviewed on an ongoing basis with significant reviews taking place following changes in guidance, good practice or prevailing standards.

Coordination with External Scrutiny Bodies (PSIAS Standard 2050)

The Audit & Risk Manager is required to share information with other providers of assurance and consulting services to ensure proper coverage and minimise duplication of efforts.

In preparing the Plan, the Audit & Risk Manager has met with the new External auditors Mazars to ensure coordination, that external auditors place reliance on Internal Audit's work where possible, and to minimise duplication of effort.

Reporting to Senior Management and the Board (PSIAS 2060)

As part of this plan, the Audit & Risk Manager will prepare and present regular update reports to the Performance, Audit & Risk Committee over the course of the financial year. The internal audit monitoring reports will review progress against the original plan in the interests of consistency and accountability. Monthly performance information will also be captured on the Council's Performance Management System 'Pentana'. Performance reports will capture the activities of the Internal Audit Team relative to the original plan.

Ongoing reporting will also highlight specific issues as they relate to risk exposures, control issues, fraud, governance or any other matters that the Audit & Risk Manager deems appropriate for consideration by the Committee. Significant issues will also be captured within the annual internal audit report.

On an annual basis, the Audit & Risk Manager will provide a report that will include the purpose, authority and responsibilities relative to the plan but also any significant issues noted in the above.

2023/24 Audit Work (PSIAS Standard 2100)

The planned number of days allocated to each audit area and corresponding outputs are shown below in *Table 1*.

Internal Audit activity evaluates and contributes to the improvement of governance, risk management and control processes using a systematic and disciplined approach as outlined in the Internal Audit Charter.

Planned audit work includes consideration of a number of different types of audit assignments including systems, regularity, and consultancy. This varied application of audit resources ensures that different aspects of HSCP business have been subjected to testing, with assurances being sought over a range of activities.

Internal Audit Plan – Allocations and Activities

TABLE 1 – Planned Days and Outputs by Audit Area

Outputs	Area	Review	Planned Days	Status	Rationale	Priority
1	Audit	**Hospital Discharges**	25	New	Review of Hospital Discharges process for the HSCP. Will investigate possibility of joint audit with the NHSGGC's internal auditors. Link to HSCP's risk register HSCP 12 'Inability to support early, effective discharge from hospital'.	1
2	Audit	**HSCP - Performance Management**	15	New	Review of how the HSCP manages performance with sample checking of indicators to help inform audit opinion on governance and controls.	3
3	Audit	**HSCP Governance - Workforce Planning**	20	New	Consideration of this as a key risk to the HSCP. Review of the arrangements put in place by the HSCP to ensure that there is a sound system of Workforce and Succession Planning. Link to HSCP Risk HSCP 07 (Risk of inability to recruit and retain the appropriate numbers of trained staff to meet requirements resulting in reduction in service or failure to meet statutory duties. Specific workforce pressure areas are Mental Health Officers, qualified Social Workers and Psychologists.)	1
4	Audit	**Carefirst Interim Payments Arrangements**	19	New	There have been changes in the internal procedures that would make this an appropriate time for Internal Audit to review arrangements in support of Internal Audit's opinion on control environment.	1
5	Audit	**Transport Policy**	15	New	Audit of application of HSCP's Transport policy in support of Internal Audit's opinion on control environment.	2
6	Regularity	**Annual Audit Report**	1	Recurring	Annual report	1

Outputs	Area	Review	Planned Days	Status	Rationale	Priority
7	Regularity	**Annual Follow Up**	2	Recurring	Follow up on previously issued recommendations	1
8	Regularity	**Annual Governance Statements**	2	Recurring	Annual requirement for accounts and to support Annual report	1
9	Regularity	**Interim Follow Up**	2	Recurring	Follow up on previously issued recommendations	1
10	Regularity	**Internal Audit Plan 2024/25**	2	Recurring	Preparation of following year's internal audit plan	1
	Total Days		**103**			

East Dunbartonshire Council

Internal Audit Charter

Gillian McConnachie
Audit & Risk Manager
June 2023

Internal Audit Charter

Introduction

The Internal Audit Charter defines the purpose, authority and principal responsibilities of the Council's Internal Audit function. Internal Audit is required to comply with the Public Sector Internal Audit Standards (PSIAS) and these requirements include maintaining an Internal Audit Charter.

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

The objective of Internal Audit is to assist Elected Members and all officers of the Council in the effective discharge of their responsibilities. To this end, the Internal Auditors will furnish them with analyses, appraisals, details of issues, advice and information concerning the activities reviewed. This audit objective includes promoting effective control at a reasonable cost.

Role

The Internal Audit activity is established by the Board, which for the purposes of Internal Audit is the Audit and Risk Management Committee (the Committee). Internal Audit's responsibilities are defined by this committee as part of their oversight role.

The main objective of Internal Audit is to provide, in terms of the PSIAS, a high quality, independent audit service to the Council which provides annual assurances in relation to internal controls and overall governance arrangements. In addition to this primary assurance role, Internal Audit will also:

- Support the Chief Finance Officer as the Council's Section 95 Officer.
- Support the Council's Chief Solicitor and Monitoring Officer
- Provide consultancy services to service areas.
- Support the Council's counter fraud function, including fact finding or investigations as appropriate.
- Provide advice and guidance on control implications for new or changed systems where appropriate.
- Support the Council and Senior Management during key transformational/change projects. Terms of reference for internal audit's involvement will be drafted and approved by the Project Lead and the Audit & Risk Manager, ensuring that the role does not compromise the internal auditor's independence.

For the purposes of this Internal Audit Charter, Senior Management is defined as Executive Officer level and above, including the Chief Executive, Depute Chief Executive and the Chief Finance Officer.

Authority and Scope

All Internal Audit staff shall have authority to:

- Enter any Council premises or land.
- Have access to, and ability to obtain copies of, all records, documents and correspondence which, in the view of the Audit & Risk Manager (or nominated representatives), are considered to relate to any matter which may have audit or assurance implications for the Council.
- Be provided with full read only access to any ICT system or other electronic files or emails in the ownership of the Council.
- Require explanations considered necessary from any employee, including Senior Management.
- Require any employee, or agent of the Council, to produce cash, stores, assets or any other property under their control or to which they have access.

The scope of Internal Audit allows for unrestricted coverage of the full range of the Council's activities. In addition, Internal Audit through the Audit & Risk Manager, where they deem necessary, will have unrestricted access to:

- The Chief Executive,
- The Audit & Risk Management Committee and all members,
- The Depute Chief Executive, the Chief Finance Officer, and the Council's Chief Solicitor and Monitoring Officer,
- Executive Officers, and
- All other Council employees.

Right of access to other bodies funded by the Council should be set out in the conditions of funding.

All employees are requested to assist Internal Audit in fulfilling its roles and responsibilities.

Independence and Objectivity

Internal Audit will remain free from interference by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content. This will ensure that the work of the Internal Audit function is independent and objective.

Internal Auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair the Internal Auditor's judgment.

Internal Auditors must exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined, as detailed in the Chartered Institute of Internal Audit's Code of Ethics.

Internal Auditors must also make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgments, as detailed in the 7 Principles of Public Life (the 'Nolan principles').

The Audit & Risk Manager will confirm to the committee, at least annually, the organisational independence of the Internal Audit activity.

Organisation

For the purposes of the PSIAS the Audit & Risk Manager is the Chief Audit Executive, also referred to as the Chief Internal Auditor. The Audit & Risk Manager is the officer responsible to the committee for the provision of an independent Internal Audit service. The Audit & Risk Manager will discharge this responsibility through the direct application of Internal Audit resources including Audit Seniors and Auditors. Where appropriate the Audit & Risk Manager may seek additional input from external providers.

The Audit & Risk Manager operationally reports to the Chief Finance Officer but also has unrestricted access to the Chief Executive.

The Audit & Risk Manager has additional responsibilities for Corporate Fraud. The Audit & Risk Manager will declare an interest for audit assignments in this area with Audit Seniors taking additional reporting responsibilities where such conflicts arise. This arrangement will address the recognised independence issues arising from the Audit & Risk Manager's other area of responsibility.

The Audit & Risk Manager is required to hold a professional qualification and be suitably experienced with Audit Seniors having suitable experience and be working towards a relevant qualification.

Responsibility

The scope of Internal Auditing encompasses, but is not limited to, the evaluation of the adequacy and effectiveness of the Council's governance, risk management and internal control processes in relation to the Council's strategic objectives; this recognises that the Internal Audit remit extends to the entire control environment of the organisation.

Internal Audit is not a substitute for the operation of effective internal controls, which are the direct and sole responsibility of local and Senior Management. However, the team's specific commitments do include (but are not necessarily limited to) the following:

- Reviewing governance processes for making strategic and operational decisions.
- Evaluating the effectiveness of all internal controls and other arrangements put in place to manage risk, in particular where there is exposure to significant financial, strategic, reputational and operational risk to the achievement of the organisation's objectives. This involves coordinating Internal Audit activities with the work of the Corporate Risk Adviser and from that, identifying high risk areas for subsequent review.
- Reviewing the reliability and integrity of financial and operating information and the means used to identify, measure, classify and report such information.

- Reviewing the systems and controls established to ensure compliance with those policies, plans, procedures, laws and regulations which could have a significant impact on operations.
- Reviewing the means of safeguarding assets
- Reviewing the Council's ethics related objectives, programmes and activities.
- Assessing the information technology governance arrangements.
- Examining and evaluating the adequacy of the Council's system of internal control, including those pertaining to the deterrence, detection and investigation of fraudulent or illegal acts.
- Evaluate the potential for the occurrence of fraud and how the organisation manages fraud risk
- Appraising the economy and efficiency with which resources are employed and the quality of performance in carrying out assigned responsibilities. Coordinating Internal Audit activities with the work of the External Auditors and providing them with information on the work of Internal Audit as required.

Based on its activity, Internal Audit is responsible for reporting significant risk exposures and control issues identified to the committee and to Senior Management, including fraud risks, governance issues, and other matters needed or requested by the committee.

Internal Audit resource may be used to support consultancy and advisory services, but not to the detriment of provision of core assurances. These consultancy activities may be included in the Internal Audit plan or agreed by the Audit & Risk Manager as a revision to the plan. Consultancy and advice notes are provided by the internal audit function to give management assurances within specific areas. These are focused pieces of audit work, which are agreed in consultation with services or as Internal Audit deem appropriate. Consultancy and Advice notes provide an independent appraisal of specific area, with limited scope. These do not always constitute a full internal audit review, but the results of Internal Audit's observation, testing and enquiry may inform an action plan to address any issues noted. These risks will be followed up as part of the planned audit cycle and may inform future planned audit activities.

Fraud and Corruption

Managing the risk of fraud and corruption is the responsibility of management. Management is also responsible for developing, implementing and maintaining systems of internal control to guard against fraud or irregularity and ensure probity in systems and operations. Internal Audit will assist management by reviewing the controls and procedures in place.

Audit procedures alone cannot guarantee that fraud and corruption will be detected, nor does Internal Audit have the responsibility for prevention and detection of fraud. However, individual Auditors will be alert in their work to risks and exposures that could allow a fraud, irregularity or corrupt practice to take place.

The Corporate Fraud and Corruption Policy lays out the responsibilities of Council Senior Management, Managers and other employees in relation to any suspicion of fraud or irregularity. The role of Internal Audit is to, where required, support the investigations into suspected fraud and report in accordance with established procedures.

Professionalism

The Internal Audit function will adhere to the PSIAS, which are based on the Chartered Institute of Internal Auditors' mandatory guidance including the Definition of Internal Auditing, the Code of Ethics, and the International Standards for the Professional Practice of Internal Auditing. This mandatory guidance constitutes principles of the fundamental requirements for the professional practice of Internal Auditing and for evaluating the effectiveness of the Internal Audit activity's performance.

Other professional guidance will also be adhered to, as applicable, to guide operations. In addition, Internal Audit will adhere to the Council's relevant policies and procedures and Internal Audit's standard operating procedures manual.

A programme of Continuous Professional Development (CPD) is maintained for all staff working on audit engagements to ensure that auditors maintain and enhance their knowledge, skills and audit competencies.

Internal Audit Plan

At least annually, the Audit & Risk Manager will submit a risk-based Internal Audit plan, consistent with the Council's objectives, to the committee for review and approval. The Audit & Risk Manager will communicate the impact of any resource limitations and significant interim changes to Senior Management and the committee.

The Internal Audit plan will be developed, based on a prioritisation of key risks for the Council, using input from Senior Management and the committee and taking into account the requirement to produce an internal audit opinion on the council's framework of governance, risk management and control. Any significant deviation from the approved Internal Audit plan will be communicated through the periodic activity reporting process to the committee.

Reporting and Monitoring

Following the conclusion of each Internal Audit engagement, a written report or consultancy note will be prepared, reviewed by the Audit & Risk Manager or Audit Seniors and distributed as appropriate. A summary of Internal Audit results will also be reported to the committee.

The Internal Audit report may include management's response and corrective action taken or to be taken in regard to the specific issues and risks. Management's response should include a timetable for anticipated completion of action to be taken and an explanation for any corrective action that will not be implemented.

The Internal Audit activity will be responsible for appropriate follow-up on engagement findings and actions. All findings will remain open on Pentana until appropriate action is demonstrably taken by management or the risk of no action is formally accepted.

Periodic Assessment

Internal Audit is subject to a Quality Assurance and Improvement Programme that covers all aspects of Internal Audit activity. This consists of an annual self-assessment of the service and its compliance with the PSIAS, ongoing performance monitoring and external assessment.

The Audit & Risk Manager is responsible for providing periodically a self-assessment on the Internal Audit activity as regards its consistency with the Audit Charter (purpose, authority, responsibility) and performance relative to the Annual Plan.

In addition, the Audit & Risk Manager will communicate to Senior Management and the committee on Internal Audit's quality assurance and improvement program, including results of ongoing internal assessments.

External assessments will be conducted at least once every five years by a suitably qualified, independent assessor. These reviews will be commissioned by the Convener of the Audit and Risk Management Committee and the Chief Finance Officer.

Other assurances provided:

The Audit & Risk Manager has been appointed as the Chief Internal Auditor of East Dunbartonshire Health & Social Care Partnership. The Audit & Risk Manager will annually provide assurance, including an overall opinion concluding on the adequacy and effectiveness of the framework of governance, risk management and control to the Health & Social Care Partnership for those systems under their strategic control.

The Internal Audit function also offers an internal audit service to the East Dunbartonshire Leisure and Culture Trust in accordance with the Service Level Agreement. Through this agreement, Internal Audit may provide assurance regarding specific systems, as defined in the terms of reference of the assignment.

Approval:

This Charter was reported to the Committee at its meeting on 8 June 2023 for approval and shall be subject to regular review by the Audit & Risk Manager and the Committee.

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 08.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20TH JUNE 2023**
REPORT REFERENCE:	**PERF/200623/08**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER, TELEPHONE NUMBER, 0141 232 8216**
SUBJECT TITLE:	**HSCP DELIVERY PLAN 2022/23 UPDATE**

1.0 PURPOSE

1.1 The purpose of this report is to update the Committee on the final position of the HSCP Delivery Plan for 2022/23.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.1 Note the update to the HSCP Delivery Plan for 2022/23.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The HSCP Board agreed the HSCP Delivery Plan 2022/23 at the IJB meeting on the 24th March 2022. The HSCP Delivery Plan draws together our strategic development priorities for the year, informed by the Strategic Plan's development priorities, the NHS Moving Forward Together Strategic Plan, the priorities of East Dunbartonshire Council as set out in the Community Planning Partnership's Local Outcome Improvement Plans, new statute and policy drivers, and identified areas for transformation change and our savings requirements.

3.2 The Delivery Plan is monitored through the HSCP Annual Delivery Plan Board comprising the Chief Officer, Chief Finance & Resources Officer, HSCP Heads of Services and organisational development and HR support from both the Council and NHS.

3.3 The projects within the Annual Delivery Plan have been classified to more clearly identify where these relate to efficiencies, improvements to service delivery, statutory / legal responsibilities, corporate priorities, sustainability and enhancement to assets. Each of the HSCP Delivery planning priorities has been classified according to these criteria and this is reflected within the highlight report for each priority. Some priorities will have more than one classification as a project may deliver efficiencies as well as improving services and outcomes for patients and service users.

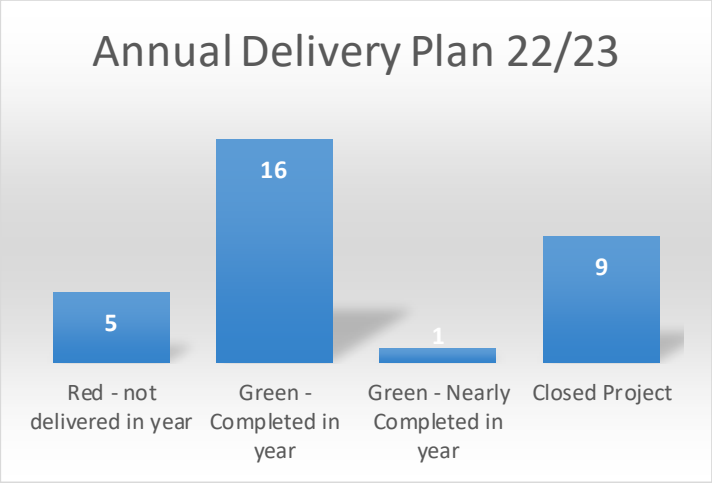
HSCP Delivery Plan 2022/23

3.4 The dashboard setting out progress on delivery of the projects to be delivered during 2022/23 is attached as **Appendix 1** with a more detailed update on the final position for each project attached as **Appendix 2.**

3.5 The delivery of the service redesign aspects of the Delivery plan for 2022/23 included as part of the Budget 22/23 is indicating a small shortfall of £0,01m at the year end, as reported through the PAR Committee and the IJB throughout the year. This means the HSCP achieved £0.439m of savings against a target of £0.449m during 2022/23. A copy of the financial implications of projects approved as part of the Budget 2022/23 are included as **Appendix 3.**

3.6 There are a total of 31 projects to be delivered within the Delivery Plan for 2022/23:-

- 17 (21) are considered at Green status, of which 16 to be closed off as complete and 1 with 90% completion – delivered
- 0 (2) are considered Amber status (at risk) – work is underway with some risk or delay to delivery.
- 5 (5) are considered Red status – not delivered as planned in year.
- 9 have been closed as completed in previous period bringing total completed in year to 25 (including 16 above)



3.7 The projects identified as in exception which have not been completed in year as planned due largely to resource issues or reliance on SG partners to support the delivery on these priorities. These relate to:

3.7.1 Implementation of Digital Action Plan 2022/23 – work continued throughout the year with SG colleagues to conclude the work on developing a digital maturity assessment for the HSCP with limited progress.

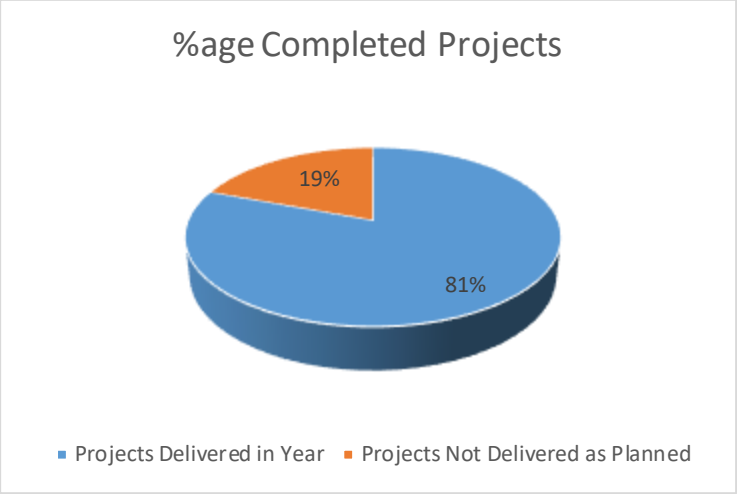
3.7.2 Review of organisational structures – key management and project posts were not recruited to as planned in year due largely to resourcing issues with role development and job evaluation.

3.7.3 Review of Community Occupational Therapy and Re-ablement service – some work has progressed within the HSCP to collate data to inform the review and progress elements of recruitment to support a re-ablement model, however a lack of resources to conduct a formal review and engagement with relevant stakeholders meant this was not concluded in this year.

3.7.4 Development of a compassionate communities model – this is reliant on endowment funding to support delivery and a change in the proposed model for delivery has required a further consideration of the use of funding for this purpose leading to delays in implementation. This will be implemented during 2023/24 now that the re-purposing of funding has now been confirmed.

3.7.5 Implementation of the recommendations from the Public Dental Service Review – changes to the structure for payment and delivery of dental services, post covid, requires to be considered and reflected in the review of services locally – this will be progressed in 2023/24.

3.8 There are 9 projects which are 100% completed and have been closed off previously and moved to the List of Completed Projects (attached as **Appendix 4), w**ith a further 16 completed at year end.



4.0 IMPLICATIONS

The implications for the Committee are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022-2025 Priorities – All. The Strategic Plan sets out the priorities and ambitions to be delivered over the next three years to further improve the opportunities for people to live a long and healthy life. The HSCP Delivery Plan sets out the priorities which will be delivered during 2022/23 in furtherance of the strategic priorities set out in the Strategic Plan.

1. Empowering People
2. Empowering Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery
7. Post-pandemic Renewal
8. Maximising Operational Integration

4.2 Frontline Service to Customers – None

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – None

4.5 Financial Implications – The HSCP Delivery Plan includes the transformation and service redesign priorities for the year including the areas requiring investment and dis-investment.

4.6 Procurement – None

4.7 ICT - None

4.8 Economic Impact – None

4.9 Sustainability – None

4.10 Equalities Implications – None

4.11 Other – None

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The risks to the delivery of each priority are set out in the highlight report specific to each area. The overall risks associated with the delivery of the plan comprise financial risk in the event that savings are not delivered as planned or areas highlighted for service improvement do not progress as planned.

6.0 IMPACT

6.1 STATUTORY DUTY – None

6.2 EAST DUNBARTONSHIRE COUNCIL - None

6.3 NHS GREATER GLASGOW & CLYDE - None

6.4 DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH – No Direction Required.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 Appendix 1 – HSCP Delivery Plan Dashboard 2022/23 March 23
8.2 Appendix 2 – HSCP Delivery Plan Highlight Report 2022/23 March 23
8.3 Appendix 3 – HSCP Savings Update 2022/23 March 23
8.4 Appendix 4 – List of Closed Projects March 23

Appendix 1

HSCP TRANSFORMATION PROGRAMME 2022/2023								
Programme overview				**Summary of RAG Status**				
Projects 22		Decisions 16		On Track 17		At Risk 0		In Exception 5
Priority	Project Name	Previous Status	Current status	Progress	Reason for RAG Status	Original Project End Date	Forecast Project End Date	Decision Required
65	Delivery of Year 2 of Children's House Project			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
52	Learning Disability: service review, action plan and implementation			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
51	Implement 22/23 Digital Action Plan			50%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
47	Social Support for Older People Strategy			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Review of Community Occupational Therapy and Reablement services across the HSCP			30%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Review of HSCP organisational structures			50%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Redesign of HSCP website			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**

Appendix 1

n/a	Review current model of Post Diagnostic Support delivery			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Increase uptake of support at a distance			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Develop HSCP Public Health Strategy and refresh objectives for Public Health Improvement Team			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Review and redefine operational approach to community led support			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Develop compassionate communities model in East Dunbartonshire			75%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Refresh HSCP Locality Plans			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Prioritising Public Protection			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Refresh HSCP Carers Strategy			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Implementation of The Promise			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to**

								agree on closure of project.
n/a	Implementation of the Children and Young People's Mental Health and Wellbeing Framework			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Unpaid work services backlog			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Joint Commissioning Plan for Unscheduled Care			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**
n/a	Delivery of a range of measures to support staff wellbeing.			90%	In progress	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Implementation of the recommendations from the Public Dental Service review Programme Board			25%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Conclude implementation of the Primary Care Improvement Plan Memorandum of Understanding (2)			100%	Complete	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project.**

Appendix 2

HIGHLIGHT REPORT

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-01-TRA Delivery of Year 2 of Children's House Project			100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	24-Mar-2022

Project Description
Ensure that cohort 2 of young people identified complete the programme and are offered permanent accommodation with support within East Dunbartonshire.

Project Sponsor	Project Manager
Claire Carthy	Raymond Walsh

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Year 2 successfully completed.	

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
£200,000	£400,000	3	N/A	• Improve outcomes for Care Experienced Young People moving on from care placements. • EDC and HSCP fulfil duties are Corporate Parents, ensures The Promise is embedded and Children's Rights (UNCRC) is enacted.

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✔	✔	✔	✔	✔

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-02-TRA Learning Disability: service review, action plan and implementation				100%	Project complete
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	28-Apr-2022			
Project Description					
Move to new Allander Day Service and development of employability, and community-based support alternatives to formal day care.					
Project Sponsor		**Project Manager**			
David Aitken		Richard Murphy; Gayle Paterson; David Radford; Caroline Smith			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Transition from Kelvinbank to the New Allander day service was completed successfully in March 2023. • Redesign of service provision and development of community based supports completed in line with 2022-23 Project Plan.					
Key Issues and Risks Requiring Escalation					
There are no significant risks or issues at this time.					
Decision Required					
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	5	N/A	• Improved facilities and services.	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-03-TRA Implement 22/23 Digital Action Plan				50%	Red - Project in exception
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	08-Nov-2022			
Project Description					
Implement 22/23 Digital Action Plan, which seeks to maximise experience of remote technology for a digitally enabled workforce, implement Analogue to Digital Telecare Transformation by 2024.					
Project Sponsor		**Project Manager**			
Jean Campbell		James Gray; Elaine Marsh			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Digital maturity assessment did not materialise as planned due to delays within SG and loss of key information to inform assessment. • SG in process of conducting a national digital assessment for HSCPs during 23/24. A number of local digital projects have concluded in year and these, along with other priorities, will continue into 23/24 as part of the next Annual Delivery Plan.		• Input to national digital maturity assessment in collaboration with Council and NHS GG&C. • Continue to progress local digital priorities through EDC HSCP Digital Programme Board.			
Key Issues and Risks Requiring Escalation					
Resources to support digital programme across HSCP, and ICT within partner bodies. Alignment to national priorities following digital maturity assessment and access to funding to support delivery.					
Decision Required					
There are no decisions required.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	3. 5, 6	N/A	• Increase in digitally enabled workforce • Reducing carbon footprint of HSCP	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-04-TRA Social Support for Older People Strategy			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	19-Jan-2023

Project Description
Development and consultation on new model for the delivery of social support options for older people to include interim contractual arrangements pending full implementation in April 2024.

Project Sponsor	Project Manager
Derrick Pearce	Kelly Gainty; Richard Murphy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• The Social Support Strategy for Older People 2023-28 was approved at the Integrated Joint Board in April 2023 and has now been published on the Council website. • The first year of the Strategy involves undertaking activities to procure, commission and develop the agreed day centre model.	

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	5, 6	N/A	• Sustainable model of service delivery in place for medium to long term

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✓	✓	✗	✓	✗	✗

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-06-TRA Review of Community Occupational Therapy and Reablement services across the HSCP			30%	Red – Project in exception

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Review of community OT and reablement service and implementation of review outcome to deliver an improved service model which addresses OT waiting times and maximise use of equipment digital options for supporting people within the community.

Project Sponsor	Project Manager
Derrick Pearce	Fiona Munro; Richard Murphy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Approval from EDC to progress with review still required. • Project included in Head of Service Plan for 2023-24.	• Project included in HoS plan for 2023-24

Key Issues and Risks Requiring Escalation
Delay to Strategic Service Review due to competing priorities and capacity challenges in EDC Digital and Business Change Team/ HR and OD. Request to progress service review is pending. Not expected to be delivered in year as planned. Project with HoS plan for 2023-24.

Decision Required
There are no decisions required.

Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	5, 6	N/A	• Integrated delivery of a Reablement approach • Increased capacity to absorb Reablement packages of care • Increase in the number of customers requiring a reduced or no package following their 6 weeks of Reablement	

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

Appendix 2

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-07-TRA Review of HSCP organisational structures	⚠	●	50%	Red – Project in exception

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Review and implement a revised operating model which is fit for purpose and aligned to the strategic priorities of the HSCP post-pandemic.

Project Sponsor	Project Manager
Caroline Sinclair	Caroline Sinclair

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Key management and project posts were not recruited to as planned during 2022/23 due to resourcing issues. • Alternative temporary arrangements put in place to project priority areas • Work will progress during early 2023/24 to support recruitment to roles.	• Continue with recruitment process to fill roles to increase adult SW capacity, consolidation of interim management arrangements and service manager capacity still to be progressed. • Continue to recruit to increase capacity across health & social care in line with additional SG monies for Adult Winter Planning. • Recruitment of Carers Lead to progress and support Carers agenda.

Key Issues and Risks Requiring Escalation
Delays in consolidation of HSCP management structure, recruitment issues to increase capacity across a range of service areas which will impact on ability to spend allocated funding in year. Resource issues to timeously evaluate jobs and processes for recruitment to post are causing delays.

Decision Required
There are no decisions required.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	3. 5, 6	N/A	• Structure is fit for purpose, maximises integration and delivers on Scottish Government commitments to enhance capacity across health & social care services

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✔	✘	✔	✘	✘

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-08-TRA Redesign of HSCP website			100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Redesign of HSCP website within scope of full EDC website design

Project Sponsor	Project Manager
Norma Marshall	Vandrew McLean; Alison Willacy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Project complete. The HSCP will continue to maintain the content and accuracy of the current website until the contract is awarded by EDC to a new website provider.	

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	3, 5, 6	N/A	• Increased hits on HSCP website pages.

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✗	✓	✗	✓	✗	✓

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-09-TRA Review current model of Post Diagnostic Support delivery				100%	Project Complete
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	N/A			
Project Description					
Review current model of PDS delivery in line with refreshed Dementia Strategy and action plan					
Project Sponsor		**Project Manager**			
Derrick Pearce		Fiona Munro			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Recommencement and refresh of East Dunbartonshire Dementia Strategy Group in progress. • Awaiting Scottish Government Dementia Strategy which will inform the EDC Dementia Strategy and Action Plan, the development of which is now a BAU activity.					
Key Issues and Risks Requiring Escalation					
There are no significant risks or issues at this time.					
Decision Required					
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	5, 6	N/A	• Improved access to Post Diagnostic Support within 6 weeks of diagnosis	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✓	✓	✗	✓	✗	✗

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-10 Increase uptake of support at a distance			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Increase technological and digital options through Telecare, digital support and supported self-management to increase uptake of support provided at a distance.

Project Sponsor	Project Manager
Derrick Pearce	James Gray; Elaine Marsh

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Support at a distance principles have been embedded and tested within HSCP and ongoing development will be carried through business as usual.	

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.

Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	5, 6	N/A	• Increase in choice and control and flexibility for service users.	

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✗	✓	✓	✓	✗	✗

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-11 Develop HSCP Public Health Strategy and refresh objectives for Public Health Improvement Team				100%	Project complete
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	N/A			
Project Description					
Develop HSCP Public Health Strategy and refresh objectives for Public Health Improvement Team					
Project Sponsor		**Project Manager**			
Derrick Pearce		David Radford			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Work progressed on changes to the strategy after the public consultation and discussions about sign off were taken forward. Further action to be determined in 23/24 within service level plans by the Community Planning Partnership and the HSCP.					
Key Issues and Risks Requiring Escalation					
There are no significant risks or issues at this time.					
Decision Required					
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	5	N/A	• Renewed focus on public health and tacking health inequalities across the HSCP	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✓	✓	✗	✓	✗	✗

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-12 Review and redefine operational approach to community led support			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Develop and implement model of community led support locally based on best practice which seeks to reduce waiting lists and divert needs to more appropriate service models

Project Sponsor	Project Manager
Derrick Pearce	Kelly Gainty; David Radford

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Trial of ConnectED sessions ended in March 2023. • The programme is currently being evaluated to consider development of delivery for the future. • The Older People Local Area Co-ordinators have supported all local older people community clubs and groups to recommence following an extended closure period. Some clubs have made the difficult decision to close permanently, however a number of new community assets were developed and remain active with membership waiting lists.	• Continue to pilot model and expand as test of change • Hold local workshop to consider application of community led support in practice in East Dunbartonshire in new year • Agree preferred model and seek sign off via SMT and IJB • Pilot first of the proposed Community Led Support 'Clinics'

Key Issues and Risks Requiring Escalation
Project will run over a number of years and while this will not be fully delivered in year, work will continue to progress to develop this model.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	5, 6	N/A	• Maximised use of community assets • Maximised self-management Increased choice and control

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-13 Develop compassionate communities model in East Dunbartonshire			75%	Red - Project in exception

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Develop and implement a delivery plan for No One Dies Alone (NODA) within East Dunbartonshire. Dependent on outcome of funding bid through endowments.

Project Sponsor	Project Manager
Leanne Connell; Derrick Pearce	Kathleen Halpin; David Radford

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Job description drafted and awaiting NHSGG&C approval before recruitment and programme development can commence	• Confirm governance for both elements of programme/service • Establish local project board and project team • Clarify local vision and objectives for project • Develop year 1 action plan and financial framework • Benchmark and gain learning with neighbouring HSCP who have already implemented

Key Issues and Risks Requiring Escalation
Potential delays in rolling out programme and awaiting confirmation from funding body on revised approach to delivering programme. Not expected to be fully delivered in year.

Decision Required
There are no decisions required.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	5, 6	N/A	N/A

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-14 Refresh HSCP Locality Plans				100%	Project complete
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	N/A			
Project Description					
Review and redefine aims of locality planning groups to deliver improved outcomes for local people via collaboration and partnership action					
Project Sponsor		**Project Manager**			
Jean Campbell; Derrick Pearce		Kathleen Halpin; Vandrew McLean; Fiona Munro; Richard Murphy			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Locality Planning has now been re-established within the HSCP and will continue to operate as Business as Usual though the re-established structures and supported by the updated locality need and demand profiles, to develop and implement 2023/24 Locality Plans. • The locality practitioner collaborative in community health and care continue to work well with scope to be expanded to other care groups.					
Key Issues and Risks Requiring Escalation					
There are no significant risks or issues at this time					
Decision Required					
The HSCP Transformation Board is asked to agree on closure of this project as it has been completed.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	5, 6	N/A	• Locality focused and integrated delivery model • Reduction in Care at Home travel	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✓	✓	✗	✓	✓	✓

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-16 Prioritising Public Protection				100%	Project Complete
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	N/A			
Project Description					
Ensuring the highest quality standards in identifying and responding to actual and potential social work public protection concerns through the implementation of 'Safe and Together', implementation of the Violence and Sex Offenders register (VISOR) and updating and implementation of the new Child Protection Guidelines					
Project Sponsor		**Project Manager**			
Claire Carthy		Alex O'Donnell			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Public protection has continued to be a priority. The Public Protection Leadership Group oversees and monitors all data relating to CP, ASP and MAPPA.					
Key Issues and Risks Requiring Escalation					
There are no significant risks or issues at this time.					
Decision Required					
There are no decisions required.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	3	N/A	N/A	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✔	✔	✔	✔	✘

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-17 Refresh HSCP Carers Strategy			100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Development of a new Carers Strategy for East Dunbartonshire for implementation from 2023 - review of existing strategy, consultation and engagement on new strategic objectives and delivery of new strategy to be completed.

Project Sponsor	Project Manager
David Aitken	Alan Cairns; Kelly Gainty

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Final consultation concluded. • Final draft strategy prepared for approval by IJB on 29th June 2023. • Carers Strategy and EQIA completed.	

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
There are no decisions required.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	5, 6	N/A	• Updated Carers Strategy to enhance access to carer support services and improve carer support and access to information. • Improved engagement and carer lead services. • Enhanced public awareness and carer friendly communities.

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✗	✓	✓	✓	✗	✗

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-18 Implementation of The Promise			100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	24-Mar-2022

Project Description
Implementation of The Promise with a focus on Family Group Decision Making, ensuring that every child grows up loved, safe and respected, able to realise their full potential.

Project Sponsor	Project Manager
Claire Carthy	Raymond Walsh

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• The Promise Steering Group has implemented an action plan and is ensuring EDC is compliant with The Promise and that key principles are being embedded	• Implementation of the Promise is a 10-year project which continues in EDC. • The Champs Board will continue to support Care Experienced Young People.

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
There are no decisions required.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	3	N/A	• Improve outcomes for Looked After Children. • Ensure EDC and HSCP fulfil duties as Corporate Parents.

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✔	✔	✔	✔	✔

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-19 Implementation of the Children and Young People's Mental Health and Wellbeing Framework			100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	24-Mar-2022

Project Description
Implementation of the Children and Young People's Mental Health and Wellbeing Framework

Project Sponsor	Project Manager
Claire Carthy	Claire Carthy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Continued to develop Tier 1 and 2 services • Ensured that bids for additional partnership funding are considered by DCYPP. • Year 3 funding has been agreed.	

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
There are no decisions required.

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	3	N/A	• Improve Tier 1 and Tier 2 mental health and wellbeing services for children, young people and families.

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✔	✔	✔	✘	✘

Appendix 2

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-24 Unpaid work services backlog			100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	24-Mar-2022

Project Description
Addressing the unpaid work services backlog and ensuring those sentenced are able to complete their hours and are not breaching any order.

Project Sponsor	Project Manager
Claire Carthy	Alex O'Donnell

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Work has continued to address the backlog and we are confident that no orders will be breached due to lack of opportunity to complete hours.	

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it is complete.

Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	4	N/A	• Enable those sentenced to complete unpaid work hours.	

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-25 Joint Commissioning Plan for Unscheduled Care				100%	Project complete
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	N/A			
Project Description					
Implementation of 22/23 actions within the Joint Commissioning Plan for un scheduled care including the establishment of a frailty hub and spoke model					
Project Sponsor		**Project Manager**			
Derrick Pearce		Eleanor Hughes; Fiona Munro; Alison Willacy			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• 22/23 actions implemented. • CAPA established and embedded within Support to Care Homes Team. • Developed a network for Activity Co-ordinators within each Care Home to provide support, share ideas and embed principles of CAPA. • Daily scrutiny of delays continues.					
Key Issues and Risks Requiring Escalation					
There are no significant risks or issues at this time.					
Decision Required					
There are no decisions required.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	5, 6	N/A	N/A	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-26 Delivery of a range of measures to support staff wellbeing.				90%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	N/A			
Project Description					
Delivery of a range of measures to support staff wellbeing and support options					
Project Sponsor		**Project Manager**			
Tom Quinn		Tom Quinn			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Activity calendars now published through the SMT and Staff forum for the period Jan - March 2023, focus is on Physical, Mental and Financial wellbeing and includes dates for information sharing based coffee mornings • Snack food available from all base locations from January 2023 • Individual relaxation sessions extended through Edvar		• Work is starting to focus on the period April - Sept 2023.			
Key Issues and Risks Requiring Escalation					
There are no significant risks or issues at this time.					
Decision Required					
There are no decisions required.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	3, 5, 6	N/A	N/A	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

Appendix 2

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-27 Implementation of the recommendations from the Public Dental Service review Programme Board				25%	Red – Project in exception
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2023	31-Mar-2023	N/A			
Project Description					
Implementation of the recommendations from the Public Dental Service review Programme Board					
Project Sponsor		**Project Manager**			
Lisa Dorian		Karen Gallacher			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Agreement reached to carry forward project into 2023/24 delivery plan.		• Develop short, medium and long term implementation plans to reflect the revised/updated recommendations. Ensure that any ongoing work feeds into the development of the new Board Primary Care Strategy and paediatric pathway work.			
Key Issues and Risks Requiring Escalation					
The pandemic had a significant impact on this programme of work and implementation was stalled. This action will be carried forward and delivered in 23/24.					
Decision Required					
There are no decisions required.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	3, 5, 6	N/A	• To maximise current and future estate, that is fit for purpose and future proof • To review service delivery model to identify gaps in staff resources and skill mix • To ensure focus on providing appropriate clinical care to those most in need • To ensure the Public Dental Service is part of the Board's Digital Strategy	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

PROJECT RAG STATUS UPDATE					
Project ID/ Project Name		**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-30 Conclude implementation of the Primary Care Improvement Plan Memorandum of Understanding (2)				100%	Project complete
Original Project End Date	**Forecast Project End Date**		**Date of last project board**		
31-Mar-2023	31-Mar-2023				
Project Description					
Conclude implementation of the Primary Care Improvement Plan Memorandum of Understanding (2)					
Project Sponsor			**Project Manager**		
Derrick Pearce			James Johnstone; Dianne Rice		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			**Actions planned in the Next Reporting Period**		
• All noted actions complete. Ongoing delivery will continue throughout 23/24 as we await further guidance from SG.					
Key Issues and Risks Requiring Escalation					
There are no significant risks or issues at this time.					
Decision Required					
There are no decisions required.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	3, 5, 6	N/A	N/A	
Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
					

East Dunbartonshire HSCP

Financial Planning 2022/23 - Savings Programme **APPENDIX 3**

Workstream	Action	Project Lead	Full Year Approved Saving 22/23	Full Year Achieved Saving 22/23
	Service Redesign (21/22 Savings Cfwd)			
Policy	Fair Access to Community Care	David	140	140
Efficiency / Service Improvement	Children's Services 'House' Project Development	Claire	200	200
	Total C/fwd Savings 21/22		**340**	**340**
	New Savings 22/23			
Efficiency / Income Generation	Charging for Telecare	Derrick	10	0
Efficiency	OP Daycare Commissioning - review	Derrick	51	51
Efficiency	Management Savings	Derrick	48	48
	Total New Savings 22/23		**109**	**99**
	Total Savings Programme 22/23		**449**	**439**

HSCP Transformation Programme 2022/23 Appendix 4

Completed/Concluded Projects

Ranking from Highest Priority to Lowest – Assessed by the Priority Scoring Matrix

Priority Scoring	Title	Current Due Date	Comments	Indicative Full Year Financial Benefit	Estimated Financial Benefit 2022/23
-	Review of commissioned mental health and alcohol and drugs services. Develop action plan for reshaping of services.	March 2023	Project not identified as deliverable within 22-23 timescales. Transformation Board agreed closure of this project at the meeting held on 9 February 2023.	N/A	N/A
-	Identify a staff base in the West locality	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 9 February 2023.	N/A	N/A
-	Mainstream testing	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 25 November 2022.	N/A	N/A
-	Refresh and streamline PPE arrangements	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 25 November 2022.	N/A	N/A
-	Review accommodation arrangements in line with SG Guidance and GGC and EDC policies	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 9 February 2023.	N/A	N/A
	Organisational Development Plan of staff orientation back to buildings	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 9 February 2023.	N/A	N/A
-	Development of Annual Strategic Delivery Plan for 22/23	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 30 August 2022.	N/A	N/A
-	Review engagement framework to support collaborative approach with	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 9 February 2023.	N/A	N/A

HSCP Transformation Programme 2022/23 Appendix 4

Completed/Concluded Projects

Ranking from Highest Priority to Lowest – Assessed by the Priority Scoring Matrix

	third and independent sector				
-	Property Strategy development and implementation	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 9 February 2023.	N/A	N/A

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 09.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20th JUNE 2023**
REPORT REFERENCE:	**HSCP/200623/09**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER (07583902000)**
SUBJECT TITLE:	**EAST DUNBARTONSHIRE HSCP RISK MANAGEMENT POLICY AND CORPORATE RISK REGISTER UPDATE**

1.0 PURPOSE

1.1 The purpose of this report is to seek the Committee's approval on the updated HSCP Risk Management Policy and provide an update on the Corporate Risks and how they are mitigated and managed within the HSCP.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.1 Approve the updated HSCP Risk Management Policy attached as **Appendix 1**.
2.2 Consider and approve the Corporate Risk Register attached as **Appendix 2**.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The HSCP Risk Management policy was developed at the inception of the IJB in August 2017. Following a recent audit of the HSCP Governance arrangements and a review of HSCP policies more generally, it was highlighted that there was a need to review and update the policy in the context of alignment with updated Council and NHSGGC strategies and to ensure that policies and procedures of the IJB are kept up to date and relevant

3.2 The HSCP Risk Management policy sets out the approach to risk management to be adopted within the HSCP, how the policy will be implemented across HSCP services, the arrangements for leadership and accountability, the resourcing to the risk management framework and the requirements around ensuring staff are properly trained in the risk management approach.

3.3 A copy of the updated Risk Management Policy is attached as **Appendix 1**.

3.4 The Corporate Risk register reflects the HSCP Board's Commitment to a culture of improved performance in the management of Corporate Risks.

3.5 Individual Service Risk Registers are reviewed and updated on a quarterly basis by the Operational Leads within the HSCP. These capture a more detailed picture of individual service risks and include those services hosted within ED HSCP.

3.6 The Corporate Risk Register is reviewed quarterly by the Senior Management Team and updated. It captures the high level risks across the HSCP and the hosted services.

3.7 The Risk Register provides full details of all current risks, in particular high level risks, and the control measures that are in place to manage these. The risks associated with the Covid pandemic have been incorporated into the wider HSCP Corporate risks where they are considered to have an ongoing impact beyond the Covid pandemic and will remain relevant for the duration of 2023 - 24.

3.8 There are a total of 14 risks included within the HSCP Corporate Risk register. This represents an overall reduction in the number of risks for the HSCP of 4 from that previously reported. This movement relates to the removal of 5 risks where it has been determined they are no longer relevant (related to impact of Covid) or can be incorporated or reflected within the other corporate risks highlighted.

3.9 There is 1 new risk included related to the failure to secure an alternative system to Carefirst for Social Work case management and provider financial payments. The risks which have been removed relate to:

- Failure to deliver the health visiting pathway in line with SG requirements – the impact on the recruitment and retention of health visitors is captured with HSCP 07 related to the wider recruitment issues across the HSCP

- Failure to deliver in house care at home services to all those vulnerable and complex individuals to allow them to remain safely at home – this risk is

reflected across a number of the corporate risks identified such as recruitment, funding restrictions and delivery of the un scheduled care commissioning plan

- Inability to support early, effective discharge from hospital – this is now included within HSCP 10 and the wider risk related to the failure to deliver on the actions to support the implementation of the un-scheduled care commissioning plan

- Heightened risk of community mental ill-health and deterioration in wider wellbeing and mental health – this related to the impact of the Covid-19 pandemic and the potential increase in demands in this area. This is now considered part of business as usual and will be managed at a service risk level.

- Failure to retain/recruit GPs (in particular but not restricted to Principal GPs) de-stabilising existing Partnerships/Practices – this is now captured in HSCP 07 related to the wider recruitment issues across the HSCP

3.10 There has been a change to a number of the risk scores within the HSCP Corporate Risk Register, these relate to:

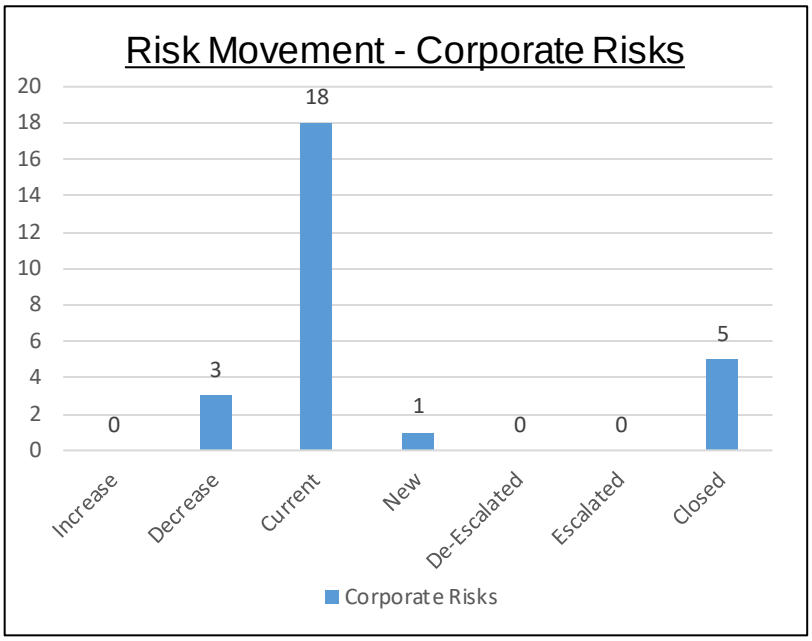
- HSCP 01 Inability to achieve recurring financial balance has moved from a score of 16 (likelihood 4, impact 4) to a score of 12 (likelihood 3, impact 4) – the IJB has been able to set a balanced budget for 2023/24 with savings identified, there is also a healthy contingency reserves balance to mitigate any in year budget pressures and unplanned events and ensure a level of financial sustainability for the HSCP in the short / medium term.

- HSCP 03 Failure to comply with General Data Protection Regulations - loss of sensitive personal data (this risk and mitigation relates to personal data held which is the data controller responsibility of NHS GG&C or ED Council) has moved from a score of 12 (likelihood 3, impact 4) to a score of 9 (likelihood 3, impact 3) – in the context of the impact, if this risk were to materialise there would be reputational damage and some potential impact on service delivery, however this is not expected to be significant and widespread across the HSCP but rather limited to individual cases.

- HSCP 04 Failure to comply with General Data Protection Regulations - failure to destroy records in line with schedule of destruction dates has moved from a risk score of 10 (likelihood 5, impact 2) to a risk score of 8 (likelihood 4, impact 2) – there is work ongoing to review file classification and rationalisation of the number of information assets underway which is expected to have a positive impact.

3.11 Of the 14 risks identified within the Corporate Risk register, 9 are considered to be high risk albeit following the risk management actions implemented, this reduces to 1 high risk area, the rest falling down to medium risks. The remaining high risk area relates to failure to deliver on actions to support the implementation of the Un-scheduled Care Commissioning Plan and inability to support early, effective discharge from hospital. In terms of delayed discharge, ongoing collaborative working across GG&C, investment of Adult Winter Support funding to create additional

capacity across in house care at home services and care homes and continued engagement with care providers will be key in managing this risk event.



3.12 A copy of the HSCP Corporate Risk Register is included as **Appendix 2**.

3.13 In terms of horizon scanning, there are a number of emerging risks for the HSCP, however the likelihood that these events may occur and the extent to which they will have a negative or positive impact on the HSCP is still under review. These relate to:

- The Scottish Government Covid enquiry
- The development and implementation of the National Care Service
- The impact or failure of the National Care Home Contract

3.14 The HSCP also has a number of service risk registers in place provides a systematic and structured method to support the risk management process. Information forming the risk register will be captured using the Datix system. The risks included are of a more operational nature, service specific and tend to be more fluid in how they appear on the register the risk score attached and the management actions to mitigate the risks. There are a total of 21 service risk registers with 32 live/active risks associated with these registers. The process for escalation to the corporate risk register will depend on a number of factors such as risk score, ability to continue to manage risk at a service level or where risk have an impact across the HSCP and are not solely within one service area.

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2022-2025 Priorities;-

1. Empowering People
2. Empowering Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery
7. Post-pandemic Renewal
8. Maximising Operational Integration

4.2 Frontline Service to Customers – None.

4.3 Workforce (including any significant resource implications) – there are particular workforce issues highlighted throughout the risk register, particularly related to the challenges in recruitment and retention of staff into key frontline services and managing ongoing absence across critical services. Workforce issues will be addressed through the HSCP Workforce Strategy.

4.4 Legal Implications – The HSCP Board is required to develop and review strategic risks linked to the business of the Board twice yearly.

4.5 Financial Implications – There are key high level risks to the HSCP which will have a financial impact going forward and where there will require to be a focus on the delivery of transformation and service redesign to support financial sustainability and the delivery of financial balance in future years.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None.

4.11 Other – None.

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 This risk register is an aggregate of all service specific Risk Registers and control measures must be reviewed and updated regularly to reduce risk.

6.0 IMPACT

6.1 **STATUTORY DUTY** – None

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The HSCP Board Risk Register contributes to East Dunbartonshire Council Corporate Risk Register and ensures the management of the risks with robust control measures which are in place.

6.3 **NHS GREATER GLASGOW & CLYDE** – The HSCP Board Risk Register contributes to NHS GG&C Corporate Risk Register and ensures the management of the risks with robust control measures which are in place.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** – HSCP Risk Management Policy May 2023
8.2 **Appendix 2** - HSCP Corporate Risk Register May 2023

East Dunbartonshire Health & Social Care Partnership

RISK MANAGEMENT POLICY

Version 2: May 2023

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

CONTENTS

POLICY – the risk management approach

East Dunbartonshire Health & Social Care Partnership Board (HSCP Board) is committed to a culture where its workforce is encouraged to develop new initiatives, improve performance and achieve goals safely, effectively and efficiently by appropriate application of good risk management practice.

In doing so the HSCP Board aims to work with EDC and NHSGG&C to provide safe and effective care and treatment for patients and clients, and a safe environment for everyone working within the HSCP construct and others who interact with the services delivered under the operational oversight of the HSCP Board.

The HSCP Board believes that appropriate application of good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, objectives, achievement of targets and fewer unexpected problems.

The HSCP Board purposefully seeks to promote an environment that is risk 'aware' and strives to place risk management information at the heart of key decisions. This means that the HSCP Board can take an effective approach to managing risk in a way that both address significant challenges and enable positive outcomes.

Key benefits of effective risk management:

- appropriate, defensible, timeous and best value decisions are made;
- risk 'aware' not risk 'averse' decisions are based on a balanced appraisal of risk and enable acceptance of certain risks in order to achieve a particular goal or reward;
- high achievement of objectives and targets;
- high levels of morale and productivity;
- better use and prioritisation of resources;
- high levels of user experience/ satisfaction with a consequent reduction in adverse incidents, claims and/ or litigation; and
- positive reputation established for the HSCP Board.
- robust planning processes based on consideration of known and potential threats and opportunities

The HSCP Board's risk management matrix identifies levels of risk using a 'likelihood/consequence' scale. Full risk matrix can be viewed at **Appendix 1.**

The HSCP Board promotes the pursuit of opportunities that will benefit the delivery of the Strategic Plan 2022-25 (1).pdf and associated financial plans.

Opportunity-related risk is evaluated in the context of the anticipated benefits for patients, clients and the HSCP Board.

Likeli-hood	Consequent Impact				
	1	2	3	4	5
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5

The HSCP Board will receive assurance reports not only on the adequacy but also the effectiveness of its risk management arrangements and will consequently value the contribution that risk management makes to its wider governance arrangements. As part of these monitoring arrangements, updates on identified risks and mitigating actions will be

brought to the Performance, Audit and Risk Committee and the full IJB on an agreed basis.

The HSCP Board, through the following risk management strategy, has established a Risk Management Framework, (which covers risk policy, procedure, process, systems, risk management roles and responsibilities).

At the time of updating this Policy (May 2023), the IJB is moving into recovery from the Covid-19 pandemic. This framework is also intended to provide flexibility, and the approach to managing risk will be reviewed regularly to ensure that it supports recovery and renewal activity.

Implementing the policy

1. Introduction

1.1 The primary objectives of this policy will be to:

- promote awareness of risk and define responsibility for managing risk within the HSCP Board and the constituent organisations;
- establish communication and sharing of risk information through all areas of the Health & Social Care Partnership;
- ensure mechanisms are in place for participation and engagement in partner organisations risk governance structure and effective joint management of risk where this is appropriate.
- initiate measures to reduce the HSCP Board's exposure to risk and potential loss; and,
- establish standards and principles for the efficient management of risk, including regular monitoring, reporting and review.
- Enable a proactive and flexible approach to managing risk, including but not limited to project activity, operational service delivery and through joint activity with partners.

1.2 This policy takes a positive and holistic approach to risk management. The scope applies to all risks directed through the Chief Officer, whether relating to the clinical and care environment, employee safety and wellbeing, business risk, opportunities or threats.

1.3 **Strategic risks** represent the potential for the HSCP Board to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk.

1.4 **Operational risks** represent the potential for impact (opportunity or threat) within or arising from the activites of an individual service area or team operating within the operational oversight of the HSCP Board's.

Operational Managers will retain responsibility for managing operational risks as these will be more 'front-line' in nature including the development of activities and controls to respond to these risks. Where a number of operational risks require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the HSCP Board. These will tend to be risks which have a high risk score,

where measures to mitigate the risks at a service level have been exhausted or where risks impact across the HSCP and are not solely within one service area.

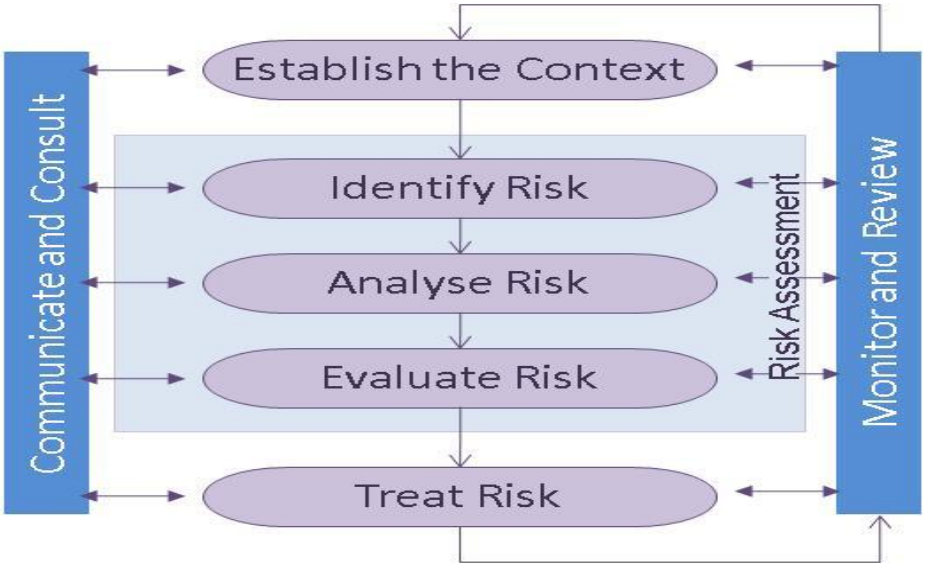
1.5 All risks will be analysed consistently with an evaluation of risk as being low/ mod/ high/ very high/ red/ amber/ green. High/very high risk (and in some cases moderate risk) will be subject to closer scrutiny by the HSCP Board.

1.6 This document represents the risk management framework to be implemented across the HSCP and will contribute to the HSCP Board's wider governance arrangements.

2. Risk management process

2.1 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects[1] It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that defensible and beneficial decisions are made.

2.2 The HSCP embeds risk management linking with the operational risk management processes of EDC and NHSGGC shown in the diagram below, across all areas of service delivery and business activities.



3. Application of good risk management across the HSCP activities

Standard procedures (3.2 – 3.10) have been implemented across all areas of activity that are under the strategic and operational oversight of the HSCP Chief officer in order to achieve consistent and effective implementation of good risk management. A risk management flowchart can be found at **Appendix 2**.

3.1 Full implementation of the risk management process. This means that risk management information should (wherever possible) be used to guide major decisions in the same way that cost and benefit analysis is used.

3.2 Identification of risk using standard methodologies and involving subject experts who have knowledge and experience of the activity or process under consideration.

3.3 Categorisation of risk under the headings below:

[1] Australia/ New Zealand Risk Management Standard, AS/NZS 4360: 2004

- Strategic Risks: such as risks that may arise from Political, Economical, Social, Technological, Legislative and Environmental factors that impact on the delivery of the Strategic Plan outcomes (responsibility of HSCP Board). At the time of writing such risks include:
    - Financial sustainability
    - Inability to recruit and retain the appropriate numbers of trained staff to meet requirements resulting in reduction in service or failure to meet statutory duties.
- Operational Risks: such as risks that may arise from or impact on clinical care and treatment, social care, patient and service user experience, employee health, safety & well-being, business continuity/ supply chain, information security and asset management (responsibility of EDC & NHSGGC), workforce planning, property and accommodation, project change based activity.

3.5 Appropriate ownership of risk. Specific risks are owned by/assigned to whoever is best placed to manage the risk and oversee the development of any new risk controls required. These individuals will be responsible for developing necessary mitigation plans for reporting on the progress made in managing specific risks.

3.4 Consistent application of the agreed risk matrix to analyse risk in terms of likelihood of occurrence and potential impact, taking into account the effectiveness of risk control measures in place. The risk matrix being utilised is attached in Appendix 1.

3.5 Consistent response to risk that is proportionate to the level of risk. This means that risk may be terminated; transferred elsewhere (ie to another partner or third party); tolerated as it is; or, treated with effective measures to bring it to a level where it is acceptable or tolerable for the HSCP Board in keeping with its appetite/tolerance for risk. In the case of opportunities, the HSCP Board may 'take' an informed risk in terms of tolerating it if the opportunity is judged to be (1) worthwhile pursuing and (2) the HSCP Board is confident in its ability to achieve the benefits and manage/ contain the associated risk.

3.6 Implementation and maintenance of risk registers as a means of collating risk information in a consistent format allowing comparison of risk evaluations, informed decision-making in relation to prioritising resources and ease of access to information for risk reporting.

3.7 Reporting of strategic risks and key operational risks to the HSCP Board, EDC and NHSGG&C when necessary.

3.8 Operation of a procedure for movement of risks between strategic and operational risk registers that will be facilitated by the Chief Officer and Senior Management Team.

3.9 Routine reporting of risk information within and across teams and a commitment to a 'lessons learned' culture that seeks to learn from both good and poor experience in order to replicate good practice and reduce adverse events and associated complaints and claims.

3.10 Risk escalation **-** If significant risks have been identified that are deemed impossible or impractical to manage at a local Management Team level, then they should be reported for review by the Chief Officer and/or Head of Service. Assessment and improvement should then be monitored through inclusion in the HSCP Corporate Risk Register; the NHS Greater Glasgow & Clyde Corporate Risk register and EDC Corporate Risk register, where appropriate. The nature of risks which may need to be escalated include:

- Significant threat to achievement of Council or health plan objectives or targets
- Assessed to be a substantial or intolerable risk
- Widespread beyond local area
- Significant cost of control far beyond the scope of budget holders
- Potential for significant adverse publicity.

VISION – for effective risk management

4. Risk management vision and measures of success

The HSCP Board's vision statement:

> *Appropriate and effective risk management practice will be embedded throughout the HSCP as an enabler of success, whether delivering better outcomes for the people of East Dunbartonshire, protecting the health, safety and well-being of everyone who engages with the HSCP or maximising opportunity, delivering innovation and best value, and increasing performance.*

4.1 In working towards this risk management vision the HSCP Board aims to demonstrate a level of maturity where risk management is embedded and integrated in the decision making.

4.2 Examples of the measures of success for this vision include:

- good financial outcomes for the HSCP Board
- successful delivery of the Strategic Plan
- meeting or exceeding targets outlined in the performance management framework
- successful outcomes from external scrutiny
- effective engagement of service users and carers
- fewer unexpected/ unanticipated problems
- fewer incidents/ accidents/ complaints

RISK - leadership and accountability

5. Governance, roles and responsibilities

5.1 HSCP Board (IJB and Performance Audit and Risk Committee)

Members of the HSCP Board are responsible for:

- oversight of the HSCP's risk management arrangements;
- receipt and review of reports on strategic risks and any key operational risks that require to be brought to the HSCP Board's attention; and

- ensuring Board members are aware of any risks linked to recommendations from the Chief Officer concerning new priorities/ policies and the like.
- Agreeing, with the IJB Chair and Vice Chair, any necessary changes to risk management arrangements in exceptional circumstances.

5.2 Chief Officer

The Chief Officer has overall accountability for the HSCP's risk management arrangements, ensuring that suitable and effective arrangements are in place to manage the risks relating to the functions within the scope of the HSCP.

The Chief Officer will keep the Chief Executives of the HSCP's constituant bodies (EDC and GGC) informed of any significant existing or emerging risks that could seriously impact the HSCP Board's ability to deliver the outcomes of the Strategic Plan or the reputation of the HSCP.

5.3 Chief Finance & Resources Officer

The Chief Finance & Resources Officer will be responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance. The Chief Finance & Resources Officer will also be responsible for financial decisions relating to the IJB's risk management arrangements.

5.4 Senior Management Team

Members of the Senior Management Team are responsiblefor:

- supporting the Chief Officer and Chief Finance & Resources Officer in fulfilling their risk management responsibilities;
- securing risk management support, guidance and training for HSCP staff;
- receipt and review of regular risk reports on strategic, shared and key operational risks and escalating any matters of concern to the Chief Officer and HSCP Board, EDC and NHSGGC; and
- ensuring that the standard procedures set out in section three of this strategy are actively promoted across their teams and within their areas of responsibility.

5.5 Operational Heads of Service

In support of the Senior Management Team the Operational Heads of Service

are responsible for:

- The identification of emerging partnership/operational risks and ongoing assessment and mitigation of these in line with assigned risk ownership.
- Regular review of partnership/operational risks through Heads of Service Group and core governance groups, and provision of regular reports to the wider Senior Management Team via agreed arrangements.
- Identification and escalation of partnership/operatinoal risks to the wider Senior Management Team for consideration and inclusion within the IJB/Corporate Risk Register as appropriate.

5.6 Core Service Governance Groups

Core Groups are in place to ensure the safe and effective delivery of services within the remit of the IJB. They have responsibility for ensuring relevant risks are identified, managed and escalated as appropriate across the following areas:-

- Clinical and Care Governance
- Health and Safety
- Property and Assets
- Information Management and Governance

5.7 Individual Risk Owners

It is the responsibility of each risk owner to ensure that:

- risks assigned to them are analysed in keeping with the agreed risk matrix;
- data on which risk evaluations are based are robust and reliable so far as possible;
- risks are defined clearly to make explicit the scope of the challenge, opportunity or hazard and the consequences that may arise;
- risk is reviewed monthly not only in terms of likelihood and impact of occurrence, but takes account of any changes in context that may affect the risk;
- controls that are in place to manage the risk are proportionate to the context and level of risk.
- Risks are regularly reviewed to ensure linkages are identified and managed from an early stage.

5.8 All persons working within the HSCP

Risk management should be integrated into daily activities with everyone involved in identifying current and potential risks where they work. Individuals have a responsibility to make every effort to be aware of situations which place them or others at risk, report identified hazards and implement safe working practices developed within their service areas.

This approach requires everyone to:

- understand the risks that relate to their roles and activities;
- understand how their actions relate to their own, their patients, services user's and public safety;
- understand their accountability for particular risks and how they can manage them;
- understand the importance of flagging up incidents and/ or near misses to allow lessons to be learned and contribute to ongoing improvement of risk management arrangements; and
- understand that good risk management is a key part of the HSCP culture.

5.9 Partner Organisations

It is the responsibility of relevant specialists from the partner organisations, (such as internal audit, external audit, clinical and non clinical risk managers and health and safety advisers) to attend meetings as necessary to consider the implications of risks and provide relevant advice. It is the responsibility of the partner organisations to ensure partnership working as part of risk management as they routinely seek to identify any residual risks and liabilities they retain in relation to the activities under the direction of the HSCP Board.

5.10 Senior Information Risk Owner

The constituent Bodies, EDC and NHSGGC, will continue to undertake a senior information risk owner role.

RESOURCING - risk management

6. Resourcing the risk management framework

6.1 Much of the work on developing and leading the ongoing implementation of the risk management framework for the HSCP Board will be resourced through the Chief Officer and Senior Management Team.

6.2 The HSCP will continue to secure risk management training/education delivered through resources already available to the HSCP from the EDC and NHSGG&C (risk managers/ risk management specialists).

7. Resourcing those responsible for managing specific risks

7.1 Where risks impact on a specific constituent body and new risk control measures require to be developed and funded, it is expected that the costs will be borne by that body.

7.2 Financial decisions in respect of the HSCP's risk management arrangements will rest with the Chief Finance & Resources Officer.

LEARNING - Training and development

8. Risk management training and development opportunities

8.1 To effectively implement this policy and strategy, it is essential for people to have the competence and capacity for managing risk and handling risk judgements with confidence, to focus on learning from events and past experience in relation to what has worked well or could have been managed better, and to focus on identifying malfunctioning 'systems' rather than people.

8.2 Training is important and is essential in embedding a positive risk management culture across all activities under the direction of the HSCP Board and in developing risk management maturity. The Senior Management Team will regularly review risk management training and development needs of staff and source the relevant training and development opportunities required.

MONITORING - activity and performance

9. Monitoring risk management activity

9.1 The HSCP Board operates in a dynamic and challenging environment. A suitable system is required to ensure risks are monitored for change in context and scoring so that appropriate response is made. This system also needs to be flexible to enable a robust and effective response to exceptional circumstances.

9.2 Monitoring will include review of the HSCP's risk profile at Senior Management Team level.

9.3 The risk register will be reported to the HSCP Board on a six monthly basis, the Performance Audit and Risk Committee at each meeting and/or as individual risks arise that require a HSCP Board response.

9.4 It is expected that constituent bodies will use HSCP Board risk reports to keep their own organisations updated on the management of the risks, highlighting any HSCP risks that might impact on the constituent organisation.

10. Monitoring risk management performance

10.1 Measuring, managing and monitoring risk management performance is key to the effective delivery of key objectives. This will include regular monitoring of (i) the number of risks which materialise (become issues); (ii) the number of risks closed; and (iii) the actual severity of the risks against previous assessments.

10.2 Key risk indicators will be linked where appropriate to specific risks to provide assurance on the performance of certain control measures. For example, specific clinical incident data can provide assurance that risks associated with the delivery of clinical care are controlled, or, monitoring PIs (Performance Indicators) can provide assurance that key financial and other risks are under control.

10.3 The performance data linked to the Strategic Plan will also inform the identification of new risks or highlight where existing risks require more attention.

10.4 Reviewing the HSCP Board's risk management arrangements on a regular basis will also constitute a 'Plan/ Do/ Study/ Act review cycle that will shape future risk management priorities and activities of the HSCP Board, inform subsequent revisions of this Policy and Strategy and drive continuous improvement in risk management across the HSCP.

COMMUNICATING - risk management

11. Communicating, consulting on and reviewing the risk management framework

11.1 Effective communication of risk management information across the HSCP is essential to developing a consistent and effective approach to risk management.

11.2 Copies of this Policy will be widely circulated via the Senior Management Team to Service Managers and will form the basis of any risk management training arranged for staff.

11.3 The Policy will be sbmubmitted to the Performance, Audit and Risk Committee for approval at its meeting of 20th June 2023.

11.4 The Policy will be submitted to the HSCP Board at its meeting of **29th June 2023**.

This Policy will be reviewed regularly to ensure that it reflects current standards and best practice in risk management and fully reflects the HSCP Board's business environment.

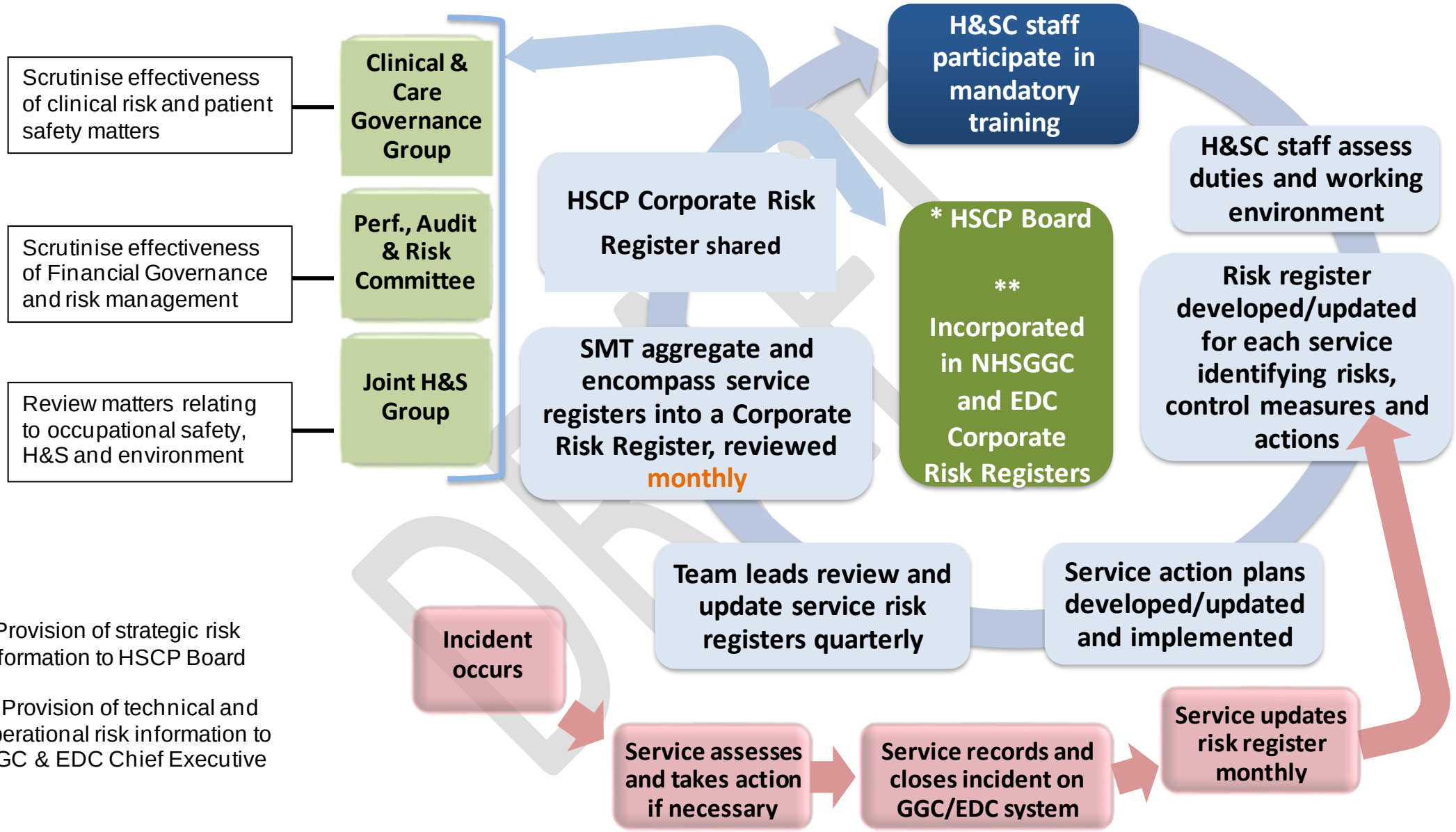
APPENDIX 1 - Risk Matrix

Risk Event	Provides a brief description of the potential risk to the organisation either strategic or operational
Cause	Provides deails of single or multiple causes that could resulti in possible risks
Effect	Describes the impact on the organisation, service user, carers, the public, other services and organisations
Control measure	Details the specific supports/controls/actions that are identified as mitigating/removing potential risk
Residual Likelihood	5X5 Likelihood risk score predicting possible risk occurring prior to implemented action
Residual Impact	5X5 Impact risk score predicting possible risk occurring prior to mitigation action
Priority Ranking	Total score and ranking using a visual Red, Amber, Green (RAG} system. Prior to mitigation action
Strategy for risk	Describes approach to be undertaken e.g. tolerate or treat risk
Action	Agreed specific actions to be implemented to mitigate/remove risk
Acceptable Likelihood	5X5 Likelihood risk score predicting possible risk occurring following implemented action
Acceptable Impact	5X5 Impact risk score predicting possible risk occurring following implemented action
Priority Ranking	Total score and ranking using a visual Red, Amber, Green (RAG} system. Following implemeted action

Example - 5X5 Risk Scoring Matrix

		Impact				
		Trivial	Minor	Moderate	Major	Extreme
Probability	Rare	Low	Low	Low	Medium	Medium
	Unlikely	Low	Low	Medium	Medium	Medium
	Moderate	Low	Medium	Medium	Medium	High
	Likely	Medium	Medium	Medium	High	High
	Very likely	Medium	Medium	High	High	High

APPENDIX 2 - Risk Management Flowchart.



* Provision of strategic risk information to HSCP Board

** Provision of technical and operational risk information to GGC & EDC Chief Executive

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Completed by	**Jean Campbell**	**Date created/ updated**	**Updated May 2023**

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

The Integration Joint Board has adopted the following scoring system which enables risks to be prioritised.

Likelihood (L)		**Consequence (C)**		**Risk (LxC)**	=	**Priority**
Almost certain	5	Extreme	5	20 - 25	=	Priority 1: VERY HIGH
Likely	4	Major	4	12 - 16	=	Priority 2: HIGH
Possible	3	Moderate	3	6 - 10	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

The Boards Shared Risk Register comprises those risks that have been assessed as being high or very high.

Risk Appetite/Tolerance matrix

Likelihood	Consequence /Impact				
	1 - Negligible	2 - Minor	3 - Moderate	4 - Major	5 - Extreme
Almost Certain - 5	5	10	15	20	25
Likely - 4	4	8	12	16	20
Possible - 3	3	6	9	12	15
Unlikely-2	2	4	6	8	10
Rare - 1	1	2	3	4	5

IJB Corporate Risk Register @ 31st May 2023

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Rank (Equals H*I)	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Rank (Equals N*O)	Priority	Risk Lead	Risk Owner
HSCP1	Inability to achieve recurring financial balance	Rising demand for services due to demographics, new legislation, new national policy, changing societal profile due to economic downturn, post covid service demand impacts arising from changed profiles of health and care usage/access during covid 'lockdown' provision and behaviours as well as increasing complexity of demand, increasing public expectations re service provision, public service financial challenges resulting in requirements to make financial efficiencies. Cost of living price increases across in house and commissioned services. SG funding settlements not as expected / non recurring nature of funding.	Reduced ability to maintain service levels leading to service reductions and potential risk of poor service / harm to individuals Cuts to staff in post Reputational risk to the HSCP	Financial	Annual budget setting process undertaken in discussion with finance leads for Council and Health Board. Specific investment from SG to support HSCP strategic objectives and system pressures - ability to set budget for 2023/24 with achievable savings targets. Annual Delivery Plan incoporating dis investment / savings options developed and delivering. Internal Budget controls/Management systems and regular financial meetings with Council and NHS finance leads. Programme of efficiency plans established for coming year.	3	4	**12**	**2**	Treat	Liaison with other Chief Finance Officers network / engagement with SG.Monitoring of delivery of efficiency plans for the coming year through the HSCP Annual Delivery Plan board. Financial recovery plan in place as needed and work with staff and leadership teams to identify areas for further efficiencies / service redesign to be escalated in year. Development of a medium term financial plan to support longer term projections.	2	4	**8**	**3**	Jean Campbell, CFRO	Chief Officer
HSCP2	Failure to deliver adequate levels of Adult Support and Protection training to ensure in-house and commissioned local services have received appropriate support to meet their statutory duties	Insufficient capacity to deliver sufficient levels of training in-house and insufficient funding available to buy in training to meet capacity shortages. Lack of clarity around roles and responsibilities Inadequate training. Inconsistent assessment and application of protection procedures.	Death or harm to Service User. Failure to meet statutory adult support and protection duties. Reputational risk to the HSCP.	Health and Safety	Chief Officers' Group and Adult Protection Committee structure in place and overseeing training delivery. Progressive multi-agency ASP learning and development programme in place: Mandatory Levels 1-3 training delivered by partner agencies, including Level 3 for SW Council Officers and managers responsible for leading statutory investigations and protective interventions. Elective Level 2 multiagency training. Relevant HSCP and partner agency staff, including commissioned services, participate in annual case file audit and improvement task groups.	3	4	**12**	**2**	Treat	Business case developed to in-source ASP training through recruitment of additional social work capacity creating more capacity at the same cost as current arrangements. Requires consideration by Council through HR processes.Recurring funding identified.	2	4	**8**	**3**	David Aitken, Head of Adult Services	Protection Chief Officers' Group
HSCP3	Failure to comply with General Data Protection Regulations - loss of sensitive personal data (this risk and mitigation relates to personal data held which is the data controller responsibility of NHS GG&C or ED Council)	Structural changes require new and more sophisticated forms of data management. Lack of understanding and awareness of Data Protection legislation Increasing demand and competing priorities cause workers to have decreased awareness and lessened regard for Information Security. Inadequate training for staff and use of technologies.	Breach of Information management legislation. Harm or reputational risk to individuals whose data is lost or inappropriately shared. Financial penalty Increased external scrutiny Reputational damage to NHS GG&C, ED Council or the HSCP Litigation	Data Protection	Professional Codes of Practice Procedures are in place on all sites for use/release of data. Monitoring of Information Governance Standards and agencies' Security Policy, Caldicott Guardian responsibilities, NHSGGC-wide Information Governance Steering Group. Information Sharing Protocol (endorsed by the Information Commissioner) in place for HSCP. An on-going programme of awareness and training will continue. Policies updated to reflect GDPR and new e-mail policies in place to meet government's secure email standards. All laptops (now including University equipment) encrypted. Extended use of electronic records. A programme of work re the systematic audit of access to electronic records is being extended beyond the Emergency Care Summary. Access to health records is controlled via a role based access protocol signed off by senior clinicians and the Caldicott Guardian.	3	3	**9**	**3**	Treat	SMT implements and reviews governance arrangements to comply with legislative requirements. Action plan in place to manage staff's adherence to GDPR including Information Asset register and Information Management Liaison Officer (IMLO) role. Digital GDPR training now mandatory for staff with network access.	2	3	**6**	**3**	Vandrew McLean, HSCP Corproate Business Manager	Chief Officer
HSCP4	Failure to comply with General Data Protection Regulations - failure to destroy records in line with schedule of destruction dates	Lack of understanding and awareness of Data Protection legislation, increasing demand and competing priorities cause workers to have decreased capapxcity and lesser regard for record destruction requirements. Volume of information assets / records is significant and duplicated across shared drive. Classification of records is cumbersome and clunky and difficult to understand.	Breach of Information management legislation. Financial penalty Increased external scrutiny Reputational damage to NHS GG&C, ED Council or the HSCP Litigation	Data Protection	A programme of work to catalogue, assign destruction dates to, and destroy records has been developed. This is implemented as/when staff capacity allows. IMLO reports to SMT on status of work. Delays in delivery due to Covid which has compounded position. Record Management Plan in place for HSCP with actions for continuous improvement.	4	2	**8**	**3**	Treat	New retention and destruction protocols for social work records (integrating paper and electronic records) being rolled out. Review of staffing position to prioritise task as we move through recovery phase. Review of file classification and rationalisation of number of information assets underway.	2	2	**4**	**4**	Vandrew McLean, HSCP Corproate Business Manager	Chief Officer
HSCP 5	Failure in service delivery through failure of business continuty arrangements in the event of a civil contingency level event	Poor/ineffective Civil contingencies planning, Lack of suitably trained resource, Disjointed partnership working.	Reputational damage Legislative requirements not being complied with. Disruption to services. Loss of life or injury to public and or staff across the HSCP. We do not fully meet the requirements of the Civil Contingency (Scotland) act 2005.	Business Continuity	Regular testing and updating of emergency plans (multi-agency response) and Business Continuity Plans; Comprehensive plans for a Pandemic outbreak.	2	5	**10**	**3**	Tolerate	Business Continuity plans. Multi agency working. Compliance with national alerts. Civil contingency. Prevent training. Winter planning. Covid-19 specific business continuity approach with transition and recovery / remobilisation planning at service and overarching levels, regularly refreshed. Development of a plan to support power supply restrictions and power blackout.	2	5	**10**	**3**	Alan Cairns, Planning, Performance & Quality Management Manager	Chief Officer
HSCP 6	Failure to secure effective and sufficient support services from NHS GG&C and EDC to plan, monitor, commission, oversee and review services as required including functions delivered by business support services.	Limited resources across NHS GG&C and ED Council to manage increasing demands and competing priorities HSCP reliance on NHS GG&C and ED Council IT infrastructure and systems. Frequency of change demands for CareFirst and NHS GG&C systems such as EMIS high and outwith our control, arrising from new reporting requirements and changing legal/policy etc underpinning requirements.	Failure to effectively and securely store and retrieve records - case management systems become outdated Inability to effectively and timeously share information Inability to be effective in electronic management and communication (e.g. arranging meetings) Inability to meet statutory reporting requirements. Inability to deliver Commissioning Strategy.	Service Delivery	Engaged in Board wide process to ensure proportionate allocation. Chief Officer attend constituent body CMT / SMT meetings.	3	3	**9**	**3**	Tolerate	Ongoign collaborative work with NHS GG&C and ED Council to share understanding of support requirements and reach agreement as to how this is delivered	3	3	**9**	**3**	Jean Campbell, CFRO	Chief Officer
HSCP 7	Inability to recruit and retain the appropriate numbers of trained staff to meet requirements resulting in reduction in service or failure to meet statutory duties. Specific workforce pressure areas are Mental Health Officers, qualified Social Workers, Personal Carers, Health Visitors, Psychologists and General Practitioners (independent contractors).	Risk reflects national and local workforce pressures. The reduction in numbers of registered staff in post. Ageing workforce able to retire, limited numbers of staff in training to take up post requiring a secondary qualification, lack of remuneration for specialist qualifications (MHOs) leading to inability to retain staff after training. Local pay and grading comparable to other areas, low rates of pay for care at home staff with year on year increases limited to SLW increases. High caseloads within health visiting service compared to other areas across GG&C. National shortage of social care workforce. National recruitment and retention challenges in relation to GPs.	Failure to accurately assess and respond to risk. Unable to provide/arrange care services Inability to meet statutory requirements/duties Service is reduced or reliance on agency cover at premium cost. Fragmented services, increased complaints, service user detriment,reputational damage. Inability to support the shift in the balance of care between secondary and primary care. Inability to support the transformational change agenda in relation to GMS contract, unscheduled care. Poorer patient/service user outcomes. Reduction / consolidation in the number of steps within the health visiting pathway.	Service Delivery	Local workforce plan in place. Vacancy management process in place. Business case developed for MHO remuneration. Work with Chief Nurse to raise concerns corporately and nationally re community nursing and health visiting workforce and make ongoing representation for funding allocation to East Dunbartonshire. Progress innovative methods for recrutiment of staff across the HSCP but particularly promoting a rolling programme of recruitment for care at home staff. Increase staff supervision, prioritise high risk / complex cases. Support national converation re GP recruitment and retention.	4	3	**12**	**2**	Treat	Develop workforce plan for 2022-2025 in line with HSCP Strategic Plan. Revised recruitment protocol in place to support SMT overview of workforce issues. Funding from SG to support additional social work and mental health officer workforce capacity to be progressed and implemented. Review options for 'market forces' review of pay and grading. Further amalgamate health visiting contacts, consider skill mix where appropriate and other mechanisms for delivery of services.	3	3	**9**	**3**	HOS	Chief Officer
HSCP 8	Failure of external care providers to maintain delivery of services particularly related to care home and care at home provision.	Uncontrollable market forces (recruitment /retention, brexit, increasing cost pressures associated with living wage an wider cost of living crisis, capacity implications due to Scottish Living Wage (SLW) / benefit cap), Increasing Care Inspectorate /Public Health demands.	Service continuity disrupted / ceases. Home /accommodation at risk, large scale / volume reprovisioning required in event of care home closure, impact on any other local related homes. Reduction in available capacity across care at home sector to meet current / future demand. Fragmented services. Increased risk of assessed needs not being met service user detriment through lack of servcies or timely intervention. Unable to meet statutory requirements & duty service user detriment through lack of services or timely intervention. Increased complaints Reputational risk to the HSCP	Service Delivery	Contract Management Framework Enhanced Risk Assessment (RAG's) / monitoring & oversight of Care Home sector regular checks / audits of Business Continuity Plans Assurance Visits Established Care Home sector lead to help support oversight arrangements CI Regulation/Inspection framework SXL team - providing national oversight of providers , Strategic Commissioning Officer post / dedicated support to care homes / care home support team	3	4	**12**	**2**	Treat	Enhanced support and monitoring across care home services, daily /weekly checks via Turas, RAC rating, Provider Forums, dedicated Officer support. Established Sector Lead, Weekly oversight via ORG, early notification alerts via SXL & Network groups, process for review of provider sustainability and adequacy of rates for service delivery.	2	4	**8**	**3**	Derrick Pearce, Head of Health & Community Care	Chief Officer
HSCP 9	Risk of failure to achieving transformational change and service redesign plans within necessary timescales	Lack of capacity within HSCP services and those supporting transformational change to deliver full change programme. Options for delivering transformation diminishing without significant impact on levels of service delivery.	Significantly negative impact on ability to delivery medium to long term organisational outcomes as per the Strategic Plan. Inability to achieve financial balance.	Service Delivery	Development and scrutiny of annual delivery plans including actions for investment / dis investment. HSCP Delivery Plan Board oversees progress. Annual Business Plan in place. Performance reporting framework established to support tracking of progress. Support through Council and NHS transformation teams to progress priorities.	3	4	**12**	**2**	Treat	Early collaborative planning with ED Council and NHS GG&C re support requirements. Work through staff and leadership teams to identify further efficiency and redesign options to bring forward in year.	2	4	**8**	**3**	Jean Campbell, CFRO	Chief Officer
HSCP 10	Failure to deliver on actions to support the implementation of the Un-scheduled Care Commissioning Plan and inability to support early, effective discharge from hospital	Lack of recurring funding to deliver on key actions. Increasing absence / recruitment difficulties across SW workforce to undertake assessments for those within a hospital setting, increasing number of admissions placing increasing demands on discharge planning, capacity and ability of care homes to take individuals pressure on care at homes services to support individuals to remain safely at home. Demands for complex care at home packages outstrips ability to supply through in house / commissioned providers. AWI legislation impacts ability to move individuals and those exercising choice and awaiting preferred care home.	Unscheduled care plan supports reduction in bed day usage and delayed discharges, therefore no improved performance would be seen in this area. Individuals remain inapropriately placed within an acute bed, reduces capacity within hospitals to manage increasing volume of admissions due to coranavirus, individuals health and reahbilitation opportunities decline placing further pressure on statutory services into the future.	Service Delivery	Idenitification of non recurring funding streams. Staff re-directed to hospital assessment team to ensure sufficient assessment function to meet demand, working closely with care providers to determine real time capacity to support discharge, commission additional care home places to meet demand, monitoring absence and enhancing capacity within care at home services to support discharge home.	4	4	**16**	**2**	Treat	Consider as part of financial planning consideration / budget process - consider virement / prioritisation and re direction of funding to support this area. Representation to SG to financially support agenda through transitional funding. Review further options for increasing capacity within care home provision and care at home through recruitment drive and further re-direction of staff. Additional investment through Adult Winter Planning funding to increase capacity across the HSCP in direct care services to support early and effective discharge.	3	4	**12**	**2**	Derrick Pearce, Head of Health & Community Care	Chief Officer
HSCP 11	Failure of some or all of General Practice to deliver core services.	Demand levels rise above available capacity within existing General Practice(s) or staffing levels fall below a level where General Practice(s) can safely operate to deliver urgent and/or vital services. Failure to retain / recruit GPs. Increased workload created to longer waiting times for specialist assessment / intervention in acute sector leading to increased numbers of enquiries and complex consultations within the community.	Local population no longer able to access appropriate safe level of medical and nursing care within their usual General Practice setting and delay in access to specialist level assessment and treatment. Potential increase in all cause morbidity and mortality and increase reliance on acute sector at a time when they are already likely to be overwhelmed.	Service Delivery	Escalation offering limited practice level flexibility to non urgent work streams with further escalation guidance in place if required. Strengthening of Business Contingency Plans by each East Dunbartonshire Practice, with confirmed 'Buddy' arrangements. Discussion and agreement on General Practice consolidation at cluster level and HSCP level 4 planning around potential single point of GP level care. Pathway in place for practices to seek support via buddy practice, cluster group or wider HSCP if required.	2	4	**8**	**3**	Treat	In addition, HSCP taking a proactive approach to liaising with local practices to offer early support with redeployment of staff or assisting buddying arrangements including the redeployment of HSCP PCIP staff where possible.	2	3	**6**	**3**	Derrick Pearce, Head of Health & Community Care	Clinical Director
HSCP 12	Failure to deliver the MOU commitments within the Primary Care Improvement Plan	Lack of adequate funding to support full delivery of the core MOU commitments, inability to recruit the required staff, lack of accommodation to support additional staffing. Cost of Vaccination Programme(VTP) greater than funding allocation available.	Failure to deliver contractual requirements, financial implications to meet contract defaults- in the form of transitionary payments, continued pressure on GPs to deliver non specialist functions identified to be met through other professional staff groups.	Service Delivery	Prioritisation of MOU commitments, maximise use of reserves to meet commitments where apropriate and non recurring, accommodation strategy to expand space capacity.	3	4	**12**	**2**	Treat	Representation to SG for funding to support full extent of MOU commitments.	2	4	**8**	**3**	Derrick Pearce, Head of Health & Community Care	Chief Officer

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 10.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20th JUNE 2023**
REPORT REFERENCE:	**PERF/200623/10**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER, TELEPHONE NUMBER, 0141 232 8216**
SUBJECT TITLE:	**HSCP DIRECTIONS LOG UPDATE**

1.0 PURPOSE

1.1 The purpose of this report is to update the Performance, Audit & Risk Committee on the status of HSCP Integrated Joint Board Directions which are recorded and issued to East Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit and Risk Committee:

2.1 Note the content of the Report.
2.2 Note the report will be remitted to the IJB.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 Directions are the mechanism by which the IJB signals to the Health Board and Local Authority the details of how the objectives of its Strategic Plan, and any other strategic decisions taken during the lifetime of the plan, are to be delivered.

3.2 The use of Directions is a legal requirement for IJB's, Health Board and Local Authorities and as such their use is subject to internal/external audit and scrutiny.

3.3 Each IJB report which has an accompanying Direction is submitted through each IJB cycle for consideration noting the Direction to be issued, revised, superseded or revoked.

3.5 The Directions Log is updated and maintained by the Corporate Business Manager.

3.6 A process to ensure all directions are reviewed and updated on the Directions Log has been introduced, following review by Internal Audit as part of HSCP governance processes. The recommendation was that to comply with statutory guidance that Directions are regularly reviewed with a robust follow up and review process.

3.7 The Directions Log is taken to the Senior Management Team meeting for regular review, highlighting impending review dates and asking for an update on the progress of the Direction the most recent review at SMT being 26th April 2023.

3.8 An update on the Directions Log will be brought to the Performance. Audit & Risk Committee and HSCP IJB on a twice yearly basis.

3.9 **Appendix 1** details the Directions Log for 2021, 2022 and 2023 IJB cycles.

3.10 There was a total of 18 Directions issued for 2021, the status of the Directions are noted as being:

Current	5
Complete	6
Superseded	7
Revoked	0

3.11 There was a total of 11 Directions issued for 2022, the status of the Directions are noted as being:

Current	3
Complete	1
Superseded	7
Revoked	0

3.12 There have been 6 Directions issued across the two IJB meetings held so far in 2023 (January and March 2023), the status of the Directions are noted as being:

Current	5

Complete	0
Superseded	1
Revoked	0

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022-2025 Priorities;-

8. Maximising Operational Integration

4.2 Frontline Service to Customers – None.

4.3 Workforce (including any significant resource implications) – None.

4.4 Legal Implications – The Public Bodies (Joint Working) (Scotland) Act 2014 required the IJB to issue Directions in writing. Directions must set out how each integrated health and social care function is to be exercised and the budget associated with that function.

4.5 Financial Implications – The IJB have statutory responsibility for the delivery of transformational service delivery within budget allocations.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – The Strategic Plan acknowledges that some individuals, or groups of individuals may face difficulties in accessing services and he Plan identifies some additional supports to address this issue. Directions issued by the IJB are likely to be instrumental in improving access to services.

4.10 Sustainability – None.

4.11 Other – None.

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The Strategic Plan and the IJB Risk Register identify risk factors which have an impact on a range of financial, governance, capacity and partnership issues. Directions from the IJB form part of the ongoing risk mitigation and management processes.

6.0 IMPACT

6.1 **STATUTORY DUTY** – The HSCP have a statutory duty to record and issue Directions to East Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The Council must comply with a Direction from the Integration Joint Board.

6.3 **NHS GREATER GLASGOW & CLYDE** - The Health Board must comply with a Direction from the Integration Joint Board.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction required.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** – East Dunbartonshire HSCP Directions Log as at 23.05.23

Update: 23.05.23

Reference no.	Report Title	Direction to	Full Text	Functions Covered by Direction	Budget Allocated by IJB to carry out direction(s)	Date Issued	With Effect From	Review Date	Current	Does this supersede, revise or revoke a previous Direction	Direction Reference supersended, revised or revoked	Link to IJB paper	Link to New Direction	Responsible Officer	Service Area	Comments	Most Recent Review (Date)
190123-05	Older People's Social Support Strategy	East Dunbartonshire Council only	The IJB herby directs East Dunbartonshire Council to: • Progress the activities associated with enacting the preferred delivery option for centre based day services and social support for older people. • Support the preferred option and its associated activities as determined by the Service Review carried out by the Older People's Day Care Delivery Group.	• Centre based day care for older people • Centre based day care for older people from BAME communities • Alternatives to day care social support • Older People Local Area Co-ordination • Human Resources • Strategic Commissioning	The total budget relating to older people's social support in 2022/23 is £1,568,423	19.01.2023	19.01.2023	Jan-24	Current	Yes	300622-04	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Chief Officer	Community Health and Care Services		19.01.2023
190123-11	Financial Performance Budget	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2022 - 25, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1	Budget 2022/23 – all functions set out within Appendix 2.	The budget delegated to NHS Greater Glasgow and Clyde is £137.450m and East Dunbartonshire Council is £71.555m as per this report.	19.01.2023	19.01.2023	23.03.2023	Superseded	Yes	171122-12 Superseded by 2	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Chief Officer	Finance and Resources		19.01.2023
230323-06	HSCP Financial Planning & Annual Budget Setting 2023/24	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council is directed to spend the delegated net budget of £73.226m in line with the Strategic Plan and the budget outlined within this report. NHS Greater Glasgow and Clyde is directed to spend the delegated net budget of £156.997m (incl. £38.382m related to set aside) in line with the Strategic Plan and the budget outlined within this report.	Budget 2023/24 – all functions set out within Appendix 7.	The budget delegated to NHS Greater Glasgow and Clyde is £156.997m and East Dunbartonshire Council is £73.226m as per this report.	23.03.23	01.04.23	May-23	Current	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Chief Officer	Finance and Resources		23.03.23
230323-07	HSCP Annual Delivery Plan 2023-24	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The Integration Joint Board directs partners to support the agreed areas of development as set out in the HSCP Annual Delivery Plan 2023-24. The Annual Delivery Plan draws together the strategic development priorities for the year, informed by the Strategic Plan's development priorities, the NHS Moving Forward Together Strategic Plan, the priorities of East Dunbartonshire Council as set out in the Community Planning Partnership's Local Outcome Improvement Plans, new statute and policy drivers, and identified areas for transformation change and our savings requirements. The Annual Delivery Plan is attached as appendix 1 to the cover report.	HSCP Annual Delivery Plan 2023-24: The business planning intentions of the HSCP Board for the period 2023-24 in pursuance of the implementation of the current Strategic Plan which covers all delegated functions of the IJB.	The funding implications, both spend and disinvestment, are set out within the body of the Annual Delivery Plan which is attached as appendix 1 to the cover report.	23.03.23	01.04.23	31.03.24	Current	Yes	240422-06	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Chief Officer	Finance and Resources		23.03.23
230323-10	Carers Strategy	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The IJB hereby directs East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board to: • Support the continuation of the existing Carers Strategy 2019-22 until completion of the new Carers Strategy 2023-26, which will be presented for IJB approval in June 2023.	Implementation of the Carers' (Scotland) Act 2016	The total budget relating to carer short break services and core funding of Carers Link in 2022/23 is £808,099	23.03.23	23.03.23	Jun-23	Current	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Chief Officer	EDHSCP		23.03.23
230323-11	Financial Performance Budget 2022/23 – Month 10	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2022 - 25, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1	Budget 2022/23 – all functions set out within Appendix 2.	The budget delegated to NHS Greater Glasgow and Clyde is £138.414m and East Dunbartonshire Council is £71.907m as per this report.	23.03.23	23.03.23	Reviewed for IJB – budget 2022/23 monitoring report will supersede this direction planned for 15th June 2023.	Current	Yes	190123 -11	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Chief Officer			23.03.23

Update: **23.05.23**

Reference no.	Report Title	Direction to	Full Text	Functions Covered by Direction	Budget Allocated by IJB to carry out direction(s)	Date Issued	With Effect From	Review Date	Current	Does this supersede, revise or revoke a previous Direction	Direction Reference supersedes, revised or revoked	Link to IJB paper	Link to New Direction	Responsible Officer	Service Area	Comments	Most Recent Review (Date)
200122-09	Financial Performance Budget 2021/22 – Month 8	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2018-22, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2021/22 – all functions set out within Appendix 4	The budget delegated to NHS Greater Glasgow and Clyde is £137.696m and East Dunbartonshire Council is £51.487m as per this report.	20.01.22	20.01.22	Complete – Budget 2021/22 monitoring report will supersede this direction planned for March 2022.	Superseded	Yes	181121-11	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	N/A	20.01.22
240322-04	Unscheduled Care Commissioning Plan (Design & Delivery Plan 2022/23 – 2024/25)	NHS Greater Glasgow and Clyde only	NHS Greater Glasgow and Clyde is directed to design and deliver the integrated system of care for health and social care services that includes the strategic commissioning intentions for acute hospital services, as outlined within this report and appendix.	All functions as they relate to the delivery of services related to the commissioning strategy for unscheduled care, and are outlined with the appendix attached to this report.	Should be implemented as outlined in the financial framework developed to support implementation of the plan.	24.03.22	24.03.22	31.03.23 *see comment	Current	No		Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Community Health and Care Services	Report will come to IJB cycle in September 2023.	26.04.22
240322-05	HSCP Strategic Plan 2022-25	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	Integration Authorities require a mechanism to action their strategic plans and this is laid out in sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act. This mechanism takes the form of binding directions from the Integration Authority to both of the Health Board and Local Authority. The Integration Joint Board directs partners to support the agreed areas of development as set out in the HSCP Strategic Plan 2022-25.	All delegated functions as set out in the current East Dunbartonshire Integration Scheme	The budget allocated to the HSCP Strategic Plan 2022-25 is notionally set out in the medium term financial plan and will be specified in more detail annually as the total HSCP budget for each of the years 2022 to 2025, to be detailed at the time of the budget setting process and as approved by the HSCP Board, which for 2022-23 will be £198.122m.	24.03.22	01.04.22	The HSCP Strategic Plan 2022-25 will be expected to operate for the full duration of its three year life-span, however this direction will be reviewed at least annually in line with the budget setting exercise.	Current	No	Previous Strategic Plan preceded revised Directions procedures)	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	East Dunbartonshire HSCP wide services	N/A	26.04.22
240322-06	HSCP Annual Delivery Plan 2022-23	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The Integration Joint Board directs partners to support the agreed areas of development as set out in the HSCP Annual Delivery Plan 2022-23. The Annual Delivery Plan draws together the strategic development priorities for the year, informed by the Strategic Plan's development priorities, the NHS Moving Forward Together Strategic Plan, the priorities of East Dunbartonshire Council as set out in the Community Planning Partnership's Local Outcome Improvement Plans, new statute and policy drivers, and identified areas for transformation change and our savings requirements. The Annual Delivery Plan is attached as appendix 1 to the cover report.	HSCP Annual Delivery Plan 2022-23: The business planning intentions of the HSCP Board for the period 2021-22 in pursuance of the implementation of the current Strategic Plan which covers all delegated functions of the IJB.	The funding implications, both spend and disinvestment, are set out within the body of the Annual Delivery Plan which is attached as appendix 1 to the cover report.	24.03.22	01.04.22	31.03.23	Superseded	Yes	Yes (reference number: 240621-17) Superseded by 230323-07	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	East Dunbartonshire HSCP wide services	N/A	23.03.23
240322-08	Financial Performance Budget 2021/22 – Month 10	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2018-22, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2021/22 – all functions set out within Appendix 2.	The budget delegated to NHS Greater Glasgow and Clyde is £137.858m and East Dunbartonshire Council is £62.658m as per this report.	24.03.22	24.03.22	Complete – Budget 2021/22 monitoring report will supersede this direction planned for June 2022.	Superseded	Yes	Yes supersedes 200122-09	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	N/A	30.06.22
240322-09	HSCP Financial Planning & Annual Budget Setting 2022/23	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council is directed to spend the delegated net budget of £70.640m in line with the Strategic Plan and the budget outlined within this report. NHS Greater Glasgow and Clyde is directed to spend the delegated net budget of £128.394m (incl. £38.514 related to set aside) in line with the Strategic Plan and the budget outlined within this report.	Budget 2022/23 – all functions set out within Appendix 6.	The budget delegated to NHS Greater Glasgow and Clyde is £128.394m and East Dunbartonshire Council is £70.640m as per this report.	24.03.22	01.04.22	15.09.22	Superseded	No	No	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	Will be superseded by Financial Monitoring report 22/23 - Mth 3 to Sept 22 IJB	24.03.22
300622-04	Older People's Social Support Strategy	East Dunbartonshire Council	The IJB herby directs East Dunbartonshire Council to: • support the undertaking of a strategic service review and options appraisal of centre based day services and social support for older people, to determine the most efficient, cost effective and needs-led delivery model in line with the strategic vision set out on the approved Older people Social Support Strategy; • support the undertaking of statutory consultation on the strategic vision set out in the approved Older People's Social Support Strategy with key partners and the public; • support the development of any appropriate commissioning or service development plans for further consolation but the IJB in line with the strategic service review and options appraisal described above.	• Centre based day care for older people • Centre based day care for older people from BAME communities • Alternatives to day care social support • Older People Local Area Co-ordination • Public, Service User and Carer Engagement • Strategic Commissioning	The total budget relating to older people's social support in 2022/22 is £1,506,436.	30.06.22	30.06.22	01/11/2022. Update going to 19.01.23 IJB	Superseded	No	No	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Community Health and Care Services		30.06.22
300622-10	Financial Performance Budget 2021/22 – Month 12 (Year End Outturn)	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2018-22, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2021/22 – all functions set out within Appendix 2.	The budget delegated to NHS Greater Glasgow and Clyde is £149.959m and East Dunbartonshire Council is £62.753m as per this report.	30.06.22	30.06.22	Complete – Budget 2022/23 monitoring report will supersede this direction planned for September 2022.	Completed	Yes	240322-08	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources		30.06.22
150922-09	Financial Performance Budget 2022/23 – Month 3	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2022 -25, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2022/23 – all functions set out within Appendix 2	The budget delegated to NHS Greater Glasgow and Clyde is £128.520m and East Dunbartonshire Council is £71.517m as per this report.	15.09.22	15.09.22	Reviewed for IJB - budget 2022/23 monitoring report will supersede this direction planned for 17th November 2022.	Superseded	Yes	Yes supersedes 240322-09	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Chief Officer	Finance and Resources	Reviewed for IJB - budget 2022/23 monitoring report will supersede this direction planned for 17th November 2022.	15.09.22
171122-06	Carers Strategy 2023-2026	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	Direction to agree and support communication and engagement process as they relate to the Carers Strategy 2023-26 based upon the 'Initial Summary Report' and 'Communication, Engagement & Participation Plan'.	Corporate Communication and Engagement services	N/A	17.11.22	17.11.22	31.03.23 *see comment	Current	Yes	Yes supersedes 160921-07	See East Dunbartonshire Health and Social Care Partnership Board	East Dunbartonshire Council	Caroline Sinclair, Chief Officer	EDHSCP	Carers Strategy is being tabled at the 29.06.23 IJB cycle	17.11.22
171122-12	Financial Performance Budget 2022/23 – Month 6	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2022 -25, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2022/23 – all functions set out within Appendix 3.	The budget delegated to NHS Greater Glasgow and Clyde is £130.836m and East Dunbartonshire Council is £71.555m as per this report.	17.11.22	17.11.22	19.01.23	Superseded	Yes	Yes supersedes 150922-09	See East Dunbartonshire Health and Social Care Partnership Board / See Dunbartonshire Council	East Dunbartonshire Council	Caroline Sinclair, Chief Officer	Finance and Resources		17.11.22

Reference no.	Report Title	Direction to	Full Text	Functions Covered by Direction	Budget Allocated by IJB to carry out direction(s)	Date Issued	With Effect From	Review Date	Current	Does this supersede, revise or revoke a previous Direction	Direction Reference superseded, revised or revoked	Link to IJB paper	Link to New Direction	Responsible Officer	Service Area	Comments	Most Recent Review (Date)
250321-04	Alcohol and Drug Partnership (ADP) Strategy and Delivery Plan 2020/2023	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire IJB directs NHS Greater Glasgow and Clyde, and East Dunbartonshire Council to agree the delivery of the ADP Strategy and Delivery Plan in accordance with the identified funding; Sections 2 and 3 of the attached report, to achieve the Priorities and Outcomes identified within Section 4 of the	Alcohol and Drug Partnership, East Dunbartonshire Alcohol and Drug Recovery Service.	Funding for the implementation of the East Dunbartonshire ADP Strategy and Delivery Plan is provided centrally by Scottish Government.	25.03.21	25.03.21	31.03.23 (see comment)	Current	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Alcohol and Drug Partnership	The ADP report will be updated in next cycle of IJB which is September 2023 as part of the national reporting update, which has changed in format causing the delay.	26.04.23
250321-08	Financial Performance Budget 2020/21 – Month 10	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2018-21, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2020/21 – all functions set out within Appendix 3.	The budget delegated to NHS Greater Glasgow and Clyde is £137.370m and East Dunbartonshire Council is £57.436m as per this report.	25.03.21	25.03.21	31.04.21	Superseded	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	N/A	25.03.21
250321-09	Financial Planning and Budget Setting 2021/22	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council is directed to spend the delegated net budget of £58.401m in line with the Strategic Plan and the budget outlined within this report. NHS Greater Glasgow and Clyde is directed to spend the delegated net budget of £118.390 (incl. £33.712 related to set aside) in line with the Strategic Plan and the budget outlined within this report.	Budget 2021/22 – all functions set out within Appendix 6.	The budget delegated to NHS Greater Glasgow and Clyde is £118.194 and East Dunbartonshire Council is £58.401 as per this report.	25.03.21	01.04.21	01.05.21	Superseded	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	Superceded by Financial Monitoring report - Mth 4 in Sept 2021	01 September 2021
240621-05	Transforming School Nursing Roles	NHS Greater Glasgow and Clyde	NHSGGC are directed to progress the recruitment and training of staff for the School Health Team utilising financial investment from the Scottish Government	Children and Families Health Teams.	The total financial investment at end point will be £218,054 with a recurring budget of £362,000.	24.06.21	24.06.21	01.09.21	Completed	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Children and Families	N/A	31.05.22
240621-06	Adult Community Nursing Service Development	NHS Greater Glasgow and Clyde	NHSGGC are directed to progress the recruitment and training of District Nurse Advance Nurse Practitioners.	Adult Community Nursing Team	The total financial investment at end point will be £782,916 with a recurring budget of £251,571	24.06.21	24.06.21	31.03.22	Completed	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Adult Nursing Services	N/A	31.05.22
240621-07	Strategic Review of Social Supports for Older People	East Dunbartonshire Council	East Dunbartonshire Council is directed to determine an appropiate interim commissioning solution to secure the delivery of centre cased day care for older people in the East and West of East Dunbartonshire in 2022/23 and 2023/24.	Formal and Informal Social Supports and Day Care for Older People.	£1m for 21/22 related to uncommitted budgets for day centre provision (excludes Milan Daycare and customers who have chosen other options out with day centre for which these funds are committed to support these other forms of social support)	24.06.21	24.06.21	24.06.22	Superseded	No	N/A	Need link to published paper on on the HSCP webpage	Superseded by 300822-04	Caroline Sinclair, Interim Chief Officer	Community Health and Care Services	IJB paper on 30.06.22	24.06.21
240621-10	Support for Care Homes	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHSGGC are directed to progress the recruitment of additional staff for the Care Home Support Team utilising COVID-19 funding in 2021-22. EDC and NHSGGC are further directed to support the efforts of the HSCP to identify and implement a future financial framework to ensure the sustainability of this team.	Residential Care for Older People, Residential Care for Adults with Disability, Older Peoples Social Work, Adult Community Nursing, Planning and Service Development Team.	A financial envelope of £234,274 is required to deliver this service to be funded from COVID-19 funding in 2021-22. Thereafter if funding is not recurring a recommendation may be brought to forward to the board for a permanent virement from another budget area.	24.06.21	24.06.21	01.09.21	Completed	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Community Health and Care Services	Directions Actions completed by both bodies	28.04.22
240621-11	Mental Health and Alcohol and Drugs Needs Assessment	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The Integration Joint Board is asked to note the contents of the reports and approve the East Dunbartonshire Mental Health and Alcohol and Drug Needs Assessment as the underpinning framework to initiate and support the review and redesign of mental health and alcohol and drug services.	Alcohol and Drug Partnership, Alcohol and Drug Recovery Service, Mental Health Teams and Commissioned Services under mental health and alcohol and drugs.	The direction is to improve the Needs Assessment as the framework to initiate and support the review and redesign of commissioned mental health and alcohol and drug services. No direction at this time in respect of budget allocation as not directing funds to service delivery at this point prior to review being undertaken.	24.06.21	24.06.21	2023 (see comment)	Current	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Alcohol and Drug Partnership, Alcohol and Drug Recovery Service, Mental Health Teams and Commissioned Services	The ADP report will be updated in next cycle of IJB which is September 2023 as part of the national reporting update, which has changed in format causing the delay.	26.04.23
240621-12	Self Directed Support (SDS) Implementation Plan 2021-2024	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire IJB directs NHS Greater Glasgow and Clyde, and East Dunbartonshire Council to implement delivery of the Self Directed Support Implementation Plan 2021-2024 to achieve the priorities and outcomes identified within	Provision of Self Directed Support	No direction in terms of budget allocation which is provided in accordance with assessed need from core funding.	24.06.21	24.06.21	Prior to conclusion of plan in 2024	Current	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Adult Services	N/A	24.06.21
240621-13	Primary Care Improvement Plan Report – May 2021	NHS Greater Glasgow and Clyde	It is recommended that HSCP Board members; Note progress against the key commitments in the new General Medical Services GMS contract and Memorandum of Understanding (MOU) and Note the remaining challenges in terms of overall affordability, workforce and premises.	This report provides an update to the Health and Social Care Partnership Board on the East Dunbartonshire Primary Care Improvement Plan (PCIP) Implementation Tracker (in draft).	Funding for 2021/2022 - £2.817k Estimated Full Year Spend - £2.828k	24.06.21	24.06.21	Bi-annually	Completed	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Community Health and Care Services	Complete. Will be a new direction on PCIP Tracker 5 to June 2022 IJB	28.04.22
240621-15	Financial Performance Budget 2020/21 – Month 12 (Year End)	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2018-21, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2020/21 – all functions set out within Appendix 2.	The budget delegated to NHS Greater Glasgow and Clyde is £144.872m and East Dunbartonshire Council is £57.719m as per this report.	24.06.21	24.06.21	Complete – Budget 2021/22 monitoring will supersede this direction	Completed	Yes	250321-08	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	Complete - Draft Accounts presented to IJB in June 2021 and final accounts signed off through PAR Committee in Sept 2021. Budget monitoring for the new financial year reported to the IJB from September 2021.	08.06.22
240621-16	HSCP Medium Term Financial Strategy 2022 – 2027	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The Integration Scheme requires East Dunbartonshire Council and NHS Greater Glasgow and Clyde to consider draft budget proposals based on the Strategic Plan as part of their annual budget setting processes. Both Partners are requested to consider this Medium Term Financial Strategy as part of their annual budget process for the period 2022 – 2027 and work with the HSCP to address the financial challenges set out.	All functions as outlined in the Medium Term Financial Strategy (MTFS) and delegated to the IJB.	The budget for the period is predicated on the financial assumptions set out within the Medium Term Financial Strategy and the actions identified to meet these financial challenges.	24.06.21	24.06.21	June 2022 following the annual budget process for 2022/23 and the assumptions revised in line with developments identified during the financial year.	Superseded	No	March 2022 IJB	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	Medium Term Financial Strategy updated as part of the Budget 2022/23 presented to IJB in March 2022.	30.06.22
240621-17	HSCP Delivery Plan 2021-22	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	The Integration Joint Board directs partners to support the agreed areas of development as set out in the HSCP Delivery Plan. The Delivery Plan draws together the strategic development priorities for the year, informed by the Strategic Plan's development priorities, the NHS Moving Forward Together Strategic Plan, the priorities of East Dunbartonshire Council as set out in the Community Planning Partnership's Local Outcome Improvement Plans, new statute and policy drivers, and identified areas for transformation change and our savings requirements. The Delivery Plan is attached as appendix 2 to the cover report.	HSCP Delivery Plan 2021-22- The business planning intentions of the HSCP Board for the period 2021-22 in pursuance of the implementation of the current Strategic Plan.	The funding implications, both spend and disinvestment, are set out within the body of the delivery plan which is attached as appendix 2 to the cover report.	24.06.21	24.06.21	01.06.22	Superseded	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	ED HSCP	superseded by Annual Delivery Plan 2022/23 - March 2022 IJB	08.06.22

Reference no.	Report Title	Direction to	Full Text	Functions Covered by Direction	Budget Allocated by IJB to carry out direction(s)	Date Issued	With Effect From	Review Date	Current	Does this supersede, revise or revoke a previous Direction	Direction Reference superseded, revised or revoked	Link to IJB paper	Link to New Direction	Responsible Officer	Service Area	Comments	Most Recent Review (Date)
160921-07	Carers Strategy 2019-2022	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire IJB directs NHS Greater Glasgow and Clyde, and East Dunbartonshire Council to extend the period for delivery of the Carers Strategy for a further year to 2023.	Support to carers across Children's, Adults and Older People's Services covered within the overall Carers Strategy.	Funding for the implementation of the East Dunbartonshire Carers Strategy as it relates to the Carers Act is provided centrally by Scottish Government. The budgets to deliver direct support services to carers is within the relevant budgets of the HSCP including supported living, respite, carers support and advice.	16.09.21	16.09.21	16.09.22	Superseded	No	Superseded by 171122-06	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	ED HSCP	N/A	17.11.22
160921-13	Financial Performance Budget 2021/2022 - Month 4	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2018-22, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2021/22 – all functions set out within Appendix 2.	The budget delegated to NHS Greater Glasgow and Clyde is £124.208m and East Dunbartonshire Council is £59.065m as per this report.	16.09.21	16.09.21	Complete – Budget 2021/22 monitoring will supersede this direction planned for November 2021	Completed	Yes	250321-09	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	N/A	08.06.22
181121-05	Winter Plan for Health and Social Care	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	NHS Greater Glasgow and Clyde and East Dunbartonshire Council are directed to recruit to the finalised workforce plan, to be refined under delegated authority, in line with the financial framework available through the SG funding allocated to deliver specific programmes of work to support winter planning pressures across health and social care services.	Adult health and social care services involved in response to winter planning pressures	As per the financial framework set out in paragraph 3.7.	18.11.21	18.11.21	01/11/2022 *see comment	Current	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Adult Health and Social Care	The Winter Plannning will form part of the Unscheduled Care Report to the next cycle of the IJB in September 2023.	26.04.23
181121-07	NHSGGC Specialist Children's Services Mental Health Recovery & Renewal CAMHS Funding	NHS Greater Glasgow and Clyde	NHS Greater Glasgow and Clyde are directed to recruit to the workforce plan set out in Appendix 2 in line with the financial framework available through the SG funding allocated to deliver specific programmes of work to improve the delivery of CAMHs services to the children of East Dunbartonshire.	NHS GG&C Mental Health Recovery & Renewal CAMHs funding	As per the financial framework set out in Appendix 2.	18.11.21	18.11.21	01/11/2022 * see comment	Current	No	N/A	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Specialist Childrens Services	The MHRR update will be taken to the next cycle of the IJB in Septembe 2023, however there is an element of this being reported through June 2023 cycle in relation to Phase 2.	26.04.23
181121-11	Financial Performance Budget 2021/22 – Month 6	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	East Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly are directed to deliver services in line with the Integration Joint Board's Strategic Plan 2018-22, as advised and instructed by the Chief Officer and within the revised budget levels outlined in Appendix 1.	Budget 2021/22 – all functions set out within Appendix 2.	The budget delegated to NHS Greater Glasgow and Clyde is £126m and East Dunbartonshire Council is £58.998m as per this report.	18.11.21	18.11.21	Complete – Budget 2021/22 monitoring will supersede this direction planned for January 2022.	Superseded	Yes	160921-13	Need link to published paper on on the HSCP webpage	N/A	Caroline Sinclair, Interim Chief Officer	Finance and Resources	N/A	18.11.21

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 11.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RSIK COMMITTEE

DATE OF MEETING:	**20TH JUNE 2023**
REPORT REFERENCE:	**PERF/200623/11**
CONTACT OFFICER:	**CAROLINE SINCLAIR, CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP**
SUBJECT TITLE:	**MENTAL WELFARE COMMISSION'S FINDINGS IN RELATION TO MENTAL HEALTH AND SPECIALIST CHILDREN'S SERVICES**

1.0 PURPOSE

1.1 The purpose of this report is to provide an update on the Mental Welfare Commission (MWC) Local Visit reports at Ward 4, The National Child Inpatient Unit, Royal Hospital for Children and Skye House the West of Scotland Adolescent Inpatient Unit, Stobhill Hospital, The reports were published during the period 1st January 2022 to 31st December 2022. The update will include the MWC recommendations and subsequent actions carried out by both wards which are hosted by East Dunbartonshire HSCP as part of Specialist Children's Services.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.1 Note the content of the Report; and

2.2 Note the recommendations and subsequent actions undertaken in relation to Ward 4, the national child psychiatric inpatient unit and Skye House the West of Scotland Adolescent psychiatric unit which are both hosted services of East Dunbartonshire HSCP

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 WARD 4, NATIONAL CHILD INPATIENT UNIT

3.1 The service offers treatment of severe and complex mental health problems from a strong and diverse multi-disciplinary team. Informal assessment and intervention takes place continually throughout the child's stay in the unit. This service is the sole child in-patient service provider for Scotland. The ward is a 6 bedded unit for 5-12 years old with some flexibility at either end according to clinical need.

3.2 The Mental Welfare Commission visited the unit on 16th November 2021 and set one recommendation. This recommendation stated, that hospital managers should explore cover arrangements for Mental Health Officers (MHOs) to ensure there is clarity and agreement regarding the responsibilities for MHO provision to the unit for those situations when the respective MHO team may be too geographically distant to attend the ward in an appropriate time frame. Additionally, consideration should be given to expanding the multidisciplinary team to include social work expertise to support children and their families as inpatients and support liaison with local authorities at the time of discharge.

3.3 In response to this, managers and clinical staff at Ward 4 explored MHO cover and confirmed that this can access a MHO employed by Glasgow City Council who is based at Skye House. Furthermore, the unit can access Hospital Social Work for advice and support in first instance. Both actions are now complete.

SKYE HOUSE, WEST OF SCOTLAND ADOLESCENT INPATIENT UNIT

3.4 This unit is a resource funded by the West of Scotland Health Boards for 12-17 year olds who suffer from a severe psychiatry disorder. A purpose built site, opened in 2009, and has 24 in-patient beds available for young people from West of Scotland Health Boards. The facility includes a school, landscaped gardens, a gym hall, and en-suite bedrooms. An MDT provide assessment, diagnosis and ongoing treatment. The philosophy of the care in the unit is to treat psychiatric and psychological difficulties in the context of the young person's personal development.

3.5 The Mental Welfare Commission made an unannounced visit to the unit on 23rd March 2022 and set four recommendations.

3.6 The first recommendation sought a review of nursing care plans and for the implementation of changes to improve their content and their use to better reflect patient care and treatment overall with greater synchronicity between the weekly MDT notes and nursing care plans in particular.

3.7 In response to this, Skye House staff included the care plan within the staff induction process and carried out an audit in relation to EMIS which includes nursing and MDT. Young people's meetings were also developed on a bi-monthly basis so that young person can input into care plans. This action in complete.

3.8 The second recommendation was in relation to infection control specifically related to Covid 19. The recommendation stated that any infection control testing and isolation policy which might impact on self- isolation in bedroom spaces and/or the freedom of movement of young people around the ward be clearly discussed with each young person to ensure that young people are clear about its voluntary nature and of the alternatives available to them. These discussions should be documented in line with policy.

3.9 In response, Skye House charge nurses have cascaded relevant information and documentation to all staff and contingencies that may be applied if the young person refuses and importance of documenting same. This action is complete.

3.10 The third recommendation stated that Hospital managers should undertake a review of the available meal options for young people, eliciting the young persons, their families and staff feedback as part of that review and explore with catering managers whether there is scope to improve the meals provided, especially in relation to the nature and range of vegetarian options.

3.11 In response to this, Skye House have undertaken feedback session with young people on available food and shared this with catering staff. Further, a young person's community group is to be asked their views on food. This action is ongoing.

3.12 The final recommendation states that on the occasions when the multidisciplinary team staff are required to provide duties such as meal time management that would ordinarily be undertaken by ward nursing staff that these are clearly documented and audited to ensure oversight of this practise to support future planning of staff provision.

3.13 In response, details of this have been inserted to the staff induction process and job plans have been assessed to accommodate this recommendation. This action is complete.

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2022-2025 Priorities;-

1. Supporting Carers and Families
2. Improving Mental Health and Recovery
3. Maximising Operational Integration

4.2 Frontline Service to Customers – improved communication and processes for children and young people in the inpatient units.

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – in line with MWC recommendations.

4.5 Financial Implications – None

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None.

4.10 Sustainability – None.

4.11 Other – None.

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 Ward 4 and Skye House will monitor completed actions from these recommendations to ensure they remain in place.

6.0 IMPACT

6.1 **STATUTORY DUTY** – None

6.2 **EAST DUNBARTONSHIRE COUNCIL** – None.

6.3 **NHS GREATER GLASGOW & CLYDE** – Ensure all MWC recommendations are implemented.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** None.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** – Mental Welfare Commissions Local Visits 2022

Item No. 12

Meeting Date **Wednesday 8th February 2023**

Glasgow City
Integration Joint Board
Finance, Audit and Scrutiny Committee

Report By: **Dr Martin Culshaw, Deputy Medical Director, Mental Health and Addictions**
Jacqueline Kerr, Assistant Chief Officer, Adult Services

Contact: **Jacqueline Kerr**

Phone: **0141 314 6250**

Mental Welfare Commission Local Visits 2022

Purpose of Report:	The purpose of this report is to present to the IJB Finance, Audit and Scrutiny Committee the findings from the Mental Welfare Commission Local Visit reports, to mental health inpatient wards in Greater Glasgow and Clyde, published during the period 1st January 2022 to 31st December 2022.

Background/Engagement:	The Mental Welfare Commission was originally set up in 1960 under the Mental Health Act. Their duties are set out in current Mental Health Care and Treatment Act. The Commission carry out their statutory duties by focusing on five main areas of work. They have a programme of visits to services who deliver Mental Health Care and Treatment to assess practice, monitor the implementation of mental health legislation, investigations, offering information and advice, and influencing and challenging service providers. The Mental Welfare Commission undertake local visits, either announced or unannounced and visit a group of people in a hospital, care home or prison service. The local visits; identify whether individual care, treatment and support is in line with the law and good practice; challenge service providers to deliver best practice in mental health, dementia and learning disability; follow up on individual cases where the Mental Welfare Commission have concerns, and may investigate further; and provide information, advice and guidance to people they meet with.

Governance Route:	This paper has been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☐ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☒ (please note below) Mental Health Services Clinical Governance Group. Not Applicable ☐

Recommendations:	The IJB Finance, Audit and Scrutiny Committee is asked to: a) Note the contents of the report; and b) Note the recommendations of the Mental Welfare Commission and the Services' response at Appendix 1.

Relevance to Integration Joint Board Strategic Plan:
These services are integral to the IJB's strategy for delivering high quality care and effective outcomes for the city's most vulnerable adults and older people.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcomes:	This report relates to: **Outcome 1** - People are able to look after and improve their own health and wellbeing and live in good health for longer. **Outcome 2** - People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. **Outcome 3** - People who use health and social care services have positive experiences of those services, and have their dignity respected. **Outcome 4** - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. **Outcome 5** - Health and social care services contribute to reducing health inequalities. **Outcome 6** - People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being. **Outcome 7** - People who use health and social care services are safe from harm. **Outcome 9** - Resources are used effectively and efficiently in the provision of health and social care services.

Personnel:	None

Carers:	None
Provider Organisations:	None
Equalities:	None
Fairer Scotland Compliance:	None
Financial:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Risk Implications:	Recommendations from Local Visits could imply that people are not receiving good quality care and outcomes. There are also reputation risks to the Health and Social Care Partnership as the local visit reports are published on the Mental Welfare Commission website.
Implications for Glasgow City Council:	None
Implications for NHS Greater Glasgow & Clyde:	Mental Welfare Commission recommendations for in-patient services managed by NHS Greater Glasgow and Clyde / Health and Social Care Partnerships have a direct impact on the public perception of NHS Greater Glasgow and Clyde and the Health and Social Care Partnerships. The report confirms detailed action plan responses to the recommendations of the Mental Welfare Commission.

1. Purpose

1.1. The purpose of this report is to present to the IJB Finance, Audit and Scrutiny Committee the findings from the Mental Welfare Commission Local Visit reports, to mental health inpatient wards in Greater Glasgow and Clyde, published during the period 1st January 2022 to 31st December 2022.

2. Background

2.1 The Mental Welfare Commission undertake local visits, either announced or unannounced; and visit a group of people in a hospital, care home or prison service. The local visits identify whether individual care, treatment and support is in line with the law and good practice; challenge service providers to deliver best practice in mental health, dementia and learning disability; follow up on individual cases where the Commission have concerns, and may investigate further; and provide information, advice and guidance to people they meet with.

3. Process

3.1 During local visits the Mental Welfare Commission review the care and treatment of patients, meet with people who use the service and also speak to staff and visitors.

3.2 Local Visits are not inspections, and the Mental Welfare Commission's report details findings from the date of the visit.

3.3 The Mental Welfare Commission provides recommendations and the service is required to provide an action plan response within three months, providing detail of the actions and timescales for completion.

4. Local Visits Reports 2022

4.1. The Mental Welfare Commission published a total of **34** Local Visit Reports during the reporting period.

4.2. The Mental Welfare Commission visited; adult, older adult, child and adolescent inpatient wards; forensic wards; learning disability services; intensive psychiatric care units (IPCU); and rehabilitation wards. Of the **34** local visits undertaken **31** were announced and **3** were unannounced. A total of **124** recommendations were made.

4.3. There were no recommendations made following an announced local visit to Broadford Ward, Stobhill Hospital (Adult Acute) on 3rd August 2022.

4.4. Details of the reports which received recommendations are outlined in the undernoted table. The recommendations and action plans are detailed at Appendix 1 which are accessible by selecting the page number:

	Mental Welfare Commission Local Visit	Date of Visit	Action Plan
1.	Claythorn House, Gartnavel Royal Hospital Specialist Learning Disability Services	19th October 2021	Page 17
2.	Netherton Unit, Glasgow Specialist Learning Disability Services	3rd November 2021	Page 18
3.	North Ward, Dykebar Hospital Older People Mental Health (complex care)	10th November 2021	Page 18

	Mental Welfare Commission Local Visit	Date of Visit	Action Plan
4.	Ward 4, National Child Inpatient Unit, Royal Hospital for Children Child Mental Health Services	16th November 2021	Page 20
5.	Blythswood House, Renfrew Specialist Learning Disability Services	26th November 2021	Page 21
6.	Mother and Baby Unit, Leverndale Hospital Specialist Mental Health Services	29th November 2021	Page 21
7.	Glenarn Ward, Dumbarton Joint Hospital Older People Mental Health (complex care)	30th November 2021	Page 22
8.	Rowanbank Clinic, Stobhill Hospital Medium Secure, Forensic Services	9th December 2021	Page 23
9.	Willow Ward, Orchard View, Inverclyde Royal Hospital Older People Mental Health (complex care)	14th December 2021	Page 26
10.	Balmore Ward, Leverndale Hospital Older People Mental Health (organic)	6th January 2022	Page 27
11.	East Ward, Dykebar Hospital Older People Mental Health (complex care)	25th January 2022	Page 29
12.	Wards 5 and 6, Campsie, Bute and Boulevard, Leverndale Hospital Low Secure, Forensic Services	23rd February 2022	Page 30
13.	Appin Ward, Stobhill Hospital Older People Mental Health (complex care)	2nd March 2022	Page 35
14.	Ward 37, Royal Alexandria Hospital Older People Mental Health (organic)	15th March 2022	Page 36
15.	Skye House, Stobhill Hospital *(unannounced)* Adolescent	23rd March 2022	Page 38
16.	Isla Ward, Stobhill Hospital Older People Mental Health (functional)	12th April 2022	Page 40
17.	Ward 3A, Leverndale Hospital Adult Acute	2nd May 2022	Page 42
18.	Ward 4A, Leverndale Hospital Adult Acute	5th May 2022	Page 43
19.	Ward 4B, Leverndale Hospital Adult Acute	5th May 2022	Page 46
20.	Arran Ward, Dykebar Hospital *(unannounced)* Rehab and Recovery Unit	25th May 2022	Page 48
21.	Armadale Ward, Stobhill Hospital Adult Acute and Adult Eating Disorder Service	1st June 2022	Page 50
22.	Intensive Psychiatric Care Unit, Leverndale Hospital IPCU	16th June 2022	Page 52
23.	Ward 39, Royal Alexandria Hospital Older People Mental Health (functional)	22nd June 2022	Page 54
24.	Wards 4A and 4B, Larkfield Unit, Inverclyde Royal Hospital Older People Mental Health (organic and functional)	7th July 2022	Page 56
25.	Cuthbertson Ward, Gartnavel Royal Hospital Older People Mental Health (organic)	16th August 2022	Page 58
26.	Rowanbank Clinic, Stobhill Hospital Medium Secure, Forensic Services	24th August 2022	Page 59

	Mental Welfare Commission Local Visit	Date of Visit	Action Plan
27.	Clyde House, Gartnavel Royal Hospital Adult Long Rehab / Complex Care	12th September 2022	Page 61
28.	McNair Ward, Gartnavel Royal Hospital Adult Acute	14th September 2022	Page 61
29.	Blythswood House, Renfrew Specialist Learning Disability Services	22nd September 2022	Page 63
30.	Portree Ward, Stobhill Hospital Intensive Psychiatric Care Unit	28th September 2022	Page 64
31.	Willow Ward, Inverclyde Royal Hospital *(unannounced)* Older People Mental Health (complex care)	29th September 2022	Page 69
32.	Rehabilitation Ward, Leverndale Hospital Rehabilitation, Adults	3rd October 2022	Page 69
33.	Iona Ward, Gartnavel Royal Hospital Older People Mental Health (complex care)	11th October 2022	Page 70

4.5 The undernoted local visits also took place in 2022 and reports will be published in 2023:

- 26/10/2022 - Rutherford Ward, Gartnavel Royal Hospital
- 02/11/2022 - Banff Ward, Leverndale Hospital
- 03/11/2022 - Ward 3B, Leverndale Hospital
- 08/11/2022 - Balmore Ward, Leverndale Hospital
- 17/11/2022 - South Ward, Dykebar Hospital
- 21/11/2022 - Kelvin Ward, Gartnavel Royal Hospital
- 24/11/2022 - Netherton Unit, Glasgow
- 29/11/2022 - Ward 4, National Child Inpatient Unit, Royal Hospital for Children
- 08/12/2022 - Jura Ward, Stobhill Hospital
- 13/12/2022 - Ward 37, Royal Alexandria Hospital

5. Mental Welfare Commission Recommendations

5.1 When local visits are undertaken the Mental Welfare Commission (MWC) review:

- Care, treatment, support and participation;
- Use of mental health and incapacity legislation;
- Rights and restrictions;
- Therapeutic activity and occupation; and
- The physical environment.

5.2 The number of recommendations made per category as a proportion of the total 124 recommendations are outlined below:

Recommendation Category	Number	Percentage
Care, treatment, support and participation	66	53%
Use of mental health and incapacity legislation	14	11%
Rights and restrictions	11	9%

Therapeutic activity and occupation	12	10%
The physical environment	16	13%
Other	5	4%
Total	**124**	**100%**

5.3 A summary of the recommendations under the related headings are as follows:

5.3.1 **Care, Treatment, Support and Participation:**
There were *sixty-six* recommendations made from twenty-six local visits. The majority of recommendations were regarding care plans, with *twenty-two* recommendations in relation to these. Recommendations included the audit of care plans on a regular basis to ensure that the interventions are person centred and that care plans are updated following evaluations to reflect any changes in the patients' needs, and of the effectiveness of interventions. Also to ensure that care plans were updated to reflect any change to legal status.

There were *four* recommendations made regarding care plans for patients who experience stress and distress, to ensure that these were person centred and identified individual triggers and strategies for de-escalation. There were *nine* recommendations regarding multi-disciplinary team (MDT) meetings, including the recording of these and of patient and relative participation. There were *three* recommendations regarding treatment forms for psychotropic medication. There were t*hree* recommendations regarding risk assessment and being accessible to staff. There were *three* recommendations made regarding 'Getting to Know Me' documentation ensuring that this was completed as fully as possible and that life history information is recorded and follows the patient when they move to a further care placement.

Examples of recommendations and services responses are detailed below:

MWC Recommendation	Service Response
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patient's progress towards stated care goals and that recording of reviews are consistent across all care plans. *(Ward 3A, Leverndale Hospital)*	Care plan audits are completed monthly to monitor the content and standards to ensure they are personal centred. These are fed back to nursing staff via nurse line management. This timescale allows nursing staff time to implement any changes and for quality assurance.
Managers should ensure that there is person centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and should be regularly reviewed and updated.	Staff to be reminded of importance of documenting in the stress and distress formulation. Discussions at supervision will take place if staff member noted to be omitting this in record keeping. Care need reviews will be implemented to reflect changes in presentation and Senior Charge Nurse will audit quarterly as well as discussing at supervision with staff. Staff to sign completed

(Balmore Ward, Leverndale Hospital)	formulations to ensure good communication with the team. Two day stress and distress training sessions for trained staff and essential training for untrained will be rolled out when staffing levels allow.
Managers should review recording and practice of MDT meetings across the wards to improve consistency, recording and patient participation. *(Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital)*	The Digital Champions Group has already requested additional training on EMIS functionality. Original training varied greatly with some areas not being notified about MDT recording sheets and other EMIS tools. Local peer audits to be reintroduced to aid streamlining across wards and inpatient service.
Mangers should review the records system to improve functionality and ensure that all Named Person paperwork is consistently recorded across all wards. *(Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital)*	There is currently a transition on to EMIS electronic record keeping. A Short Life Working Group has been set up to ensure training on the use of this and Digital champions identified in each ward to take this forward. Local peer audits to re-commence to ensure that all wards are streamlined across the service.
Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on both a T2 or T3 form, where required, and a system of regular auditing compliance with this should be put in place. *(Arran Ward, Rehab & Recovery Unit, Dykebar Hospital)*	A weekly ward Audit drawn up by Clinical Governance and implemented and audited by the Practice Development Nurse (PDN) team, results of weekly Audit to be forwarded to PDNs each week. A warning entered on to the HEMPA (Hospital Electronic Prescribing and Medicines Administration) which will automatically flag up each time the patient is accessed on the system, giving notice that the patient has current T2/3 in place. Check sheet introduced to be used during weekly MDTs, this will direct the team to check if patient has a current T2 or T3 and the expiry date.

5.3.2 **Use of Mental Health and Incapacity Legislation:**
There were *fourteen* recommendations made from thirteen local visits. There were *four* recommendations specific to individual sites. Of the recommendations, *ten* were in relation to recording practices, of which *two* were regarding medication treatment forms, *five* regarding power of attorney or guardianship and *three* regarding Section 47 certificates.

Examples of recommendations and services responses are detailed below:

MWC Recommendation	Service Response
Mangers should review staff training around the use of the different areas of the Adults with Incapacity (AWI) (Scotland) Act 2000. *(Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital)*	Training is ongoing for staff through the GG&C Learnpro modules and specific to AWI. As part of the Newly Qualified Nurses induction, and available to those that need refresher, AWI is included as part of the staff awareness around the Act. Information folder regarding AWI available for staff. Contact Legislation Advisor to discuss specific learning needs for AWI.
Managers should ensure that where there is a Power of Attorney (POA) or guardianship in place, copies of the powers granted are held on file. *(East Ward, Dykebar Hospital)*	Staff are contacting relatives/medical records to ensure all POA or guardianship is in place. When received all paperwork to be placed in files.
Managers should carry out an audit of consent to treatment forms to ensure these are up to date and cover all prescribed medication. *(Rowanbank Clinic, Stobhill Hospital)*	Initial audit to be carried out to find baseline standard. Already in place is the Ward 'champion' list in each clinical area with staff assigned to have responsibility over the diarising of expiry dates of T2/T3 documents whilst having an overall awareness that the prescribed treatments are concordant with current permissions. They should highlight and query any discrepancies with the MDT. Core Assurance Standards System in development to replace Mental Health Services core audits.

5.3.3 **Rights and Restrictions:**

There were *eleven* recommendations made from eight local visits in relation to Rights and Restrictions. Of the recommendations, *four* were regarding visiting arrangements, *two* regarding the promotion of Advance Statements*, one* recommendation was made at an individual site but relates to all adult and old age psychiatry inpatient wards and *four* recommendations were regarding specific issues at individual sites.

Examples of recommendations and services response are detailed below:

MWC Recommendation	Service Response
Managers should ensure that visiting arrangements are in line with current Scottish Government Guidance. *(Ward 4A, Leverndale Hospital)*	Staff followed NHSGGC guidelines on visiting due to covid transmission rate within Glasgow to safeguard our vulnerable patient group. The person centred visiting lead is currently carrying out an audit across all areas to ensure person centred visiting is imbedded in to routine practice.

Managers should ensure that a programme of training is supplied to all staff in relation to advance statements which should be promoted in the ward and these discussions be clearly documented in the patient's clinic notes and care plan. *(IPCU, Leverndale Hospital)*	Staff will promote advance statements for patients within IPCU although recognise that whilst within IPCU this may not be appropriate to complete but will encourage and promote pathways where advance statements should be discussed.
Managers should review bed provision across adult and old age psychiatry to ensure there is adequate capacity within each service to meet demand. *(Ward 39, Royal Alexandria Hospital)*	The provision of beds will be discussed twice daily at the service Huddle, whilst taking into consideration GG&C Bed Management Policy. Discussed at Senior Management level and identified on the Health and Safety Risk Register.

5.3.4 **Therapeutic Activity and Occupation:**
There were *twelve* recommendations made from ten local visits regarding therapeutic activity and occupation. Of the recommendations *four* were regarding access to activities; *four* regarding recording of when a patient accepts or declines to participate in an activity; and *three* in relation to activities being person centred.

Examples of recommendations and services response are detailed below:

MWC Recommendation	Service Response
Managers should ensure that patients have access to meaningful activity and occupation seven days per week. *(Ward 4A, Leverndale Hospital)*	Ward has dedicated time from Patient Activity Co-ordinator and Recreational Therapy staff during core hours. Ward staff also provide input to meaningful activity 7 days per week.
Managers should ensure that when a patient accepts or declines activities offered, this is noted in the patient's file. *(Ward 3A, Leverndale Hospital)*	Staff meetings / handovers taken place to discuss that all staff should be clearly documented on a daily basis when patients have been offered activities and any patients refusing to participate should also be documented. Patient Activity Co-ordinator and Therapeutic Activity Nurses also document daily any participation of ward based activities.
Activity care plans should be reviewed to include person-centred information about the individual's hobbies, skills and interests. *(Appin Ward, Stobhill Hospital)*	Therapeutic Activity Nurses to review care plans to ensure they are person centred and are created with the individual. Care plans to be audited weekly. Senior Charge Nurse to liaise with Practice Development Nurse in regards care plan training sessions.

5.3.5 **The Physical Environment:**
There were *sixteen* recommendations made from thirteen local visits regarding the physical environment. Of the recommendations *four* were in relation to

ensuring that the environment is fit for purpose and addresses the needs of patients; *three* recommendations were regarding consideration of single room accommodation; *four* regarding maintenance/improvement work; and *five* recommendations were regarding specific issues at individual sites.

Examples of recommendations and services response are detailed below:

MWC Recommendation	Service Response
Managers should undertake a main sitting area environmental audit and develop an action plan to deliver an environment that is fit for purpose and supports staff to meet the complex needs of this patient group. *(North Ward, Dykebar Hospital)*	Liaising with Occupational Therapy department and Art Therapist exploring ways to improve the main sitting area, including the purchase of wall murals and paintings. New furniture purchased for sitting area and wall decals mounted. Patients also encouraged to make use of the "pop-up bar area" which has a TV and patio doors that open out into the garden. Nursing and Occupational Therapy engage in activities with patients in this room and staff make use of the patio area with the patients in warmer weather.
Managers should consider ward refurbishment to provide single room accommodation to ensure privacy and maximum benefit to patients. *(Arran Ward, Rehab & Recovery Unit, Dykebar Hospital)*	NHS Greater Glasgow & Clyde are in the process of implementing their Mental Health Strategy. Part of this work involves bed-modelling, with a proposal for a reduction in Rehab beds to fund the development of community rehab services. Subsequent reconfiguration of the inpatient estate will include opportunities to remove older and less suitable wards for the patient population.
Hospital managers should undertake a review of the available meal options for young people, eliciting the young persons, their families and staff feedback as part of that review and explore with catering managers whether there is scope to improve the meals provided, especially in relation to the nature and range of vegetarian options. *(Skye House, Stobhill Hospital)*	We will undertake a feedback session with a group of young people on their views on the available food. We will seek their views on what they would like to see available. We will share our findings with the hospital catering service and seek their agreement to adjust.

5.3.6 **Other comments:**

There were *five* recommendations made from five visits. Of the recommendations, *two* were regarding food provision; *two* recommendations relating to staffing at two sites; and *one* regarding providing information on care decisions and progress of patients to relatives.

Examples of recommendations and services' response are detailed below:

MWC Recommendation	Service Response
Managers should discuss with catering managers the issues raised in regard to the food provision as a matter of urgency and report back progress to the Commission within two months of publication of this report. *(Rowanbank Clinic, Stobhill Hospital)*	Clinical Service Manager is in dialogue with hotel services regarding the ongoing issues with menus and food delivery. High turnover of hotel services staff impacts on the way in which completed menus are gathered from the wards for onward processing. Right Patient, Right Meal, Right Time policy review currently underway. Ward has taken over fruit delivery for our own area. We now can order fresh fruit that patients order instead of receiving a random selection once per week. This has improved uptake of fresh fruit and reduced waste. Our directorate Dietician meets with the Catering Manager quarterly to highlight issues and collaborate on solutions. The portion or size of the meals has been an ongoing complaint – these portions are calorie counted, nutritionally balanced and meet the dietary requirements of the generic patient group. Individuals requiring a modified diet as part of dietetic intervention are catered for. Senior Charge Nurse attends the Food, Fluid and Nutrition Group for Mental Health Partnerships to represent Forensic services.
Managers should take action to ensure staffing levels are adequate at all times to ensure patient safety and care. *(Glenarn Ward, Dumbarton Joint Hospital)*	Each shift requirements are monitored by nurse in charge. There is a contingency plan, including escalation protocol in place that supports safe staffing.
Managers should ensure that staff are proactive in providing information on care decisions and progress of patients to relatives. *(Ward 39, Royal Alexandria Hospital)*	Discussed at nurse line management the importance of follow up face to face discussion at visiting times with appropriate relatives/carers.

6. Themes

6.1 The themes from the Local Visit reports and recommendations are as follows:

- care plans - ensuring that care plans are person centred and reflect patients' goals;

- recording of the use of Mental Health and Incapacity Legislation; including treatment forms for psychotropic medication and power of attorney or guardianship;
- recording of multi-disciplinary team meetings;
- access to and recording of activity provision;
- the physical environment;
- visiting arrangements; and
- staffing challenges.

6.2 Work undertaken to address the issues include:

- **Care Plans**
  The Quality Improvement Sub-Group of the Mental Health Services Clinical Governance Group is reviewing care plan standards and discussing improvement work in this area, taking the Mental Welfare Commission's Good Practice Guidance on care plans into consideration as well as reviewing good practice from other inpatient wards. Furthermore, nursing priorities include person centred assessment care planning, involving patients, carers and relatives in all aspects.

- **Recording of Use of Mental Health and Incapacity Legislation**
  Treatment Forms
  Treatment forms for psychotropic medication (T2/T3 forms) assurance audits were carried out within Mental Health Adult inpatient wards in 2022 and an action plan developed. An audit was then undertaken in Community Mental Health Teams. Weekly audits in all mental health wards in GG&C have been implemented and are part of the core audits. Peer audits take place on a six monthly basis and these have also been added to the nursing Combined Care Assurance Audit Tool. A Pharmacy led audit is undertaken annually. A Seven Minute Briefing on 'Treatment forms for use under the Mental Health Act' has been developed as a learning tool and was circulated widely to staff in November 2022. (Appendix 2)

  Power of Attorney or Guardianship
  A boardwide action for improvement has been identified of the recording of patient Proxy information in patient records and to ensure that this is accessible. The action will be taken forward by Inpatient Service Managers.

- **Recording of Multi-disciplinary Team (MDT) meetings**
  An inpatient MDT template is held on EMIS Web which is required to be completed. A Board-wide communication from the Deputy Medical Director, Mental Health and Addictions was issued regarding MDT recording, the communication included a reminder to staff that MDT discussions should only be recorded on the MDT templates held in EMIS.

- **EMISWeb Health Care System**
  Work is currently being undertaken to progress the mental health inpatient estate to be as paper-lite/paperless as possible. Preparatory work has been completed which included the gathering of copies of paper documentation used within inpatient wards and the development of draft

versions of these within EMIS Web. A short life working group was established consisting of frontline staff across mental health services to review, pilot and roll out the templates within agreed timescales. It is expected that this work will be concluded by June 2023.

- **Activity Provision**
  It is acknowledged that activity provision has been impacted upon by the Covid-19 pandemic, including the absence of community based activities. Staff have supported patient activity creatively on wards, through examples such as, in South Glasgow, the development of therapeutic person centred activity packs tailor made to meet individual needs. In Forensic Services Occupational Therapists developed Safe Boxes which contain specific "What Matters to You" information. SPARKS (Sharing, Problem Solving, Achieving, Resilience, Knowledge, Strengths) groups for the ADHD community have been successfully run, which has helped with the ADHD waiting list initiative and will have elements of activity. In Inverclyde Journey Through Dementia, an occupational therapy activity based programme, has been rolled out. Home Based Memory Rehab for people with mild cognitive impairment under 65 years and people over 65 years with either mild cognitive impairment or Dementia has also continued to be delivered. Activity provision is now generally improving.

  Recording of activity participation was an issue reported in the recommendations; service responses advise that staff have been reminded to clearly document participation or when a patient declines to participate in an activity.

- **The Physical Environment**
  The majority of recommendations are site specific issues and local actions will be implemented. Environmental issues will also be factored into strategic proposals, including during the review of the older people mental health estate. The move to single room accommodation is supported, however is subject to financial agreement.

- **Visiting Arrangements**
  It is acknowledged that visiting arrangements have been impacted upon across all sites due to the Covid-19 pandemic. Visiting arrangements were mentioned in twenty-three of thirty-four reports, however of these there were five recommendations. Services have followed guidelines on visiting which have included restrictions during the course of the pandemic. Some changes to visiting included booking systems being implemented to accommodate visiting, limitations on the number of visitors and duration of the visit, use of technology for virtual visits and also utilising outdoor space. Ward staff recognise the importance of family involvement and support this where possible. Some comments from the Local Visits referred to the environment where visits take place on some sites and lack of privacy due to communal areas being utilised. A relative at two sites expressed concerns/felt that the visiting booking system was unnecessarily restrictive. Some positive comments reported that there were no issues in accommodating visits, of visiting hours being extended during restrictions, and that these arrangements had continued following positive feedback from visitors. Visiting is returning to near pre-pandemic

arrangements, however this is subject to review and responding to current circumstances.

- **Staffing**
  Mental Health Services continue to experience significant pressures across both inpatient and community settings due to staff vacancies and absence. GG&C Mental Health Services are fully engaged with the Scottish Government's Mental Health and Wellbeing Workforce Advisory Group and are holding local stakeholder engagement events to assist with national workforce planning. There have been one hundred and nine Newly Qualified Nurses successfully recruited in 2022 for GG&C. A rolling centralised recruitment advert for nursing posts continues and recruitment events have taken place. A recruitment drive is also being undertaken for medical staff within General Adult and it is hoped that some vacant posts will be successfully filled by Spring 2023.

7. Good Practice

7.1 The Mental Welfare Commission may opt to include in each report good practice noted at the visit. Examples of good practice from the reports published in 2022 included:

- The work that the clinical team has undertaken in developing child friendly care plans to promote inclusion of the child inpatients in their care and to ensure their care plans take cognisance of their views. The high quality of the care planning and record keeping in general within the ward made within the constraints of the EMIS system to support efficient navigation of notes and records. The MWC also commended the attempts made by the clinical team to provide opportunities for Mental Health Officers in training to learn about the use of compulsory measures in the under 12s which can be a complex area at times*. (Ward 4, National Child Inpatient Unit)*
- A number of life story books which have been developed by the patient activity co-ordinator and occupational therapy staff in collaboration with the patients and their families. These were hard backed albums which contained information about the individual's family, school and work life and interests. Relatives and staff used these to stimulate conversation and reminisce with the patients, and these go with the patient when they transfer to other settings, providing valuable information about the person for their care team*. (Willow Ward, Orchard View, Inverclyde)*
- The quality of the note keeping for the multidisciplinary team meeting was of a very high standard and reflected areas of good practice in the service. The dedication and commitment of staff from all parts of the unit to support the young people's care during what has been very challenging times during the Covid-19 pandemic and lockdown. *(Skye House, Stobhill)*
- The clinical team have proactively engaged with Adult Support and Protection procedures led by the local Health and Social Care Partnership. The recording of these meetings was fully evidenced in patient files and formed part of their care planning, risk assessment and management. *(Arran Ward, Rehab & Recovery Unit, Dykebar)*
- The service has gained Accreditation for Inpatient Mental Health Services (AIMS) around the patient journey. A significant amount of focussed work had taken place to achieve this. *(Blythswood House, Renfrew)*

8. Governance Arrangements and Shared Learning

8.1 Governance arrangements are in place to ensure the robust monitoring of the Local Visit Reports. As Chair of the Mental Health Services Clinical Governance Group (MHSCGG), the Deputy Medical Director for Mental Health and Addictions takes a summary report to each meeting of the NHSGGC Board Clinical Governance Forum which occurs bi-monthly.

8.2 Where local HSCP or Care Group governance committees consider that there is learning or issues to be shared with the wider Mental Health Service, or advice to be sought, then this is reported to the MHSCGG.

A reciprocal arrangement exists with the MHSCGG disseminating learning and guidance, or seeking information from local HSCP or Care Group governance committees. Feedback from the MHSCGG should therefore feature on the standing agenda of local HSCP and Care Group governance committees.

Board wide awareness/learning is implemented/shared via a number of mechanisms:

- Email alerts/notifications
- Staffnet
- Patient Safety Bulletin
- MyPsych App
- Seven Minute Briefings

Board wide actions may also be delegated to the following groups to implement in conjunction with Heads of Service and other operational managers:

- Quality Improvement Sub-group
- Mental Health Policy Steering Group

8.3 An End of Year meeting took place with the Mental Welfare Commission on 9th December 2022, with representatives from the six Health and Social Care Partnerships. The meeting had a focus on the local developments and issues that arose from local visits to services and the recommendations. An Action Log has been developed in response to issues raised.

9. Recommendations

9.1. The IJB Finance, Audit and Scrutiny Committee is asked to:

a) Note the content of the report; and
b) Note the recommendations of the Mental Welfare Commission and the services' response at Appendix 1.

Appendix 1

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
19/10/2021	Claythorn House, Gartnavel Royal Hospital	1. Managers should urgently review the care plan documentation and ensure all nurses are aware of how to complete these appropriately.	MWC Care Planning Guidance session will be included in Continuous Professional Development (CPD) calendar for nurses. This will include detail on how to complete a review including signing and dating and making sure reviews include robust and full updates identifying patient progress and impact of nursing intervention. Guidance to be included in care plan audits, and discussed during Multi-disciplinary team meetings (MDTs) and nurse supervision sessions.	July 2022	All staff had face to face training on completion of care plans. Presentation was provided by Practice Development Nurse. Care plan audits have been completed and staff have regular 1:1 with senior staff to discuss care plans. MWC care planning guidance referenced in these discussions.
19/10/2021	Claythorn House, Gartnavel Royal Hospital	2. Managers should follow-up with estates services to ensure a replacement bath is acquired as soon as possible.	Contact estates in writing seeking urgent replacement of bath.	January 2022	Bath replaced in March 2022

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
03/11/2021	Netherton Unit, Glasgow	1. Managers should audit the review process and documenting of care plan reviews to ensure they contain appropriate information that benefits the individual patient detailing their progress since last review.	MWC Care Planning Guidance session will be included in CPD calendar for nurses. This will include detail on how to complete a review including signing and dating and making sure reviews include robust and full updates identifying patient progress and impact of nursing intervention. Guidance to be included in care plan audits, and discussed during Multi-disciplinary Team (MDTs) and nurse supervision sessions.	July 2022	An audit tool was developed and completed for nursing care plans. As part of that process there was a focus on reviewing if patient goals and outcomes were noted and achieved. Nursing care planning guidance sessions were held as part of face to face development days for registered nurses. These sessions incorporated information on the MWC person centred care plans guidance. MWC person centred care plans guidance is discussed regularly with all staff at supervision and senior nursing staff have participated in group reflective supervision on care planning.
10/11/2021	North Ward, Dykebar	1. Managers should review staffing arrangements to ensure that patients have access to the full range of professionals required to meet their needs.	• The vacant Clinical Psychology post has been recruited to and will be filled once the candidate completes all necessary checks. • Renfrewshire Mental Health Services have an ongoing recruitment drive to fill vacancies in all areas.	September 2022 Completed	The Clinical Psychologist is now in post and is working with patients in North Ward. Recent recruitment of registered and unregistered nursing staff has reduced the number of vacancies within North Ward. Further adverts to

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
					recruit to the remaining posts is underway.
10/11/2021	North Ward, Dykebar	2. Managers should undertake an audit to ensure the powers granted to proxy decision makers are held on file.	• Audit completed. • Families of patients with missing paperwork contacted to provide a copy of this for files – awaiting some paperwork to be provided.	June 2022 Completed (still awaiting some documentation from relatives)	North Ward have received most copies of the required paperwork from carers. They will be contacting the remaining carers again in January 2023.
10/11/2021	North Ward, Dykebar	3. Managers should undertake a main sitting area environmental audit and develop an action plan to deliver an environment that is fit for purpose and supports staff to meet the complex needs of this patient group.	• Currently liaising with Occupational Therapy (OT) department and Art Therapist exploring ways to improve the main sitting area, including the purchase of wall murals and paintings. • New furniture purchased for sitting area and wall decals mounted. • Patients also encouraged to make use of the “pop-up bar area” which has a TV and patio doors that open out into the garden. Nursing and OT engage in activities with patients in this room and staff make use of the patio area with the patients in warmer weather.	Completed February 2022 Completed	The Art Therapist worked with the ward staff to purchase wall murals/decals and pictures for the ward. These have now been installed. The pop-up bar is used for several activities by the Occupational Therapist and nursing staff.
10/11/2021	North Ward, Dykebar	4. Managers should undertake a review of the current system for managing laundry.	• Staff have been informed to ensure all patient clothing labelled correctly and sent to laundry in relevant labelled laundry bag. • Ward Domestic Staff have been asked to alert Nursing Staff if patient clothing has not returned from laundry.	Completed Completed	New staff are informed of the guidance on patient laundry during the induction.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
16/11/2021	Ward 4, National Child Inpatient Unit	1. Hospital managers should explore cover arrangements for MHOs for the unit to ensure there is clarity and agreement regarding the responsibilities for MHO provision to the unit for those situations when the respective MHO team may be too geographically distant to attend the ward in an appropriate time frame. Additionally, consideration should be given to expanding the multidisciplinary team to include social work expertise to support children and their families as inpatients and support liaison with local authorities at the time of discharge.	We have explored Mental Health Officer (MHO) cover and we can access a MHO employed by Glasgow City Council who is based at Skye House. In terms of Social Work access we can access Hospital Social Work for advice and support in first instance.	Complete Complete	Complete - MHO cover accessed from Glasgow Council Complete – Social Work access from hospital services

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
26/11/2021	Blythswood House, Renfrew	1. Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.	MWC Care Planning Guidance session will be included in CPD calendar for nurses. This will include detail on how to complete a review including signing and dating and making sure reviews include robust and full updates identifying patient progress and impact of nursing intervention. Guidance to be included in care plan audits, and discussed during MDTs and nurse supervision sessions.	July 2022	An audit tool was developed and completed for nursing care plans. As part of that process there was a focus on reviewing if patient goals and outcomes were noted and achieved. Nursing care planning guidance sessions were held as part of face to face development days for registered nurses. These sessions incorporated information on the MWC person centred care plans guidance. MWC person centred care plans guidance is discussed regularly with all staff at supervision and senior nursing staff have participated in group reflective supervision on care planning.
29/11/2021	Mother & Baby Unit, Leverndale Hospital	1. Managers should explore with relevant IT personnel the options to adapt functions within the EMIS, the electronic note system, to facilitate the recording and review of care planning documentation.	Recent meeting with programme leads from EMIS to explore uploading documents that currently remain as paper document in the patients notes including care plans. Senior Charge Nurse has been invited to be part of a short life working group to look at making all the current paperwork into templates specific to perinatal.	September 2022 for templates to be composed. June 2023 for the templates to be made live on EMIS.	Action completed 26/05/2022 Work is continuing and the aim is to be paper-free/paper-light by 09/06/2023.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			This is also a Greater Glasgow and Clyde issue that is effecting many of the acute sites. A list of all the templates required to be made paper free on EMIS will be taken to the short life working group.		
29/11/2021	Mother & Baby Unit, Leverndale Hospital	2. Managers should arrange for review of access policies to the ward for family members, including parents to the ward, during the Covid 19 pandemic to ensure any restrictions are proportionate to the risks, consistent with wider practise, justified and necessary in their scope and function.	For a significant period of time there has been restriction on visiting during the Covid pandemic to all hospitals. We have for the most part been able to continue with two named visitors and this had been in a designated area within the ward. We have recently at the beginning of May been able to move forward so that one person (father/partner/carer) have been able to visit in an unrestricted manner to the patient area which has been previously been restricted. We hope in the coming months to be able to further review the visiting arrangement and hope to be able to further reduce any restrictions.	Ongoing review of visiting both within the West of Scotland Mother and Baby Unit to reflect GGC wide visiting guidelines but also reflecting the unique ward environment.	Action complete since the 26th September 2022.
30/11/2021	Glenarn, Dumbarton Joint Hospital	1. Managers should engage with their social work peers to ensure that social work input is available when required.	Referral pathways in place that support a client of Glenarn Ward who required a social work assessment and intervention.	Completed	Actions complete
30/11/2021	Glenarn, Dumbarton Joint Hospital	2. Managers should take action to ensure staffing levels are adequate at all	Each shift requirements are monitored by nurse in charge. There is a contingency plan, including escalation protocol in place that supports safe staffing.	Completed	Actions complete

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
		times to ensure patient safety and care.			
09/12/2021	Rowanbank Clinic, Stobhill Hospital	1. Mangers should review records and Kardex system to improve functionality.	• This project is already underway. Digital Champions group set up looking and transferring the final parts of paper care plan onto EMIS. • Review of care plan documentation in tandem with transfer across to EMIS.	Anticipated full completion to electronic records 12-18months	Service continues to work alongside eHealth with the development of EMIS.
09/12/2021	Rowanbank Clinic, Stobhill Hospital	2. Managers should review recording and practice of MDT meetings across the wards to improve consistency, recording and patient participation.	• Digital Champions group has already requested additional training on EMIS functionality. Original training varied greatly with some areas not being notified about MDT recording sheets and other EMIS tools. • Local peer audits to be reintroduced to aid streamlining across wards and inpatient service.	March meeting cancelled due to COVID. Dates for further meetings and roll out of training dates to follow Local peer audit calendar to be revisited by Professional Nursing Group and Nursing Development Group	Meetings continued bi-monthly, however Forensic Services now in line with Mental Health Services and all meetings cancelled until the New Year. Digital Champions identified with a view to picking up and linking in with other services to support full roll out throughout the beginning of 2023.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
09/12/2021	Rowanbank Clinic, Stobhill Hospital	3. Managers should carry out an audit of consent to treatment forms to ensure these are up to date and cover all prescribed medication.	• Initial audit to be carried out to find baseline standard. • Already in place is the Ward 'champion' list in each clinical area with staff assigned to have responsibility over the diarising of expiry dates of T2/T3 documents whilst having and overall awareness that the prescribed treatments are concordant with current permissions. They should highlight and query and discrepancies with the MDT. • Core Assurance Standards System (CASS) in development to replace Mental Health Services core audits.	• Completed by 01/04/2022 • Reviewed monthly • Anticipated implementation June 2022	Wards maintain own monthly review and take to MDT. Peer audit schedule being developed by Professional Nurses Group (PNG) to include T2/T3's Liaison with Chief Nurse and Mental Health Services to support development of CASS standards for Forensic services held up June 2022 roll out. Implementation date set for 04/01/2023.
09/12/2021	Rowanbank Clinic, Stobhill Hospital	4. Managers should discuss with catering managers the issues raised in regard to the food provision as a matter of urgency and report back progress to the Commission within two months of publication of this report.	• Clinical Service Manager in dialogue with hotel services regarding the ongoing issues with menus and food delivery. High turnover of hotel services staff impacts on the way in which completed menus are gathered from the wards for onward processing. • Right Patient, Right Meal, Right Time policy review currently underway.	• Quarterly review • End 2022	Complaint submitted to Advocacy services by patient group which then seen Hospital managers and Advocacy link together to meet with Hospital Catering. Continue to await NHSGGC publication of the reviewed 'Right meal' Right Time, Right Place'.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			• Rowanbank has taken over fruit delivery for our own area. We now can order fresh fruit that patients order instead of receiving a random selection once per week. This has improved uptake of fresh fruit and reduced waste.	• Completed	Agreement made to recommence sending cold meats bread etc. for a supper. Discussion to add 'finger food' options to 4 weekly food rota.
			• Our directorate dietician meets with the catering manager quarterly to highlight issues and collaborate on solutions.	• Quarterly meetings.	Meeting organised for end December for Catering services to meet with patient group for them to feedback themselves. Also, to give Catering services an idea of Forensic Services and how it is unique from the other services that they provide food to.
			• The portion or size of the meals has been an ongoing complaint – these portions are calorie counted, nutritionally balanced and meet the dietary requirements of the generic patient group. Individuals requiring a modified diet as part of dietetic intervention are catered for. • Senior Charge Nurse attends the Food, Fluid and Nutrition group for Mental Health Partnerships to represent Forensic services.	• Complete	Review of menu submissions and changes to ensure menus are being received on time, meaning less substitutes being provided over food ordered. Bi monthly meetings agreed.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
14/12/2021	Willow Ward, Orchard View, Inverclyde	1. Managers should audit care plans to ensure these reflect current needs and reviews are meaningful.	Mental Health Combined Care Assurance Audit Tool (MHCCAAT) completed 28/04/2022. Outcome Result - 98% of patients have appropriate ongoing assessment of their care needs documented throughout their admission to hospital. Care plan review discussed as part of Nurse Line Management.	Action complete	Actions taken were immediate and ongoing monitoring will be conducted via the MHCCAAT tool.
14/12/2021	Willow Ward, Orchard View, Inverclyde	2. Managers should ensure MDT notes contain information on decisions taken and actions required.	Mental Health Combined Care Assurance Audit Tool (MHCCAAT) completed 28/04/2022.	Action complete	Actions taken were immediate and ongoing monitoring will be conducted via the MHCCAAT tool.
14/12/2021	Willow Ward, Orchard View, Inverclyde	3. Managers should undertake an audit to ensure that where there is a proxy decision maker, a copy of the powers granted are on file.	Mental Health Combined Care Assurance Audit Tool (MHCCAAT) completed 28/04/2022 Outcome Result 96% of Patient in hospital who are subject to legislation have accurate records ensuring all those looking after them provide the least restrictive, person centred care. Where appropriate, there was evidence of the authority to treat without consent (i.e. is there evidence of AWI or MHA application). Where patients had an appointed Power of Attorney/Guardian, a copy of the documentation was available. The Mental Health Combined Care Assurance Audit Tool will be completed	Action complete	Actions taken were immediate and ongoing monitoring will be conducted via the MHCCAAT tool.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			twice yearly and provides ongoing monitoring of compliance with recording and storage of all patient records.		
06/01/2022	Balmore Ward, Leverndale Hospital	1. Managers should ensure that 'Getting to Know Me' documentation is completed as fully as possible and life history information is recorded and follows the patient when they move to a further care placement.	Family complete the document and some patients do not have family members which makes gathering of information difficult. Families to be encouraged to complete and staff will explain the importance of this. Information on life story from care homes filed beside Getting to Know Me (GTKM). Encourage Nursing Assistants and all disciplines to add information on likes/dislikes and life story to GTKM document. Weekend staff will review GTKM documents weekly. Documentation to be explored to capture this information.	By 30th October 2022	Completed 29/08/2022 Continue to encourage Health Care Support Worker to write in GTKM document and weekend staff asked to review GTKM. Communication book introduced to capture relevant information. Simplified documents developed.
06/01/2022	Balmore Ward, Leverndale Hospital	2. Managers should ensure care plans are person-centred and updated following evaluations to reflect changes to the patients' needs and the effectiveness of interventions.	Communication to be sent to staff and continue to alert staff to the standards required and comment on the changes in needs and review of the interventions that are in place as well as adding new interventions as appropriate. Care planning sessions to be arranged by Professional Development Nurse. Awareness raised during supervision with minimum quarterly review on content of care plans by senior nurses. Senior Charge Nurse will raise awareness	By 30th October 2022	Monthly audit results are emailed to staff with changes needing made. Care plans are discussed at each supervision session. Care planning sessions are taking place for staff week beginning 29/08/2022 all staff should be seen with the exception of staff on nightshift. Dates in the future to be made for them.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			to staff of need to ensure Allied Health Professional input with patients is documented in care plan.		
06/01/2022	Balmore Ward, Leverndale Hospital	3. Managers should ensure that there is person centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and should be regularly reviewed and updated.	Staff to be reminded of importance of documenting in the stress and distress formulation. Discussions at supervision will take place if staff member noted to be omitting this in record keeping. Care need reviews will be implemented to reflect changes in presentation and Senior Charge Nurse will audit quarterly as well as discussing at supervision with staff. Staff to sign completed formulations to ensure good communication with the team. Two day stress and distress training sessions for trained staff and essentials training for untrained will be rolled out when staffing levels allow.	By 30th October 2022	Information for staff displayed in ward to aid recording of stress and distress. Training programme developed with regular training available in Leverndale and other hospital sites. Formulations are readily available for staff to read. Supervision sessions for all staff take place fortnightly for Stress and Distress.
06/01/2022	Balmore Ward, Leverndale Hospital	4. Managers should ensure that activity care plans are person centred reflecting the individual's preferences, interests and abilities and that activity participation is recorded and evaluated.	Occupational Therapy (OT) staff to advise Therapeutic Activity Nurse (TAN) and other staff on where to find PAL (pool activity level) assessment and OT intervention plans. Printed copy of these will be added to care plan TAN has a folder for activities and will also ensure information is available for all staff. Nursing assistants also to be made aware	By 30th October 2022	Access to info improved and TAN writing in EMIS. Folder in each office and staff encouraged to input information.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			of the importance of the small tasks or communication methods that make a positive outcome for individual patients and will be asked to capture that information to add valuable information to person centred care planning and evaluation. Versions of GTKM are available with activity checklist. Options for roll out of this version will be explored.		
25/01/2022	East Ward, Dykebar Hospital	1. Managers should review their audit processes to improve the quality of mental health care plans to reflect the holistic care needs of each patient, and identify clear interventions and care goals.	1. Charge nurse / senior charge nurse review of audit process for care planning. 2. Care plans to reflect holistic needs with clear goals/interventions. 3. New Combined Care Assurance Audit Tool (CCAAT) has been introduced to all mental health wards in NHS GGC. Care planning is one aspect of this.	June 2022 - Completed	The new CCAAT audit tool is now in use in East Ward. Care plans are reviewed as part of line management supervision, with an emphasis on person centred plans and clear goal setting.
25/01/2022	East Ward, Dykebar Hospital	2. Managers should ensure that there is a clear person centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.	1. East Ward manager attending a series of Short Life Working Group meetings focusing on Stress and Distress. 2. All staff have attended training in Stress and Distress Pre-Pandemic. Some new members of staff booked in for stress and distress training. 3. Standard recognised that all older adult patients will have stress and distress care plans completed within 2 weeks of admission to an assessment ward. 4. Senior Charge Nurse recognises that East Ward do not admit but may inherit patients from assessment wards that do	June 2022 New staff trained by August 2022 Ongoing Continuous Care plans to be completed by August 2022	The Clinical Psychologist for the ward is working with the nursing staff on stress and distress care plans. There is a full year's timetable of Stress and Distress training available for staff to attend. The SCN books all new staff onto this as part of their induction.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			not have a stress and distress care plan. 5. Senior Charge Nurse's having twice weekly meetings as able to go over paperwork and devise stress and distress care plans for all patients.	In place by August 2022	
25/01/2022	East Ward, Dykebar Hospital	3. Managers should take action to ensure that psychology provision is reinstated.	New Psychologist is due to commence in August.	In place by August 2022	In place by August 2022
25/01/2022	East Ward, Dykebar Hospital	4. Managers should ensure that where there is a POA or guardianship in place, copies of the powers granted are held on file.	Staff are contacting relatives/medical records to ensure all POA or guardianship is in place. When received all paperwork to be placed in files.	For completion June 2022	The ward staff have contacted all carers for patients with POA or Guardianship in place for copies of the paperwork. The ward now has most of these within patient's files and will re-contact any carer who has still to send these in by January 2023.
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital	1. Mangers should identify a timescale for the re-opening of previous on-site facilities to aid with patient rehabilitation.	• Unfortunately over the pandemic on site facilities were closed as part of the prevention of the spread of Covid. These have not reopened and are part of the Leverndale site rehabilitation provision so not run by Forensics services but we do utilise them. At this time there is no plan for these to reopen but we continue to link in with the hospital site for any further discussion of future rehabilitation facilities. • Our Acorn project is under review as the premises were no longer fit for purpose and there are future plans to reinstate a garden project once funds are secured.	Minimum of monthly liaison with Mental Health Services for progress updates. Endowment bid submitted.	Mental Health Services have started to open these services slowly, however not for use by Forensic patients currently. Awaiting update. Bid successful December 2022. Occupational Therapy now devising a plan on how best to utilise/maximise the

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
					space for the patient benefit. Endowment must be spent by the end of March 2023.
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital	2. Medical staff should ensure all patients are clear on their in-patient journey and discharge plans.	• Responsible Medical Officer meets with patients weekly to discuss ongoing journey and future discharge plans. • Care Programme Approach meetings planned to enable all agencies involved to discuss needs and plans for future discharge. • Patient key worker also meet 1:1 with patient to discuss on going plans. • Throughout the pandemic access to support workers and community supported accommodation was put on hold. Providers are now recruiting to posts for supported accommodation and access to these has recommenced in the past few months. This provision will increase as progress is made and staff are in post and patients will commence on their staged rehabilitation plans.	Effective immediately	Maintenance through Senior Charge Nurse monitoring on ward whilst peer audit schedule being reviewed and developed.
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital	3. Managers and medical staff should regularly review the suitability of all patients placed in Campsie House to ensure that the ward continues to the meet their needs.	Campsie is a small environment with limited scope to develop beyond the existing floor plan. Capital planning has been involved at looking at any alterations that could be possible to increase floorplan and suitability of the area. The dining room area was extended previously to allow for further space and a smaller day area created to help increase quiet space for the patients. A quiet	Review of ward and how space is being utilised with MDT and Falls Coordinator.	Amendment to flooring. Nursing team reviewing current use/changes to how space is used. Nurse Consultant leading on an EQIA (equality impact assessment) on Campsie Ward.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			sensory room is available for patients to use for additional quiet space. An option that could be explored is the feasibility of a temporary creation of a further quiet area that was previously a bedroom will be considered.		
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital	4. Managers should review recording of MDT meetings to improve consistency and ensure patient participation and views are evident on the forms.	• Digital Champions group has requested additional training on EMIS functionality. Original training varied greatly with some areas not being notified about MDT recording sheets and other EMIS tools. • Local peer audits to be reintroduced to aid streamlining across wards and inpatient service. • Future plans for EMIS are looking at electronic technology that will allow for the patient to add in their views and evidence their participation.	• Bi-monthly Digital champions meeting to take forward future plans and evidence training. Further meetings and roll out of training dates planned through coming year. • Local peer audit calendar to be revisited by Professional Nursing Group and Nursing Development Group	Meetings continue with next one planned for February 2023. Professional Nurse Group (PNG) and Nursing Development Group (NDG) to bring back plan for audit in February 2023.
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit,	5. Mangers should review the records system to improve functionality and ensure that all Named Person paperwork is consistently recorded across all wards.	There is currently a transition on to EMIS electronic record keeping. A Short Life Working Group (SLWG) has been set up to ensure training on the use of this and Digital Champions identified in each ward to take this forward.	A SLWG has been set up to ensure training on the use of this and Digital champions identified in each	Roll out of EMIS across Forensic and Mental Health Services to recommence together in January 2023.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
	Leverndale Hospital		Local peer audits to re-commence to ensure that all wards are streamlined across the service.	ward to take this forward. Peer audit schedule to be discussed at Professional Nursing Group	Scheduled to be brought to Professional Nursing Group meeting 2nd February 2023
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital	6. Mangers should review staff training around the use of the different areas of the Adults with Incapacity (AWI) (Scotland) Act 2000. **and** 7. Managers should ensure all staff understand and appropriately manage patient funds ensuring consistency for those subject to Part 4 of the Adults with Incapacity (Scotland) Act 2000.	Regular meetings are held with Patients affairs as part of the MDT to ensure that all funds are managed appropriately. Training is ongoing for staff through the GG&C Learnpro modules and specific to AWI. As part of the Newly Qualified Nurses induction, and available to those that need refresher, AWI is included as part of the staff awareness around the Act. Information folder regarding AWI available for staff. Contact Legislation Advisor to discuss specific learning needs for AWI.	6 monthly meetings with Patient Affairs department. Staff supported with protected time to achieve module completion. Available on ward for ease of access/quick reference	Monthly updates of compliance shared widely. Maintenance at Ward level Time diaried every day in every ward for protected time for staff on duty. AWI Champion maintains this folder. Updating and renewing as new guidance is published alongside linking in with Patient Affairs/Legislation eam
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure	8. Mangers should hold regular discussions with commissioners and Social Work Managers in the local Health and Social Care Partnership to improve the	Community Placements were kept running during the pandemic on a reduced basis so that everyone attending did get a regular session. Forensic services are linked in to the	Meetings bi-monthly with current providers and Forensic services represented on this	Planned presentation to the NHSGGC Moving Forward Together group in first meeting of 2023.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
	Unit, Leverndale Hospital	provision of community activities for patients.	Employability pathway review with our OT colleagues looking at structured and meaningful activity for mental health across the GG&C board. A paper has been written by the Forensic Directorate in regard to commencing our own services and this has been presented at the Moving Forward Together group, looking at structured placements for our patients as they transition to the community.	group.	
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit, Leverndale Hospital	9. Mangers should address the concerns raised by patients regarding the current restrictions relating to the serving of lunch in Ward 5 and 6.	Patients are encouraged to attend at all meal times to ensure that dietary and food, fluid and nutrition needs are being met. Meals are calorie calculated and nutritionally balanced and meet the dietary requirements of the patient group. Mealtimes used to educate round a balanced diet. Integrity of the ward area is also required at these times to ensure that all cutlery items are accounted for before and after mealtimes.	Senior Charge Nurse will discuss options with patients at ward meeting and take forward ideas from the patient group about how best to take this forward and what best suits at these times.	Raised at Community meetings within Ward 5 and 6 with no one forth coming with issues or potential changes that could be supported. Teams continue to find the issues and support change to benefit patient group. Continue to wait on the reviewed and renewed publication from NHSGGC.
23/02/2022 and 24/02/2022	Wards 5 and 6, Campsie, Bute and Boulevard, Low Secure Unit,	10. Managers should continue address patient concerns with regard to the food on offer in Wards 5 and 6.	• Clinical Service Manager in dialogue with hotel services regarding the ongoing issues with menus and food cycle • Right patient, Right Meal, Right Time policy review currently underway. • The portion size of the meals has been	Quarterly reviews in place	Advocacy involvement has commenced to support taking action forward. Dietician due to return from leave January 2023 and meeting of full team alongside Hospital Catering team in March 2023.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
	Leverndale Hospital		an ongoing complaint – these portions are calorie counted, nutritionally balanced and meet the dietary requirements of the generic patient group. Individuals requiring a modified diet as part of dietetic intervention are catered for. • Senior Charge Nurse (SCN) attends the Food, Fluid and Nutrition Group for Mental Health Partnerships to represent Forensic services. • Senior Charge Nurse attends Food, Fluid and Nutrition Group for Regional Services to represent Forensic Services.		SCN continues to attend bi monthly meetings and shares developments. Lead Nurse continues to attend monthly meetings and shares developments through Forensic Governance structures.
02/03/2022	Appin Ward, Stobhill Hospital	1. Multidisciplinary team (MDT) minutes should include a record of those in attendance.	Nursing staff will remind medical staff /staff completing MDT to ensure an accurate record of those in attendance is completed.	With immediate effect. Action completed on 03/10/2022.	Documentation has significantly improved.
02/03/2022	Appin Ward, Stobhill Hospital	2. Managers should audit care plans on a regular basis to ensure the interventions are person centred and care plans are updated following evaluations to reflect any changes in the individuals care needs and legal status.	Care plan audit checklist implemented and Senior Charge Nurses/Charge Nurses will audit care plans on a weekly basis. Senior Charge Nurse to liaise with practice development nurse regarding care plan training sessions.	With immediate effect. Action completed on 03/10/2022.	Care plans being audited weekly. Care planning training sessions useful.
02/03/2022	Appin Ward, Stobhill Hospital	3. Care plan reviews should include adequate information on patient presentation, impact of interventions and progress towards the care goal.	SCN to liaise with Practice Development Nurse regarding care plan training sessions.	With immediate effect. Action completed on 03/10/2022.	Care plans being audited weekly.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
02/03/2022	Appin Ward, Stobhill Hospital	4. Managers should audit S47 certificates to ensure that consultation with proxy decision makers is recorded.	To audit on a weekly basis, whilst completing care plan audits.	With immediate effect. Action completed on 03/10/2022.	All Section 47 certificates being audited on weekly basis.
02/03/2022	Appin Ward, Stobhill Hospital	5. Activity care plans should be reviewed to include person-centred information about the individual's hobbies, skills and interests.	Therapeutic Activity Nurses to review care plans to ensure they are person centred and are created with the individual. Care plans to be audited weekly. Senior Charge Nurse to liaise with Practice Development Nurse in regards care plan training sessions.	With immediate effect. Action completed on 03/10/2022.	Therapeutic care plans completed for all patients. Getting to know me forms completed.
02/03/2022	Appin Ward, Stobhill Hospital	6. Managers should review the positioning of the safes for potential ligature risk.	Senior Charge Nurse to liaise with Health and Safety and Operations Co-ordinator and take appropriate action regarding risks.	Actioned immediately.	Awaiting removal of same.
15/03/2022	Ward 37, Royal Alexandria Hospital	1. Managers should, as a priority, review their audit processes to improve the quality of mental health care plans to ensure these are person-centred and updated, to accurately reflect the patient's current needs, planned interventions and legal status.	Senior Charge Nurse to carry out weekly reviews of care plans and liaise with associate nurses to keep up to date. Band 6 Nurse will be responsible for care plan audits. Person centred care planning guidance emailed to all staff. Nurse Line Management 6/8 weekly to discuss any issues regarding care planning with staff and if further support is required.	6 months – June 2023	Actions in progress.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
15/03/2022	Ward 37, Royal Alexandria Hospital	2. Managers should, as a matter of urgency, ensure that there is a clear person-centred plan of care for patients who experience stress and distress, which incorporates the information from their Newcastle formulation, where this exists. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.	To have all trained staff completing the 2 day stress and distress training. Ongoing essentials in dementia training for Band 3 Health Care Support Worker – help identify triggers and patterns in patients stress/distress. Staff have started to complete and liaising with psychology and families to complete stress and distress Newcastle model for their allocated patients.	6 months – June 2023	Actions in progress.
15/03/2022	Ward 37, Royal Alexandria Hospital	3. Managers should audit section 47 certificates to ensure that consultation with proxy decision makers is recorded.	Weekly AWI (adults with incapacity) checks completed by Senior Charge Nurse. Incorporate AWI checks at weekly MDT meetings with family involvement	6 months – June 2023	Actions in progress.
15/03/2022	Ward 37, Royal Alexandria Hospital	4. Managers should ensure the current review delivers an outcome which addresses the provision of an environment that is fit for purpose and supports staff to meet the complex needs of this patient group as a priority.	All repairs reported to estates as soon as possible. Repairs list kept up to date and chased up if not completed. Building is not fit for purpose and does not meet the complex needs of patients. This is an ongoing discussion at higher management level.	Continuous action	Continuous action

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			NHS Greater Glasgow & Clyde are in the process of implementing their Mental Health Strategy. Part of this work involves bed-modelling, with a proposal for a reduction in Older People Mental Health (OPMH) beds to fund the development of community OPMH services. Subsequent reconfiguration of the inpatient estate will include opportunities to remove older and less suitable wards for the patient population.	A decision on the final bed model is expected in 2023.	A decision on the final bed model is expected in 2023
23/03/2022	Skye House, Stobhill Hospital	We ask that Hospital Managers undertake a review of nursing care plans and implement changes to improve their content and their use to better reflect patient care and treatment overall with greater synchronicity between the weekly MDT notes and nursing care plans in particular.	Ensure care planning part of the induction process for new staff. Review of the use of the EMIS Nursing care plan. Review of feedback from nurses and wider MDT of current process. Consideration of change of process to improve and options appraisal. Test of updated process.	March 2023	Included in induction - Care plan audit completed in relation to EMIS – this includes nursing and MDT - Young people's meetings developed bi-monthly so that young person can input into Care plans

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
23/03/2022	Skye House, Stobhill Hospital	We recommend that any infection control testing and isolation policy which might impact on self- isolation in bedroom spaces and/or the freedom of movement of young people around the ward be clearly discussed with each young person to ensure that young people are clear about its voluntary nature and of the alternatives available to them. We recommend any verbal discussion is supported by written documentation outlining the policy and entering a copy of this into patient records following the discussion, clearly documenting in the notes what has been discussed and what has been understood. Similar records reflecting the discussion of the impact of any infection control testing and isolation policy on the relationship between parents and their children should also be clearly documented.	We will discuss in the charge nurse meeting for cascade to all staff to undertake the following: - Inform all staff of need to have and document discussion - Ensure all staff understand where to get up to date information on the Boards policies - Consider with staff contingencies that may be applied if the young person refuses and importance of documenting same.	October 2022	Complete – staff reminded regarding documentation and updated on infection control procedures

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
23/03/2022	Skye House, Stobhill Hospital	Hospital managers should undertake a review of the available meal options for young people, eliciting the young persons, their families and staff feedback as part of that review and explore with catering managers whether there is scope to improve the meals provided, especially in relation to the nature and range of vegetarian options.	We will undertake a feedback sessions with a group of young people on their views on the available food. - We will seek their views on what they would like to see available We will share our findings with the hospital catering service and seek their agreements to adjust.	October 2022	Engagement with catering regarding poor supply and choice especially regarding vegetarian options, agreement that orders can be from wider range of menus - Young person's community group to be asked regarding their views on food
23/03/2022	Skye House, Stobhill Hospital	We recommend that on the occasions when multidisciplinary team staff are required to provide duties such as meal time management that would ordinarily be undertaken by ward nursing staff that these are clearly documented and audited to ensure oversight of this practise to support future planning of staff provision.	MDT staff, for some disciplines, would see as core to role. Included in induction of staff - in workforce planning the number of hours per patient is measured for tasks so as to capture staffing requirement	October 2022	Included in induction - 7 hours per patient for ED is planned into staffing at present - Completed
12/04/2022	Isla Ward, Stobhill Hospital	1. Managers should audit MDT notes to ensure these are clearly identified as such on EMIS and contain a record of those present, detail of the decisions taken and a clear action plan.	Discussed actions with all MDT members of the ward team. All aware of the requirement to clearly record in EMIS the names of all those who attend an individual patients MDT discussion and the rational for decisions taken regarding the individual's care and treatment plan.	Discussions to take place with MDT ward members by end June 2022 SLWG to meet by end June 2022	The MDT SLWG has been held monthly since June – the group have been exploring different issues raised regarding MDT practice and how to improve this as a site. The site is now looking to

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			To promote consistency across the mental health campus a MDT Short Life Working Group (SLWG) was initiated to ensure delivery of above.	Audit of MDT notes to be completed by end July 2022 and repeated in November 2022	establish MDT rooms which will facilitate virtual attendance and funding has been granted for this. The group has also developed a site timetable for MDTs to better facilitate MDT working and provided guidance to nursing and medical staff on use of the MDT templates in documenting discussion and actions. An audit of MDT practice on Isla ward conducted by the Quality Improvement Nurse demonstrated improvement.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
12/04/2022	Isla Ward, Stobhill Hospital	2. Managers should audit care plans on a regular basis to ensure care plans are updated following evaluations to reflect any changes in the individuals care needs and legal status.	Senior Charge Nurses/Charge Nurses to review 1 x patient care plan per week to ensure care plans are updated to reflect any agreed changes, including changes within an individual's legal status. 2x charge nurses employed, named nurse system implemented. Care plan audit on a weekly basis. Outcomes discussed during line management supervision.	Audit of Care Plans to be completed by end November 2022 to demonstrate improvements in practice are ongoing	Isla ward now has an established Named Nurse system to facilitate more consistent review of care-plans. The patient group is split into two groups lead by the Charge Nurses and each patient is assigned a named nurse and associate nurse. The ward has also recently developed a group diary for monitoring required reviews of care plan paperwork. The Senior Charge Nurses/Charge Nurses are auditing care-plans on a weekly basis to monitor practice and a site audit is to be conducted in December 2022 by the Quality Improvement Nurse.
02/05/2022	Ward 3A, Leverndale Hospital	1. Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patient's progress towards stated care goals and that recording of reviews are consistent across all care plans.	Care plan audits are completed monthly to monitor the content and standards to ensure they are personal centred. These are fed back to nursing staff via nurse line management. This timescale allows nursing staff time to implement any changes and for quality assurance.	31st October 2022	Line Management Supervision utilised to offer support to Named Nurses regarding person centred approach to Care Plans. Charge Nurse audit/monitor same. Collaborative Care Plan reviews carried out routinely and reflect progress or in relation to goals set collaboratively with

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
					patient/carer/staff documented via EMIS.
02/05/2022	Ward 3A, Leverndale Hospital	2. Managers should ensure that visiting arrangements are in line with current Scottish Government Guidance.	Staff followed NHSGGC guidelines on visiting due to covid transmission rate within Glasgow to safeguard our vulnerable patient group. Person centred visiting lead is currently carrying out an audit across all areas to ensure person centred visiting is imbedded in to routine practice.	31st October 2022	Person Centred Visiting in place.
02/05/2022	Ward 3A, Leverndale Hospital	3. Managers should ensure that when a patient accepts or declines activities offered, this is noted in the patient's file.	Staff meetings / handovers taken place to discuss that all staff should be clearly documented on a daily basis when patients have been offered activities and any patients refusing to participate should also be documented. Patient Activity Coordinator and Therapeutic Activity Nurses also document daily any participation of ward based activities.	21st October 2022	All staff providing activity – whether Patient Activity Coordinator, Therapeutic Activity Nurses, Health Care Support Worker, Recreational Therapy or Allied Health Professionals documenting patient participation, or refusal via EMIS.
05/05/2022	Ward 4A, Leverndale Hospital	1. Managers should ensure that for patients who have particular dietary requirements, there is range of healthy and varied options.	Catering department routinely audit menu choices, taking account of dietary requirements and patient feedback.	October 2022	Menu choices available. Catering department monitor same based on audit/feedback.
05/05/2022	Ward 4A, Leverndale Hospital	2. Managers should ensure that during religious festivals there is specific provision for patients to observe and have access to services that support their cultural needs.	Spiritual service available to all patients. Senior Charge Nurse to raise profile of this service to staff and patients within Ward 4A. Chaplain onsite who can support access to support patients cultural needs.	November 2022	Profile regarding Spirituality service raised – responsive service to all patients facilitating spiritual needs.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
05/05/2022	Ward 4A, Leverndale Hospital	3. Managers should ensure that care plans address the specific needs of individual patients.	Senior Charge Nurse and Charge Nurse team supporting Named Nurse process to ensure specific needs of individual patients are addressed.	November 2022	Line Management Supervision utilised to offer support to Named Nurses re person centred approach to Care Plans. Charge Nurse audit/monitor same. Collaborative Care Plan reviews carried out routinely, documented via EMIS.
05/05/2022	Ward 4A, Leverndale Hospital	4. Managers should ensure that risk assessment documentation is updated accordingly and accessible to all staff.	Craft risk assessments updated in line with NHSGGC policy. This is accessed via patient records on EMIS. Accessible to all staff who work with the individual patients.	August 2022	Evidence that CRAFT risk assessments and management plans updated as indicated – available on EMIS.
05/05/2022	Ward 4A, Leverndale Hospital	5. Managers should work with Health and Social Care Partnerships to ensure timely discharge for patients.	Leverndale Hospital have a dedicated Hospital Social Worker who supports timely discharges. Leverndale Hospital have an Integrated Discharge Team who meet regularly, identifying barriers to discharge and looking at solutions. NHSGGC are in process of reviewing discharge processes.	October 2022	Integrated Discharge Team, inclusive of hospital based Social Work continue to support MDT with timely discharge planning. MDT participate in Ward 4A bed management meeting as well as huddle to explore potential barriers to discharge.
05/05/2022	Ward 4A, Leverndale Hospital	6. Managers should ensure medication records are reviewed for patients requiring forms (T2 and T3) authorising treatment under the Mental Health Act and ensuring s47 certificates are completed appropriately.	NHSGGC have implemented a board wide action plan to address this.	August 2022	Most recent T2/T3 compliance audit supports this.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
05/05/2022	Ward 4A, Leverndale Hospital	7. Managers should ensure that visiting arrangements are in line with current Scottish Government Guidance.	Staff followed NHSGGC guidelines on visiting due to covid transmission rate within Glasgow to safeguard our vulnerable patient group. Person centred visiting lead is currently carrying out an audit across all areas to ensure person centred visiting is imbedded in to routine practice.	October 2022	Person Centred Visiting in place.
05/05/2022	Ward 4A, Leverndale Hospital	8. Managers should ensure that patients have access to meaningful activity and occupation seven days per week.	Ward 4A has dedicated time from Patient Activity Co-ordinator and Recreational Therapy staff during core hours. Ward staff within Ward 4A also provide input to meaningful activity 7 days per week.	August 2022	Patient Activity Coordinator, Activity Recreational Therapy, in reach and activity and events available at Recreational Therapy Department. Allied Health Professional activity Psychological Therapy Groups where indicated. Nursing Staff providing socialisation activity at evenings and weekends – notice boards utilised to communicate same.
05/05/2022	Ward 4A, Leverndale Hospital	9. Managers should ensure that when a patient accepts or declines activities that are offered, this is noted in the patient's file.	Senior Charge Nurse highlighted this to all staff who undertake activities to document each time a patient if offered activity but declines.	October 2022	All staff providing activity – whether Patient Activity Coordinator, Therapeutic Activity, Health Care Support Worker, Recreational Therapy or Allied Health Professionals documenting patient participation, or refusal via EMIS.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
05/05/2022	Ward 4B, Leverndale Hospital	1. Managers should ensure that during religious festivals there is specific provision for patients to observe and have access to services that support their cultural needs.	Spiritual service available to all patients. Senior Charge Nurse to raise profile of this service to staff and patients within Ward 4B. Chaplain onsite who can support access to support patients cultural needs.	October 2022	Profile regarding Spirituality service raised – responsive service to all patients facilitating spiritual needs.
05/05/2022	Ward 4B, Leverndale Hospital	2. Managers should ensure that for patients who have particular dietary requirements, there is range of healthy and varied options.	Catering department routinely audit menu choices, taking account of dietary requirements and patient feedback.	October 2022	Menu choices available. Catering department monitor same based on audit/feedback.
05/05/2022	Ward 4B, Leverndale Hospital	3. Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards their stated care goals and where a recording of reviews is consistent across all care plans.	Senior Charge Nurse and Patient Activity Co-ordinator have met in focus groups with Patients to identify what a person centred care plan means to them. Ward 4B is piloting a document that patients have worked on. This will be reviewed three months in to the process to ensure it meets patient needs and goals.	December 2022	Line Management Supervision utilised to offer support to Named Nurses re person centred approach to Care Plans. Charge Nurse audit/monitor same. Collaborative Care Plan reviews carried out routinely and reflect progress or in relation to goals set collaboratively with patient/carer/staff documented via EMIS.
05/05/2022	Ward 4B, Leverndale Hospital	4. Managers should work with Health and Social Care Partnerships to ensure timely discharge for patients.	Leverndale Hospital have a dedicated Hospital Social Worker who supports timely discharges. Leverndale Hospital have an Integrated Discharge Team who meet regularly, identifying barriers to discharge and looking at solutions. NHSGGC are in process of reviewing discharge processes.	October 2022	Integrated Discharge Team, inclusive of hospital based Social Work continue to support MDT with timely discharge planning. MDT participate in Ward 4B bed management meeting as well

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
					as Huddle to explore potential barriers to discharge.
05/05/2022	Ward 4B, Leverndale Hospital	5. Managers should ensure that risk assessment and MDT recording is robust and available to all staff as required.	Craft risk assessments updated in line with NHSGGC policy. This is accessed via patient records on EMIS. Accessible to all staff who work with the individual patients.	October 2022	Evidence that CRAFT risk assessments and management plans updated as indicated – available on EMIS.
05/05/2022	Ward 4B, Leverndale Hospital	6. Managers should ensure that visiting arrangements are in line with current Scottish Government Guidance.	Staff followed NHSGGC guidelines on visiting due to covid transmission rate within Glasgow to safeguard our vulnerable patient group. Person centred visiting lead is currently carrying out an audit across all areas to ensure person centred visiting is imbedded in to routine practice.	October 2022	Person Centred Visiting in place.
05/05/2022	Ward 4B, Leverndale Hospital	7. Managers should ensure that when a patient accepts or declines activities that are offered, this is noted in the patient's file.	Senior Charge Nurse highlighted this to all staff who undertake activities to document each time a patient is offered activity but declines.	October 2022	All staff providing activity – whether Patient Activity Coordinator, Therapeutic Activity Health Care Support Worker, Recreational Therapy or Allied Health Professionals documenting patient participation, or refusal via EMIS.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
05/05/2022	Ward 4B, Leverndale Hospital	8. Managers should ensure that patients have access to meaningful activity and occupation seven days per week.	Ward 4B has dedicated time from Patient Activity Co-ordinator and Recreational Therapy staff during core hours. Ward staff within Ward 4B also provide input to meaningful activity 7 days per week.	October 2022	Patient Activity Coordinator Activity, Recreational Therapy in reach and activity and events available at Recreational Therapy Department. Allied Health Professionals activity. Psychological Therapy Groups where indicated. Nursing Staff providing socialisation activity at evenings and weekends – notice boards utilised to communicate same.
25/05/2022	Arran Ward, Rehab & Recovery Unit, Dykebar Hospital	Managers should ensure that all DNACPR (do not attempt cardiopulmonary resuscitation) decisions are reviewed and there is a consistent system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.	DNACPR expiry date entered on to EMIS warning system, this will flag up each time any member of staff accesses the patients on EMIS, the warning must be acknowledged before staff member can continue. DNACPR will be clearly marked in patient paper notes and paper work contained therein. DNACPR will be clearly marked on white board in staff office. DNACPR expiry date recorded on white board in office.	3 months - Completed 3 months - Completed 3 months - Completed 3 months - Completed	All DNACPR expiry dates are now on the EMIS warning system. Copies of the DNACPR paperwork are now in place for all appropriate patients. DNACPR expiry dates have now been added to the patient at a glance boards.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			Check sheet introduced to be used during weekly MDTs which will direct the team to check if patient has a current DNACPR and expiry date.	3 months - Completed	The MDT check sheet is now in place.
25/05/2022	Arran Ward, Rehab & Recovery Unit, Dykebar Hospital	Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on both a T2 or T3 form, where required, and a system of regular auditing compliance with this should be put in place.	A weekly ward Audit drawn up by Clinical Governance and implemented and audited by the Professional Development Nurses (PDN) team, results of weekly Audit to be forwarded to PDNs each week. A warning entered on to the HEMPA (Hospital Electronic Prescribing and Medicines Administration) which will automatically flag up each time the patient is accessed on the system, giving notice that the patient has current T2/3 in place. Check sheet introduced to be used during weekly MDTs, this will direct the team to check if patient has a current T2 or T3 and the expiry date.	3 months - Completed 3 months - Completed 3 months - Completed	The SCN or Charge Nurse completes a weekly audit of all T2 and T3 paperwork and informs the medical staff of any required changes. HEPMA is now in place within the ward, which alerts staff to existing T2 and T3 paperwork.
25/05/2022	Arran Ward, Rehab & Recovery Unit, Dykebar Hospital	Managers should ensure that staff have good awareness in relation to advance statements which should be promoted with patients in the ward and these discussions be clearly documented in the	Check sheet introduced to be used during weekly MDTs which will direct the team to check if patient has a current Advance Statement and if not, to discuss whether it's appropriate to offer this to the patient at this time, details of discussion to be recorded on patient's notes on EMIS. Named nurse to discuss advance statement with patients who do not	3 months - Completed 3 months - Completed	Advance Statements are now discussed at the MDT to increase their use. The Senior Charge Nurse and Charge Nurses discuss Advance Statements with

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
		patient's clinic notes and care plan.	presently have one explaining rational behind them during 1:1 monthly care plan reviews and document discussion in EMIS.		the staff at line management supervision.
25/05/2022	Arran Ward, Rehab & Recovery Unit, Dykebar Hospital	Managers should consider ward refurbishment to provide single room accommodation to ensure privacy and maximum benefit to patients.	NHS Greater Glasgow & Clyde are in the process of implementing their Mental Health Strategy. Part of this work involves bed-modelling, with a proposal for a reduction in Rehab beds to fund the development of community rehab services. Subsequent reconfiguration of the inpatient estate will include opportunities to remove older and less suitable wards for the patient population.	A decision on the future Adult Mental Health Rehab bed model for NHS GGC is expected to be agreed in 2023.	There has been some improvements made to the aesthetics of the ward, with new furniture for the public rooms and bedrooms. Raised flower beds and new seating have been added to the atrium. The Rehab sub group, as part of the NHS GGC Mental Health Strategy group, continue to meet to discuss bed modelling and future improvements to the service.
01/06/2022	Armadale Ward, Stobhill Hospital	Managers should ensure that section 47 treatment plans are completed, available and correctly filed in accordance with the AWI Code of Practice (3rd edition).	A checklist to monitor practice in completing and storing Section 47 Certificates will be added to the ward weekend checklist to ensure that care plans are being reviewed and all relevant paperwork is in date.	With Immediate Effect – September 2022	Checklist is in place as part of the weekend checks and also added as part of weekly care plan reviews. Senior Charge Nurses and Charge Nurses will continue to monitor and review weekly.
01/06/2022	Armadale Ward, Stobhill Hospital	Managers should ensure that when a patient accepts or declines activities offered this is noted in the patient's file.	Ward staff will liaise with Therapeutic Activity Nurses and create a diary that can be shared for recording and planning activity. Staff will document clearly who was invited and who declined to attend activities throughout the day. This will,	With Immediate Effect – September 2022	Diary is in place and is being used frequently – an audit in October by the Quality Improvement Nurse demonstrated improvements.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			also, be documented on EMIS in the daily notes.		
01/06/2022	Armadale Ward, Stobhill Hospital	Managers should ensure that a system is in place to ensure maintenance requests are responded to in a reasonable time frame.	Ward staff will report all maintenance issues via the Facilities Management service desk taking note of reference numbers and date reported. Staff will liaise with the Operations Manager who will review outstanding requests on a weekly basis. The Operations Manager will liaise with Estates to ensure repairs are carried out in a timely manner.	With Immediate Effect – September 2022	Maintenance diary is in place and being used consistently by staff. Any outstanding repairs are escalated weekly. An audit in October by the Quality Improvement Nurse demonstrated improvement.
01/06/2022	Armadale Ward, Stobhill Hospital	Managers should ensure that the garden area is maintained to provide a safe, pleasant and easily accessible area for patients and visitors.	Ward staff will ensure that the garden area is inspected weekly and fit for purpose and any damaged furniture is quickly reported via the Facilities Management system. Staff will liaise with the Operations Manager to escalate any reports where required.	With Immediate Effect – September 2022	Maintenance diary is in place and being used consistently by staff. Any outstanding repairs are escalated weekly. An audit in October by the Quality Improvement Nurse demonstrated improvement.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
16/06/2022	IPCU, Leverndale Hospital	Managers must ensure the prescribing of 'as required' medications is in line with NHSGGC policy and best practice guidelines to ensure dosages, routes of administration and maximum daily dose are clear.	Full discussion regarding medication at MDT. Ward Management Team will reinforce policy/guidance via various communication forums. Senior Management Team reiterate policy/procedure, provide Significant Adverse Event Review (SAER) feedback. Ward Pharmacist delivering training for Registered Clinicians in IPCU regarding use of IM (intramuscular) Medication – with discussion re de-escalation, oral medication options. HEPMA implementation. Audit of discretionary medications to ensure administration and maximum daily dose are adhered to.	This will be a continuous monitoring process. Communications have been sent out via email, reinforced at handovers and nurse line management supervision.	
16/06/2022	IPCU, Leverndale Hospital	Managers should ensure there is patient and staff participation in care planning and that this is evidenced in the care file.	Senior Charge Nurse initial review of Nursing Care Plan Documentation - Professional Development Nurse (PDN) deliver Care Plan Support Sessions - Named Nurse role to be highlighted – includes collaboration with all Patient and Carers - Senior Charge Nurse/Charge Nurse ongoing Care Plan audit regarding Nurse Care Plan/Named Nurse role following	November 2022	A further visit has taken place and formal feedback will be received once the final report is issued.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			PDN support session - Newly Qualified Nurses/new staff to have access to this support		
16/06/2022	IPCU, Leverndale Hospital	Managers should ensure regular participation and engagement with the patient, their families and named person at multidisciplinary team meetings.	MDT audit completed - Senior Charge Nurse review of MDT framework in IPCU (intensive psychiatric care unit) - Carers/relatives to be invited to MDT – aware of contact options outwith MDT - Named Nurse regular contact with carer/relative and prior to every MDT – follow up contact also arranged	November 2022 Will be audited to ensure adherence	A further visit has taken place and formal feedback will be received once the final report is issued.
16/06/2022	IPCU, Leverndale Hospital	Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form, where required, and a system of regular auditing compliance with this should be put in place.	T2/T3 action plan implemented. Seven Minute Briefing issued.	Communications sent out and reinforced in July. Regular audit processes continue	A further visit has taken place and formal feedback will be received once the final report is issued.
16/06/2022	IPCU, Leverndale Hospital	Managers should ensure that a programme of training is supplied to all staff in relation to advance statements which should be promoted in the ward and these discussions be clearly documented in the patient's clinic notes and care plan.	Staff will promote advance statements for patients within IPCU although recognise that whilst within IPCU this may not be appropriate to complete but will encourage and promote pathways where advance statements should be discussed.	November 2022	A further visit has taken place and formal feedback will be received once the final report is issued.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
16/06/2022	IPCU, Leverndale Hospital	Managers should ensure that reviews of enhanced levels of observation take place and are recorded in line with Improving Observation Practice guidelines.	MDT framework in IPCU setting reviewed – all enhanced observations discussed via MDT, reviewed in line with current policy - robust care planning re enhanced observations Enhanced observations discussed at each handover to ensure staff are fully aware of patients status, risks and level of observation Nurse in charge to ensure staff adhering to current policy - PDN team to deliver In-House training sessions regarding Safe & Supportive observations 13th September, 16th September, 6th October ensuring all staff have attended. - Policy Implementation Group roll out of Continuous Intervention Policy	Senior Charge Nurse and Charge Nurse continue to reinforce adherence to current policy.	
22/06/2022	Ward 39, Royal Alexandria Hospital	Managers should review visiting arrangements to ensure the ward provides a pleasant and positive experience for visits and that arrangements are in line with national guidance.	The ward will ensure visiting arrangements are followed in line with MH GG&C Covid Discussion Forum and Greater Glasgow and Clyde NHS.	Completed	Visiting is available from 10am until 9pm. There is protected meal times. However, visitors assisting a patient with their meal may visit during these times.
22/06/2022	Ward 39, Royal	Managers should review bed provision across adult and old age psychiatry to ensure	The provision of beds will be discussed twice daily at the service Huddle, whilst taking into considerations GG&C Bed	Completed	The twice daily local huddle continues to look at bed pressures to ensure optimal

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
	Alexandria Hospital	there is adequate capacity within each service to meet demand.	Management Policy. Discussed at Senior management level and identified on the Health and Safety Risk register.		and appropriate use of the bed establishment. Where there are issues that prevent this, these are escalated to senior management for consideration.
22/06/2022	Ward 39, Royal Alexandria Hospital	Managers should undertake an audit of the environment and develop a plan to address the identified issues of lack of suitable shower/bathing facilities, limited facilities for activity provision and visiting and the absence of access to a therapeutic kitchen.	NHS Greater Glasgow & Clyde are in the process of implementing their Mental Health Strategy. Part of this work involves bed-modelling, with a proposal for a reduction in Older People Mental Health (OPMH) beds to fund the development of community OPMH services. Subsequent reconfiguration of the inpatient estate will include opportunities to remove older and less suitable wards for the patient population.	2023	An environmental audit has been completed in Ward 39, using the Kings Fund audit tool. NHS GGC Older People's Mental Health Services review is ongoing and will consider ward environments. It is anticipated that the review will publish its recommendations in 2023.
22/06/2022	Ward 39, Royal Alexandria Hospital	Managers should ensure that staff are proactive in providing information on care decisions and progress of patients to relatives.	Discussed at nurse line management the importance of follow up face to face discussion at visiting times with appropriate relatives/carers.	30th September 2022	Nursing staff are now proactively providing information regarding care with carers during visiting times.
07/07/2022	Ward 4A and 4B, Larkfield Inverclyde Royal Hospital	Managers should audit MDT notes to ensure these are clearly identified as such on EMIS and contain a record of those present, detail of the decisions taken and a clear action plan.	MDT preparation guides and application to EMIS templates provided to nursing staff. Discussion with Consultant and guidance to medical staff on use of MDT template. Preparation of MDT template has been incorporated into the weekly work schedule.	Completed 01/12/2022 and will remain ongoing	Completed 01/12/2022 and will remain ongoing

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
07/07/2022	Ward 4A and 4B, Larkfield Unit, Inverclyde Royal Hospital	Managers should put in place the necessary support and audit processes to ensure that 'Getting to know me' documentation is fully completed and that life history information is recorded and follows the patient when they move to a further care placement.	Occupational Therapy will continue to gather information as part of initial interview process which will be uploaded to EMIS This can be used to help inform 'Getting to know me' documentation. 6 weekly audit at MDT – Senior Charge Nurse has formulated a checklist to conduct check. Patient Activity Coordinator collating information for Getting to know me and What matters to me.	Completed 01/12/2022 and will remain ongoing	Completed 01/12/2022 and will remain ongoing
07/07/2022	Ward 4A and 4B, Larkfield Unit, Inverclyde Royal Hospital	Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.	Occupational Therapy staff will continue to attend and contribute to Stress and Distress meetings led by Psychology. Process of supporting staff to formulate person centred stress and distress if appropriate for the patient 14 days from admission.	Completed 01/12/2022 and will remain ongoing	Completed 01/12/2022 and will remain ongoing

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
07/07/2022	Ward 4A and 4B, Larkfield Unit, Inverclyde Royal Hospital	Managers should review their audit processes to improve the quality of care plans to ensure these are person centred and updated to accurately reflect the patient's current needs and planned interventions.	Occupational Therapy (OT) lead carries out 6 monthly documentation audit to ensure OT documenting is completed to a high standard. Discussion between Senior Charge Nurse and nursing staff to complete care plans as per the MWC Person Centred Care Plans good practice guidance. All care plans reviewed at nurse line management supervision. CCAAT tool for 6 monthly peer and yearly Professional Development Nurse audit keeping provides further quality assurance.	Completed 01/12/2022 and will remain ongoing	Completed 01/12/2022 and will remain ongoing
07/07/2022	Ward 4A and 4B, Larkfield Unit, Inverclyde Royal Hospital	Managers should, as a priority, provide line management and have the practice development nurse support the ward to ensure that the above recommendations are implemented.	Senior Charge Nurse/Charge Nurse to provide nurse line management to staff. Discussed with Professional Development Nurse and audit of care plans requested.	Completed 01/12/2022 and will remain ongoing	Completed 01/12/2022 and will remain ongoing
07/07/2022	Ward 4A and 4B, Larkfield Unit, Inverclyde Royal Hospital	Managers should ensure that where a power of attorney or guardianship is in place, copies of the powers granted are held on file.	Managers audit 6- 8 weekly at MDT to ensure all appropriate paperwork within notes. Discussion with medical staff/consultant and nursing staff on admission and on Adults with Incapacity (AWI) application to request copy of paperwork.	Completed 01/12/2022 and will remain ongoing	Completed 01/12/2022 and will remain ongoing

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
07/07/2022	Ward 4A and 4B, Larkfield Unit, Inverclyde Royal Hospital	Activity care plans should be reviewed to include person centred information about the individuals' hobbies, skills and interests.	Occupational Therapy (OT) will utilise 'Activity checklist' where appropriate and upload to EMIS ensuring information is considered in OT treatment plan. Care plans are reviewed at nurse line management – support and discussion from Professional Development Nurse to formulate person centred care plan. Professional Development Nurse audit at MDT 6-8 weekly.	Completed 01/12/2022 and will remain ongoing	Completed 01/12/2022 and will remain ongoing
16/08/2022	Cuthbertson Ward, Gartnavel Royal Hospital	Risk assessments should be located in the assessment section of EMIS for ease of access and review.	• Ward team will link in with eHealth to ascertain how to transfer from consultation to assessment section • Once this has been identified the ward management team will circulate a Standard Operating Procedure detailing how to do this • Routine audit will ensure practice has been bedded in	End February 2023	Action in progress
16/08/2022	Cuthbertson Ward, Gartnavel Royal Hospital	Managers should review their audit processes to improve the quality of care plans to ensure these are consistently person centred, reviews are undertaken and care plans updated to accurately reflect the patient's current needs and planned interventions.	• Care plan audit is via peer led Combined Care Assurance Audit Tool system thus ensuring objectivity. • The above is supplemented by local audit/system modification which includes: 1. Care Plan Checklist: this extrapolates the key elements of person centred care and acts as an aide memoire for staff and the basis of the local weekly audit.	End March 2023	Action in progress

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			2. Weekly audit: to implement above. This will be conducted by the 2 Charge Nurses for their respective teams. • Recirculate the MWC Guidance on person centred care planning. • Allocate protected care plan time so staff can balance their challenging priorities.		
16/08/2022	Cuthbertson Ward, Gartnavel Royal Hospital	Managers should regularly audit the "Getting to Know Me" documentation to ensure this is fully completed and life history information is recorded and follows the patient when they move to a further care placement.	• See above. • Ward team have constructed a weekend checklist to ensure there is no slippage on audit/action.	End March 2023	Action in progress
16/08/2022	Cuthbertson Ward, Gartnavel Royal Hospital	Managers should ensure that where a power of attorney or guardianship is in place, copies of the powers granted are held on file.	• Included in initial assessment, care plan front page and MDT document thus ensuring it has been requested and adhered to. • The aforementioned audit process will monitor adherence to this. • Key Worker has responsibility to engage with families to obtain copy, if in their possession. • Familial non-engagement with this request will be discussed at MDT meeting and actioned.	End March 2023	Action in progress
24/08/2022	Rowanbank Clinic, Stobhill Hospital	Managers should review patient attendance at MDT meetings across the wards to improve ease of access for	Review of 4 weeks of Multi-disciplinary Team (MDT) records for all inpatients revealed evidence that three of the eight wards in the clinic had patients attend	Complete	Complete

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
		all patients who wish to participate.	MDT meetings either regularly or occasionally. Clinical teams report that no concerns about patient access to MDT's raised by their patient group. Similarly there have been no complaints either informal/formal raise with managers regarding this. In order to evidence patients perspective is represented there was a joint scoping exercise undertaken by Interim Lead Nurse and Circles Advocacy. Brief questionnaire on the MDT meeting preferences was circulated to the patient group. Findings were collated and distributed to clinical teams and the Clinical Governance Group. The ability to accurately evidence patient involvement with MDT meetings alongside other aspects of their care has been raised with the Digital Champions forum. As patient files move to EMIS, it has become increasingly challenging to evidence active patient involvement as EMIS is not a patient facing system.	Outcome/findings to be discussed at Governance meeting and Professional Nurse Group (PNG) meeting with Senior Nurses, in January 2023. Digital Champions aim is to have all necessary forms online by July 2023.	Action due January 2023. Action due July 2023.
24/08/2022	Rowanbank Clinic, Stobhill Hospital	Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patient's	Care plan audit completed and feedback to senior staff in the clinical areas.	Complete Continuous action	Action complete Continuous action

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
		progress towards stated care goals and that recording of reviews are consistent across all care plans.	Ongoing involvement in forums in relation to the transition to electronic patient records. Peer review schedule being reinvigorated following the completion of the augmentation of the Acute Care Assurance Standards (CAS) to meet Mental Health Services standards.	Deadline for CAS 01/01/2023. Peer review schedule for implementation thereafter.	Action in progress and will be rolled out by February 2023.
12/09/2022	Clyde House, Gartnavel Royal Hospital	Managers should ensure that the ward environment is welcoming, fit for purpose and provide the Commission with an update on the programme for refurbishment, including timeframes.	Hospital management have implemented a number of refurbishments since the last visit. This has meant that that there been improvements in the ward environment as well as the garden area. The refurbishments are listed below: - Group room has been refurbished to include; new flooring, painting and furniture. - All flooring replaced to all communal and clinical areas. - New ventilation system in kitchen area. Senior Charge Nurse will meet regularly with Inpatient Service Manager/Operations Coordinator and prioritise work taking in to account facility/Healthcare Associated Infection/Healthcare Environment Inspectorate audits and patient and staff opinion.	Completed. Continuous action	Completed.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
12/09/2022	Clyde House, Gartnavel Royal Hospital	Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.	The review of the NHSGG&C rehabilitation service remains ongoing. To enable a refurbishment of the ward to be undertaken to include the provision of individual en-suite facilities would require capital investment. This would not be within the scope of the hospital manager's role to progress a project of that magnitude however the recommendation has been highlighted via our line-management structure and escalated to appropriate decision authority making level which is out with Gartnavel Royal Hospital.	The review of the NHSGG&C rehabilitation service remains ongoing.	The review of the NHSGG&C rehabilitation service remains ongoing.
14/09/2022	McNair Ward, Gartnavel Royal Hospital	Managers should regularly audit care plans to ensure they are person-centred, include all the individual's needs, ensure individuals participate in the care planning process and are given opportunities to engage in care plan reviews.	Care plans are audited by the Team Leaders on a fortnightly basis and this is supplemented by a peer audit. The Team Leaders focus on person centeredness' and processes but struggle with the hybrid system currently in operation which means they move between paper and electronic records. Evidencing patient involvement is not helped by this. It is anticipated that we will re-engage with accreditation via AIMS (Accreditation for Inpatient Mental Health Services) soon which addresses and assists in formatting process which demonstrates involvement (which we think is taking place) is a slightly more smooth and sophisticated manner. Staff will ensure to document on identified needs if patient is not willing to engage in signing	One month - end December 2022	Ongoing audits by ward management team ensure that recommendations and actions are carried out.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			so as to evidence that involvement with this has been attempted/encouraged.		
14/09/2022	McNair Ward, Gartnavel Royal Hospital	Managers should ensure all one-to-one sessions between a patient and nurse are clearly documented in a patient's file.	The report comments on clear evidence of the nursing staff being on top of the patient's care and history and this can come about having 1:1's and structured assessment and re-assessment. Nursing staff will ensure to differentiate on EMIS when a one to one session has taken place rather than record all entries under progress notes. Nursing reassessments will also take format of having a care plan review which will highlight each identified need being discussed with the patient.	One month - end December 2022	System in place to ensure one-to-one sessions take place and clearly documented in patient's electronic file as such. A system is also in place to ensure that re-assessment dates are recorded.
22/09/2022	Blythswood House, Renfrew	Managers should ensure that patient activity is prioritised and that clear plans are in place for each patient throughout the week to participate in meaningful activity. This activity should be recorded in the daily notes.	Utilise Activity Nurse via Bank three times weekly to increase both group and individual activities both on and off site. Review of individual and group activities to be carried out by activity nurse and Occupational Therapy. Audit of activity levels to be carried out by Occupational Therapy and Medical Trainee in January.	Commenced December 2022. Will be reviewed 31st January 2023 31st January 2023 31st January 2023	Commenced December 2022. Will be reviewed 31st January 2023 31st January 2023 31st January 2023

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			All staff to ensure activities are recorded on EMIS notes.	Service Manager will review 31st January 2023	Service Manager will review 31st January 2023
22/09/2022	Blythswood House, Renfrew	Service and estates managers should ensure that improvement works are carried out promptly to the benefit of the patients.	New furniture purchased (complete). Agree redecoration programme for all pods including bedrooms. Soft and wall furnishings to be purchased for pods. Named nurses/patient/family to ensure suitable personalisation of bedrooms.	To be completed by 28th February 2023.	To be completed by 28th February 2023.
28/09/2022	Portree Ward, IPCU, Stobhill Hospital	Managers should ensure that a clear rationale and communication is offered and recorded to ensure that patients understand why they remain suitable for care in an IPCU.	The Senior Charge Nurse (SCN) and Inpatient Operational Nurse Manager will liaise with the Consultant Psychiatrist regarding documentation of Multi-disciplinary Team (MDT) discussion to ensure rationale for place in IPCU (intensive psychiatric care unit) is being discussed, documented and reviewed regularly with the patients. This will be further supported by work undertaken by the MDT short life working group. The SCN and Charge Nurses (CN) will ensure nursing staff are developing care plans which detail progress towards transfer to an open ward environment –	January 2023 December 2022	

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			the SCN and CNs will continue to conduct ward audits of care plans to monitor this. The Inpatient Operational Nurse Manager will attend MDT discussion at Portree Ward at least once a month to ensure discussions are occurring regarding patient ongoing suitability for IPCU. After each MDT a nominated staff member will email the Bed Manager to inform them of any patients who are identified for transfer to a Locality (Open) ward so that a bed can be identified and transfer scheduled and realised. Audit to be scheduled for early February to ascertain if rational has been documented re: continued IPCU care, patient awareness of plan and if email was sent to Bed Manager. Repeat audit to be scheduled for early March to ascertain if rational has been documented re: continued IPCU care, patient awareness of plan and if email was sent to Bed Manager. Third and final audit to be scheduled for early April to ascertain if rational has been documented re: continued IPCU care,	January 2023 December 2022 February 2023 March 2023 April 2023	Attended MDT 04/01/2023 Achieved in practice Action due February 2023 Action due March 2023 Action due April 2023

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			patient awareness of plan and if email was sent to Bed Manager.		
28/09/2022	Portree Ward, IPCU, Stobhill Hospital	Managers should ensure there is patient involvement and participation in care planning which is personalised, to ensure that this is evidenced in each care plan.	The SCN will raise the need to actively encourage individuals to participate in collaborative care planning to improve and evidence personalised and person care and treatment. This will be discussion at the next ward team meeting which will be attended by the Inpatient Operational Nurse Manager and Quality Improvement Nurse. The SCN and CNs will ensure staff are receiving regular Line Management Supervision to identify any gaps in training or additional support required. The SCN and CNs will continue to conduct ward audits of care plans to ensure improvement is being maintained. The Senior Charge Nurse will liaise with the Advanced Nurse Practitioners (ANPs) and Professional Development Nurses (PDNs) regarding additional training for staff in terms of care planning. The Quality Improvement Nurse will conduct service audits of care plans to ensure improvement is being maintained.	January 2023 December 2022 and ongoing action January 2023 January 2023 First audit February, 2nd Audit March and 3rd April 2023	December 2022 and ongoing action First audit February, 2nd Audit March and 3rd April 2023

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
			The ward has recently altered the Named Nurse system and will ensure patients are assigned to a Named Nurse Group in order to encourage peer-support among staff and ensure care plans are reviewed.	December 2022	
28/09/2022	Portree Ward, IPCU, Stobhill Hospital	Managers should ensure that all young people who are subject to care in the IPCU, should be able to freely access education without any barriers, if they are well enough to participate in education activity.	Inpatient Operational Nurse Manager will liaise with CAMHS services regarding this and ensure there is a pathway to enable young people to access education without any barriers whilst an inpatient in IPCU. Staff awareness of pathway to be delivered. SCN and CNs will ensure there are care plans devised to address educational needs for adolescent patients – devised in collaboration with CAMHS services.	January 2023 January 2023 January 2023	
28/09/2022	Portree Ward, IPCU, Stobhill Hospital	Managers should ensure regular participation and engagement with the patient, their families and named persons in regard to multidisciplinary team meetings.	The ward will continue to ensure family and carers are regularly offered an appointment to attend MDTs – this is advertised on the ward. Senior Charge Nurse / Inpatient Operational Nurse Manager in conjunction with Mental Health Network will create a questionnaire to ascertain from family and named persons to identify any potential barriers that prevent attendance at MDTs.	December 2022 February 2023	Action due February 2023

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
28/09/2022	Portree Ward, IPCU, Stobhill Hospital	Manager should ensure that patients have access to advocacy services at all times whilst subject to any provisions of mental health legislation.	The ward will continue to utilise the new Named Nurse Group system to ensure that staff are supporting each other in ensuring patients are engaged in discussion of advocacy services and referrals are completed where appropriate. The Inpatient Operational Nurse Manager has arranged a meeting with Advocacy Services Planning and Performance Officer to discuss advocacy input on the wards and how to improve this.	December 2022 December 2022	Advocacy Services Planning and Performance Officer and Quality Improvement Nurse met on 30/12/2022 and have agreed a plan to improve Advocacy input into ward.
28/09/2022	Portree Ward, IPCU, Stobhill Hospital	Managers should ensure that a programme of training is supplied to all staff in relation to advance statements which should be promoted in the ward and these discussions be clearly documented in the patient's clinical notes and care plan.	The Quality Improvement Nurse will link in with the Mental Health Network regarding their programme for advance statements. The Quality Improvement Nurse will link in with the PDNs and ANPs regarding local training for ward staff.	January 2023 January 2023	Advanced Statements - Quality Improvement Nurse has contacted the Mental Health Network (MHN) to provide input into the Ward. Advocacy Services Planning and Performance Officer will also follow up with MHN as part of contract monitoring.
28/09/2022	Portree Ward, IPCU, Stobhill Hospital	Managers should ensure that all maintenance and improvement works are carried out urgently to meet the basic standards of care for the benefit of all patients.	The ward will continue to utilise the Maintenance Diary in place to record any repairs reported, incident number and date. The ward staff will monitor this and ensure any overdue repairs are escalated to the Operations Coordinator who will liaise with Estates to ensure these are being addressed in a timely manner.	December 2022	Action achieved.

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
29/09/2022	Willow Ward, Orchard View, Inverclyde	Managers should review their audit processes to ensure care plans are updated to accurately reflect the patients' current needs, planned interventions and legal status.	1. Care plans will be reviewed as part of the Multi-disciplinary Team (MDT) meetings to ensure they are accurate and reflect the patients' current needs, planned interventions and legal status. 2. Staff should clearly document any changes to the care plan and ensure this is communicated effectively to the MDT. 3. Care plans will be reviewed by the Named Nurse as a whole on a monthly basis and any changes communicated effectively to the MDT. 4. As part of GGC Care Assurance System (CAS) process, all patient documentation including the patient care plan will be self-audited by the ward bi-monthly and bi-annually by peer audit utilising the Combined Care Assurance Audit Tool (CCAT).	Immediate/ongoing Immediate/ongoing Immediate/ongoing Bi-monthly & Bi annually.	Actions complete and will be ongoing.
03/10/2022	Rehab Ward, Leverndale Hospital	Managers should ensure regular contact with the local general practitioners to ensure that, at a minimum, annual health checks are undertaken for each patient.	Action plan not yet due – due March 2023.		
03/10/2022	Rehab Ward, Leverndale Hospital	Managers should undertake a review into the need for therapeutic activity nurse provision to support for the ward.	Action plan not yet due – due March 2023.		

Return to summary table

Date of Visit	Local Visit	Local Visit Recommendations	Action Plan Response to Recommendations	Timescales for implementation of Actions	Update
03/10/2022	Rehab Ward, Leverndale Hospital	Managers should ensure that the ward environment is upgraded to create a conducive setting for rehabilitation and that consideration be given to single room accommodation.	Action plan not yet due – due March 2023.		
11/10/2022	Iona Ward, Gartnavel Royal Hospital	Managers should audit care plans to ensure there is consistent use of appropriate language.	Discussions have taken place with staff with regards identifying that consistent, appropriate language is used when formulating care plans. The care plans will be audited and those which reference violence and aggression will be reviewed and re-written to acknowledge the stress and distress that may be the cause of underlying behaviours.	Completed on 7th December 2022	Actions complete
11/10/2022	Iona Ward, Gartnavel Royal Hospital	Information on the locked door policy and how to gain access or exit the ward should be displayed in the vicinity of the ward entrance.	The policy is now displayed at the front door of the ward and staff offer an explanation to relatives and visitors the rationale behind utilising this policy.	Completed on 7th December 2022	Actions complete

Return to summary table

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 12.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20TH JUNE 2023**
REPORT REFERENCE:	**HSCP/200623/12**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER, TELEPHONE NUMBER, 0141 232 8216**
SUBJECT TITLE:	**ACCOUNTS COMMISSION REPORT – INTEGRATION JOINT BOARDS FINANCIAL ANALYSIS 2021/22**

1.0 PURPOSE

1.1 The purpose of this report is to present the Accounts Commission report on Integration Joint Boards Financial Analysis 2021/22.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.0 Note the contents of the Accounts Commission report on Integration Joint Boards Financial Analysis 2021/22.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 This Accounts Commission report provides a high-level independent analysis of the financial performance of Integration Joint Boards (IJBs) during 2021/22 and their financial position at the end of that year. It also looks ahead and comments on the financial outlook for IJBs in 2022/23 and financial planning in the medium and longer terms.

3.2 The key messages from the report are set out below:

IJB finances 2021/22

- IJBs returned significant surpluses in 2021/22, mainly due to additional funding received late in the financial year for specific policy commitments, including Covid-19, as well as underspends on the cost of providing services.

- Total IJB reserves have doubled in 2021/22 to £1,262 million largely due to additional funding received late in the financial year for national policy commitments, including the response to Covid-19. Due to changes to future anticipated IJB Covid-19 spend, the Scottish Government are exploring options to recover around two thirds of Covid-19 related reserve balances held at the 2021/22 year end.

- The pandemic continued to impact on the delivery of IJB savings plans, with the Scottish Government providing specific financial support in 2021/22 to support unachieved savings on a non-recurring basis. This typically means that these savings have to be achieved in future years. It is essential that comprehensive plans are in place, demonstrating how IJBs will achieve recurring savings and support required service transformation.

Medium- and longer-term outlook for IJB finances

- IJBs have a projected funding gap of £124 million for 2022/23. Fourteen per cent of the 2022/23 projected funding gap is anticipated to be bridged by drawing on reserves, with other savings delivered on a non-recurring basis. Savings options had not been identified for 28 per cent of the gap. The identification and delivery of recurring savings and reducing reliance on using reserves to fund revenue expenditure is key to ensuring long-term financial sustainability.

- Three quarters of IJBs have recently updated their Medium Term Financial Plans (MTFPs). Doing so allows IJBs to respond more effectively to the long-term impacts of Covid-19, alongside increased cost pressures, including rising demand and inflation.

3.3 The Accounts Commission report is included as **Appendix 1**.

4.0 IMPLICATIONS

The implications for the Committee are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2022-2025 Priorities;-

1. Empowering People
2. Empowering Communities

3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery
7. Post-pandemic Renewal
8. Maximising Operational Integration

4.2 Frontline Service to Customers – None

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – None

4.5 Financial Implications – None

4.6 Procurement – None

4.7 ICT - None

4.8 Economic Impact – None

4.9 Sustainability – None

4.10 Equalities Implications – None

4.11 Other – None

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 There risks identified within the Accounts Commission report relate to the financial sustainability of IJBs going forward and the need to identify recurring savings to support expenditure.

6.0 IMPACT

6.1 **STATUTORY DUTY –** None.

6.2 **EAST DUNBARTONSHIRE COUNCIL** - None

6.3 **NHS GREATER GLASGOW & CLYDE** - None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 **Appendix 1** – Accounts Commission report 'Integration Joint Boards Financial Analysis 2021/22'.

Integration Joint Boards

Financial analysis 2021/22

ACCOUNTS COMMISSION

Prepared by Audit Scotland
April 2023

Contents

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

Health and social care integration: Update on progress
November 2018

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

Health and social care integration
December 2015

Key messages

IJB operating context

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

IJB financial and service challenges

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

IJB finances 2021/22

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

Medium- and longer-term outlook

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

Introduction

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

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

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

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

What is an Integration Joint Board?

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

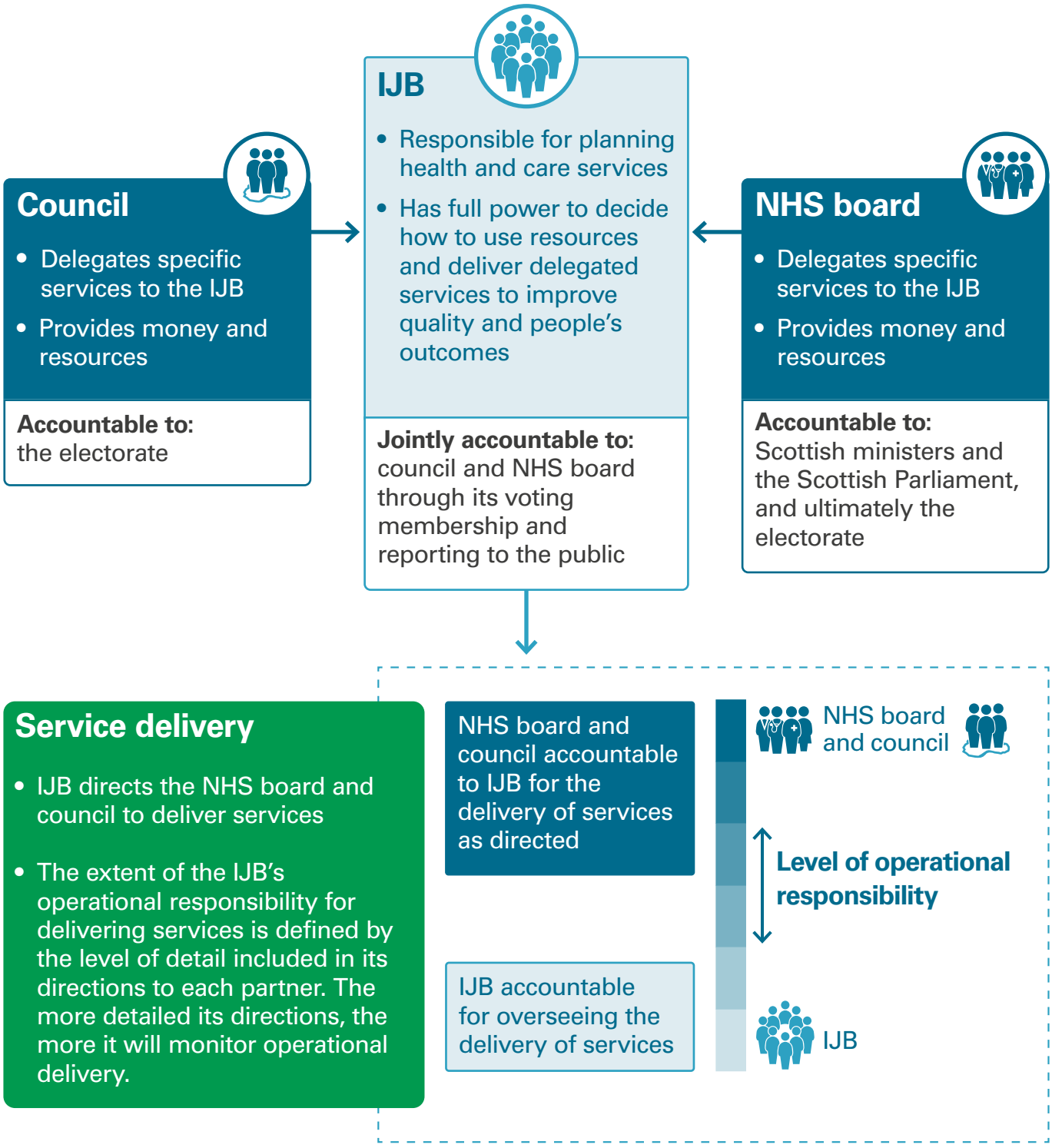
There were around 208,360 people working across social care services in Scotland in 2021.

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

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

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

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



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

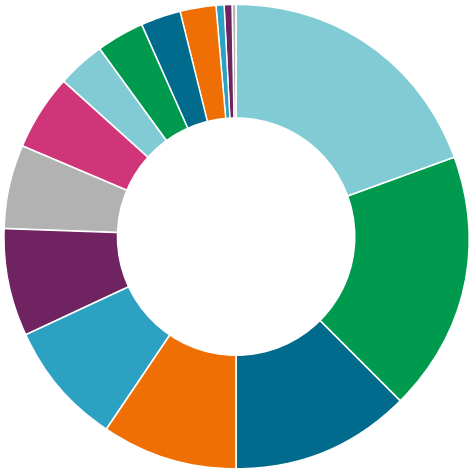
7. IJBs provide a wide range of services to vulnerable members of the community. Each IJB differs in terms of the services they are responsible for and local needs and pressures. The Act sets out the services that are required to be delegated to the IJB as a minimum, with the largest areas including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

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

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

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

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



Source: Fife IJB revenue budget 2021 to 2024

Funding and expenditure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delivery of savings continues to be impacted by the pandemic

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

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

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

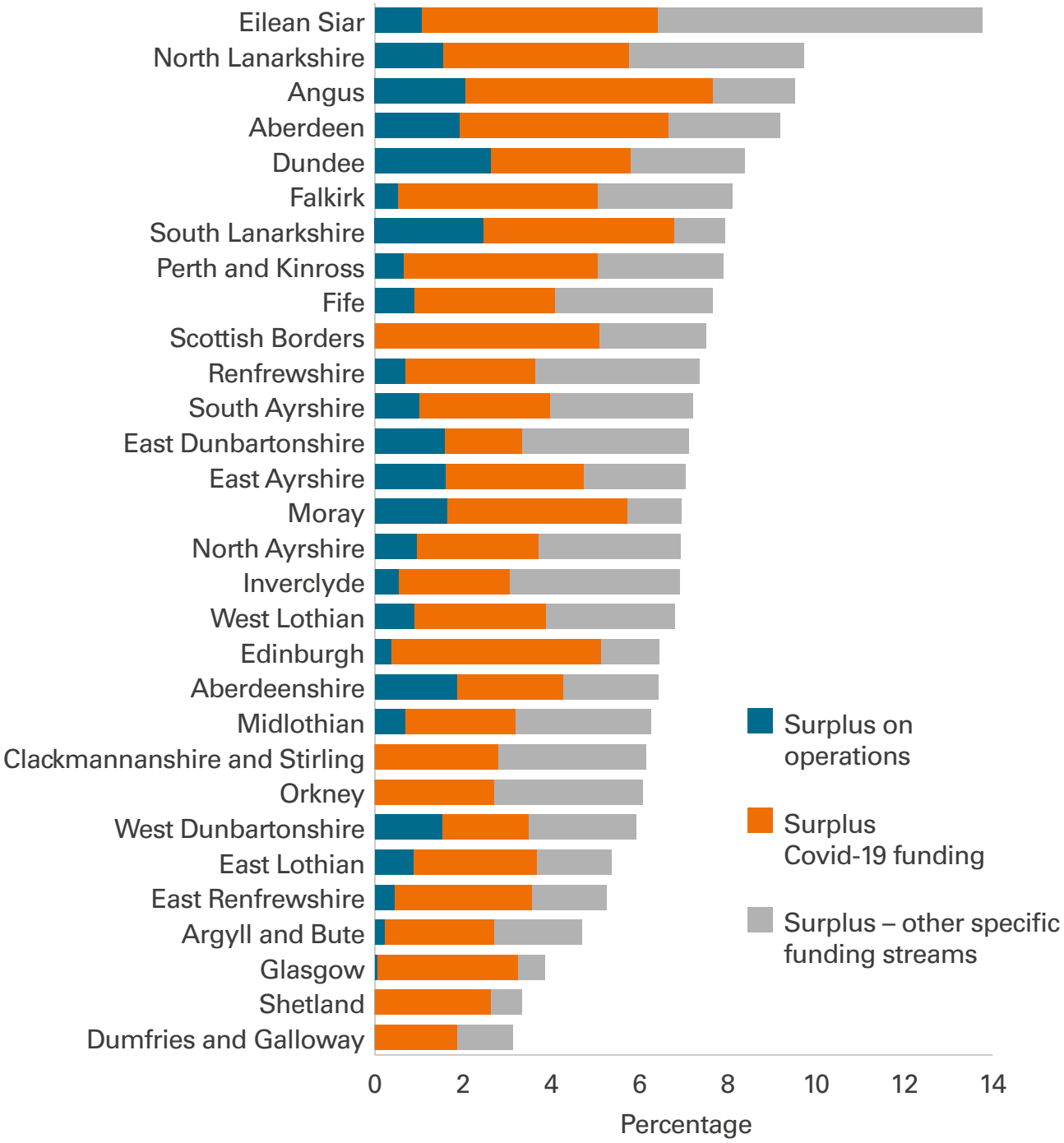
18. Savings delivered, or funded, on a non-recurring basis largely get carried forward to be achieved in future years. It is essential that comprehensive plans are put in place to demonstrate how IJBs intend to achieve ongoing saving requirements on a recurring basis and support required service transformation.

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

Exhibit 1.

Surplus as a proportion of net cost of services

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



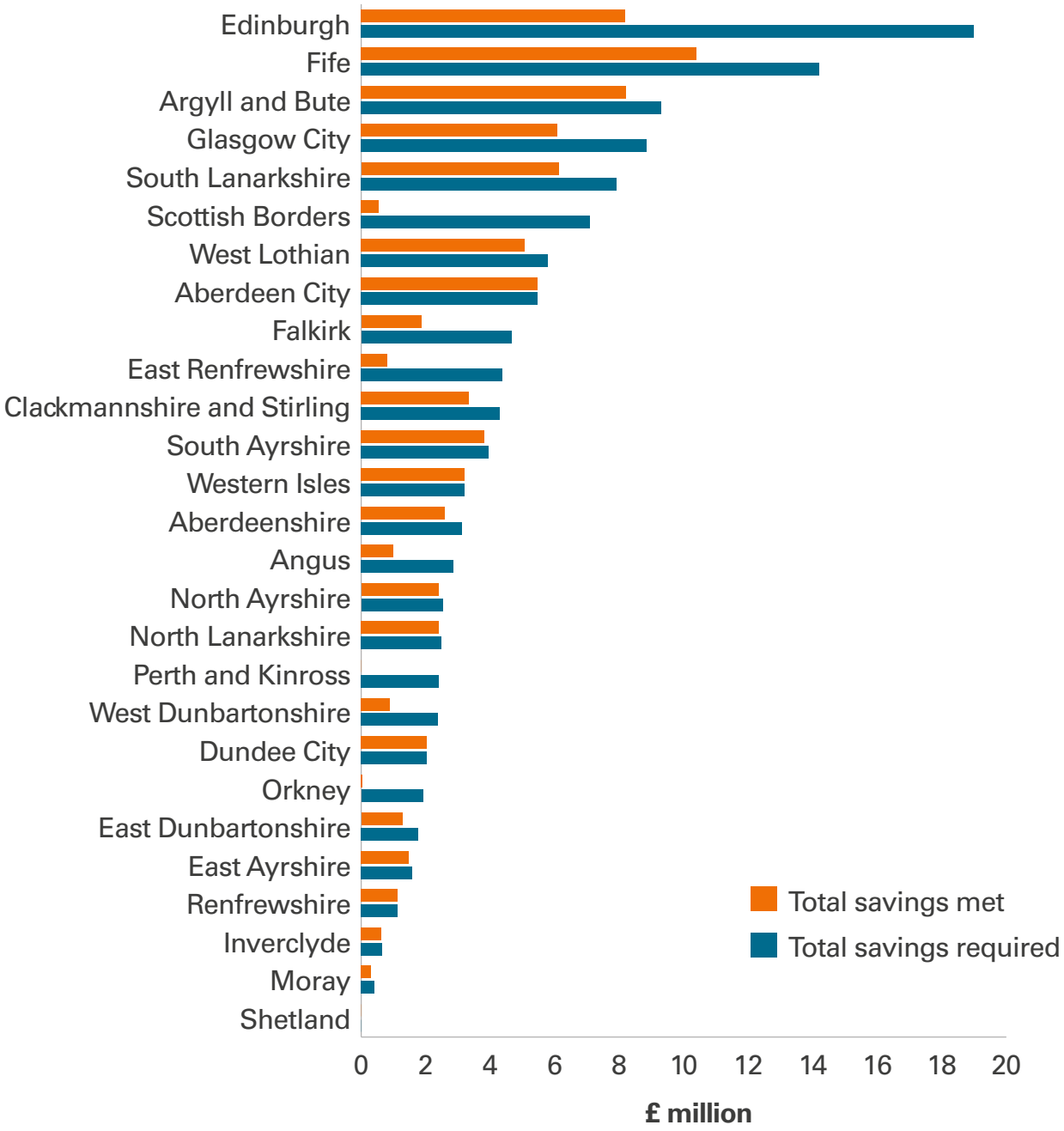
Notes:
1. Dumfries and Galloway, Shetland and Scottish Borders recorded deficits on the costs of providing services, requiring additional contributions from partner bodies.
2. Orkney and Clackmannanshire/Stirling IJBs reported break-even on the costs of providing services.
3. For South Lanarkshire and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

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

Exhibit 2.

2021/22 Savings performance

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



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

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

Reserves

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

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

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

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

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

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

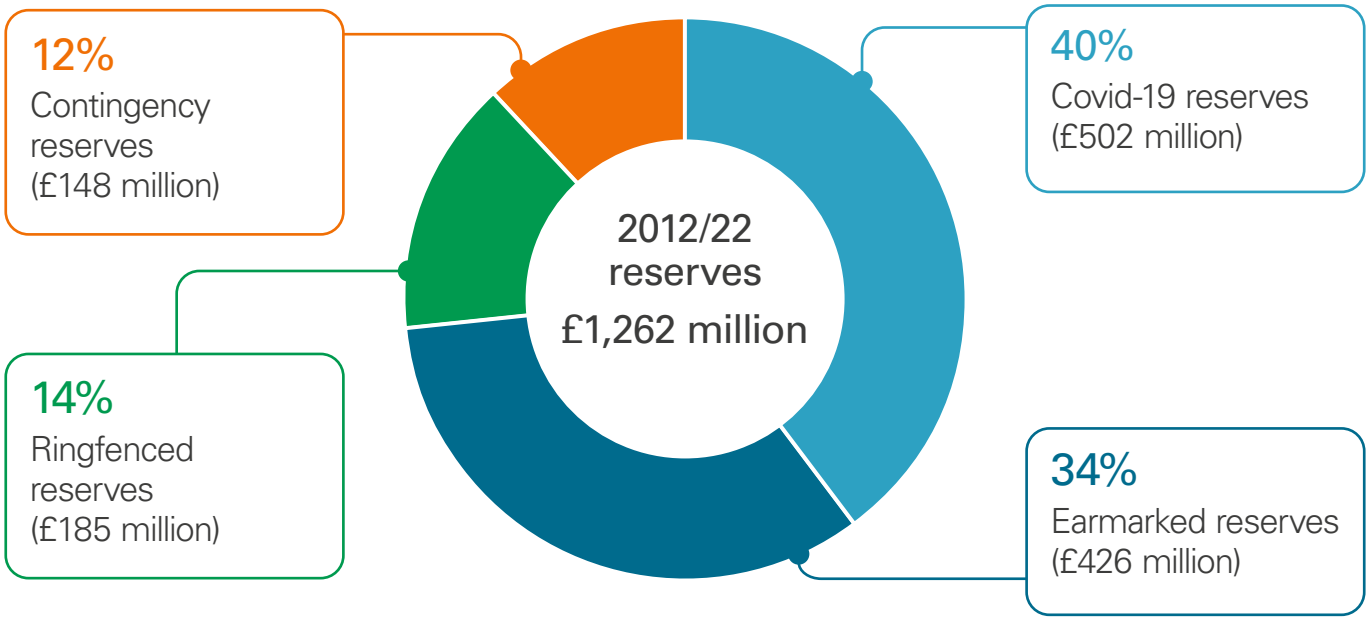
22. It is anticipated that there will be engagement with the IJB Chief Finance Officers in April 2023 to determine any adjustments required around Covid-19 related expenditure incurred during the remainder of 2022/23.

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

Exhibit 3.

2021/22 reserves

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



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

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

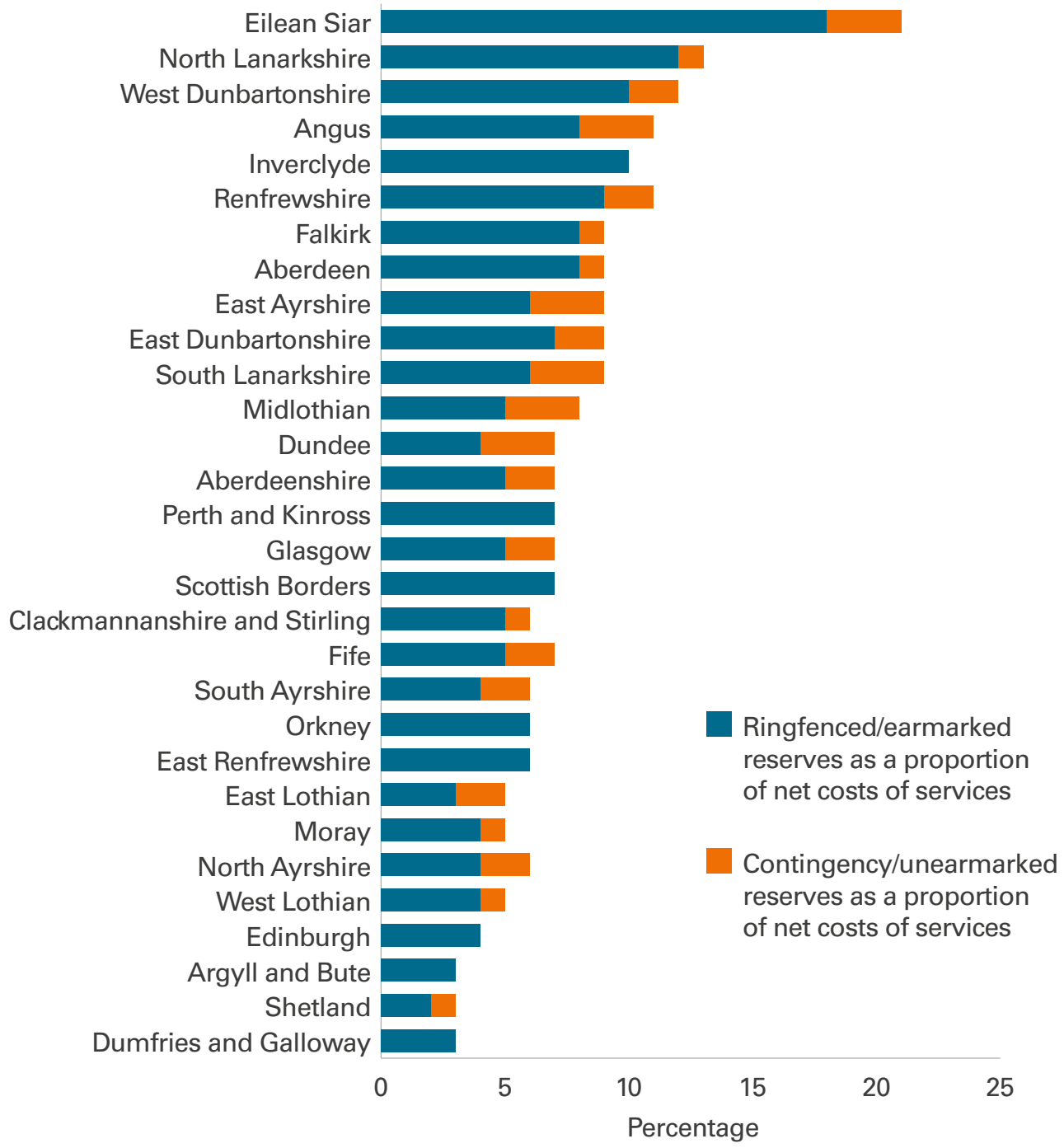
23. Once Covid-19 related reserves are excluded, 19 per cent of reserves were classified as contingency reserves, increasing from 16 per cent in 2020/21. Individual proportions ranged from zero to 43 per cent, with 14 IJBs having contingency reserves representing over 20 per cent of individual IJB total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

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

Exhibit 4.

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

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



Source: 2021/22 Audited Accounts

Financial outlook

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

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

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

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

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

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

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

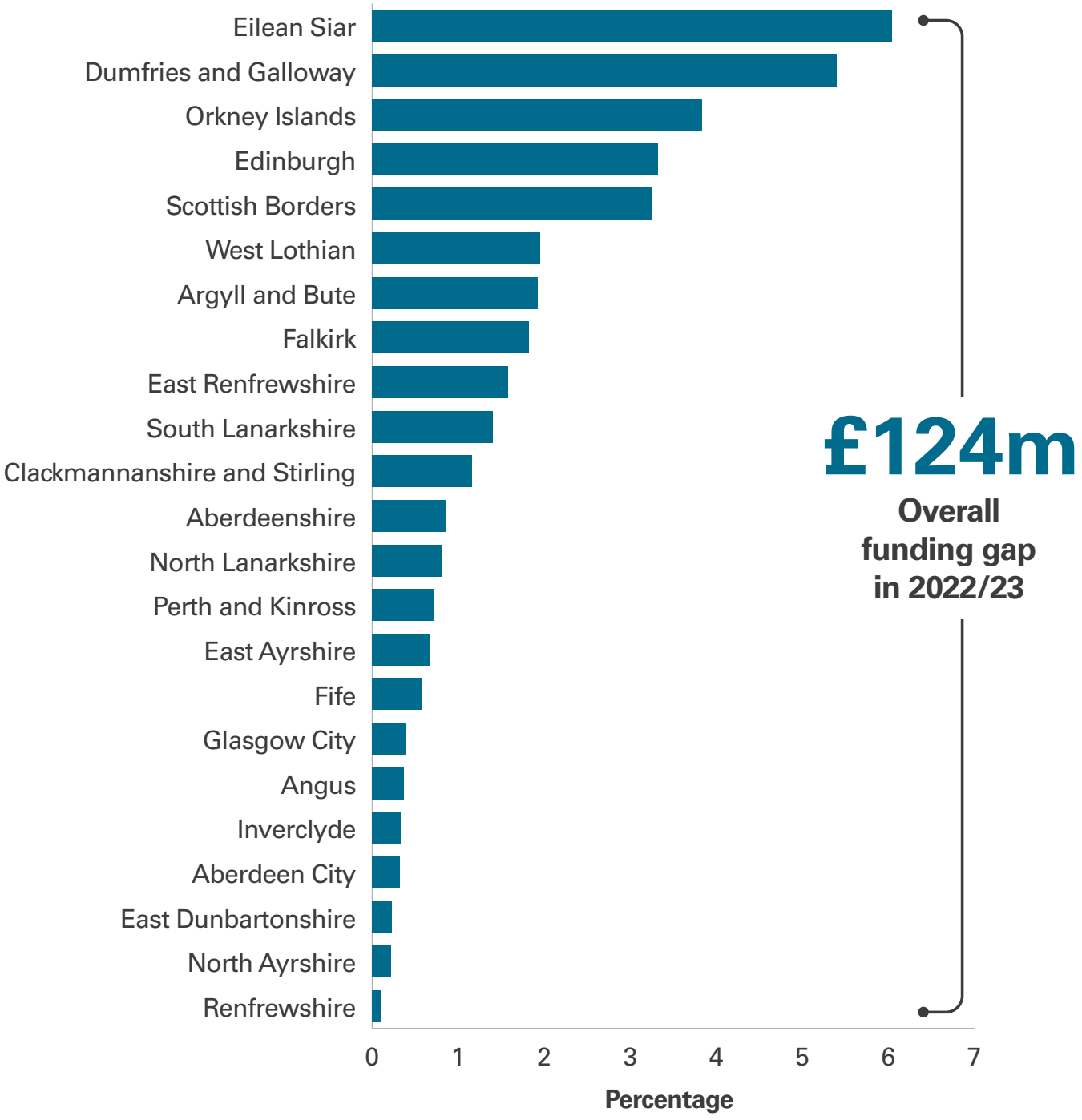
29. From a review of 2021/22 Annual Audit Reports, auditors reported that future funding gaps are unlikely to be addressed through efficiency and transformation savings alone. The scale of the challenges faced by IJBs means that services will need to change if they are to be sustainable in the future.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

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

Exhibit 5.

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

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



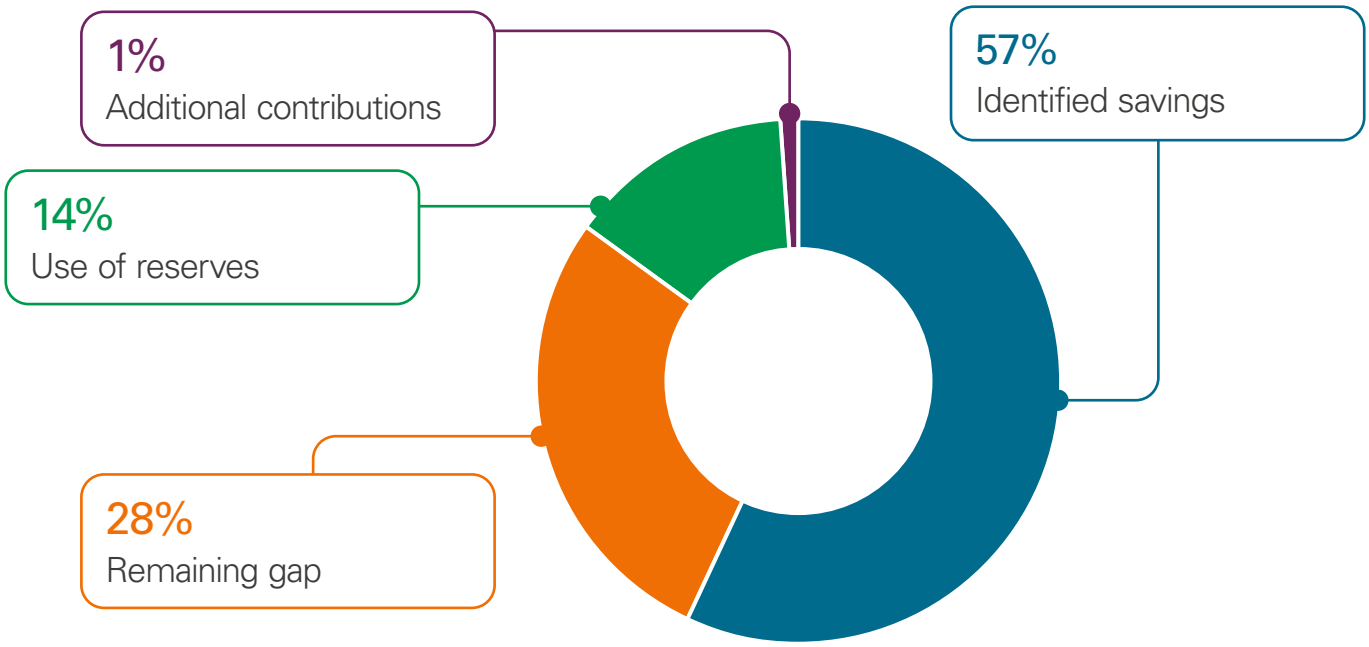
Notes:
1. Seven IJBs report no funding gap for 2022/23.
2. In some cases it was not clear from reports whether unachieved savings brought forward were included in the 2022/23 funding gap.

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

Exhibit 6.

2021/22 IJB funding gap planned action

The use of non-recurring reserves makes up 14 per cent of plans to bridge the funding gap.



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Integration Joint Boards

Financial analysis 2021/22

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East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 13.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**20th JUNE 2023**
REPORT REFERENCE:	**PERF/200623/13**
CONTACT OFFICER:	**CLAIRE CARTHY, INTERIM HEAD OF CHILDREN'S SERVICES AND CRIMINAL JUSTICE**
SUBJECT TITLE:	**JOINT INSPECTION OF SERVICES FOR CHILDREN AT RISK OF HARM – INSPECTION REPORT AND ACTION PLAN**

1.0 PURPOSE

1.1 The purpose of this Report is to advise members of the publication of the Joint Inspection of Services for Children at Risk of Harm Inspection Report and the development of an accompanying action plan to ensure delivery of the improvement areas identified in the inspection

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit and Risk Committee:

2.1 Note the publication of the Joint Inspection of Services for Children at Risk of Harm Inspection Report;

2.2 Note the Action Plan for delivery

2.3 Note that the Delivering For Children and Young People's Partnership will oversee delivery of the Action Plan, which will also be discussed regularly with East Dunbartonshire's Care Inspectorate link Strategic Inspector.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 On 26 September 2022 the Care Inspectorate wrote to the East Dunbartonshire Community Planning Partnership to advise that the Care Inspectorate, Education Scotland, Her Majesty's Inspectorate of Constabulary in Scotland and Healthcare Improvement Scotland would undertake a joint inspection of services for children at risk of harm in East Dunbartonshire.

3.2 The remit of these joint inspections is to consider the effectiveness of services for children and young people up to the age of 18 at risk of harm.

3.3 The inspections look at the differences Community Planning Partnerships are making to the lives of children and young people at risk of harm and their families.

3.4 The active phase of the inspection took place between October 2022 and February 2023 and the inspection report was published 18 April 2023. The inspection report is attached as **Appendix 1** to this report.

3.5 The inspection report highlights areas of good practice and areas for further development and concludes on an assessment grading for a single quality indicator 2.1, from the inspection framework, 'impact on children and young people'. The inspection report has graded the services in East Dunbartonshire as 'Good'. An evaluation of good is applied where performance shows important strengths which clearly outweigh any areas for improvement. The strengths will have been assessed as having a significant positive impact on children and young people's experiences and outcomes.

3.6 The report highlighted the following strengths and areas of good practice:

- Many children and young people said that they got the right help to make and keep loving relationships with those they cared about. We saw how some were being supported to maintain relationships with brothers and sisters, as well as with parents.
- Support for children's wellbeing, planning of care and provision of good nurturing relationships was rated as good or better in regulated care inspections.
- Almost all children and young people told us they felt safe where they lived all or most of the time. Asylum seeking young people felt well supported, safe and helped to maintain cultural links. Interpreters were provided for individual children or parents.
- Young people were being listened to about what mattered to them, felt involved and were aware of their rights. Many children and young people had the opportunity to develop consistent and enduring relationships with key staff.
- Children and young people had been directly engaged in service developments such as the House project. In other examples, including record keeping, they were influencing changes in practice.
- Staff we spoke with demonstrated a child-centred approach to providing services to improve the wellbeing of children and young people.
- Statutory and voluntary agencies were working well together to provide practical support for children, young people and their families. A range of services from pre-birth to teenage, provided early and effective intervention in response to emerging concerns.
- Children and young people had benefitted from their safety and wellbeing having been a key priority for leaders throughout the Covid-19 pandemic.

3.7 The scrutiny partners concluded that they were confident that partners in East Dunbartonshire have the capacity to make changes to service delivery in the areas that require improvement. This was based on the following factors:

- Evidence of strong partnership working, and staff and leaders being committed to improving outcomes for children, young people and families.
- High levels of confidence from staff in their knowledge and abilities, supported by evidence from records reading.
- Similar levels of support from staff about their leaders' ability to continue to drive change and make improvements.
- Well-developed management information and self-evaluation practice capable of identifying areas for improvement and further action.
- Collaborative inter-agency practice, including the role of the third sector, providing services to children at risk of harm and their families.
- Recent commitments to changes in practice, including the introduction of the Safe and Together model, and an emphasis on trauma informed practice.
- The partnership's own self-evaluation had already identified many of the areas for improvement found by the inspection team, which showed that they knew themselves well and had a solid foundation to make improvements.

3.8 Scope for improvement was identified in awareness and consistent availability of advocacy services, further opportunities for the voices of children who were, or had been, at risk of harm to inform strategic planning, scope to improve the quality of chronologies, waiting times for access to specialist CAMHS services and scope to further develop analysis of impact and outcomes for children and their families.

3.9 An action plan has been developed in response and its implementation will be overseen by the DCYPP on behalf of the Community Planning Partnership. There will also be regular discussion with East Dunbartonshire's Care Inspectorate link Strategic Inspector. The Action Plan is attached as **Appendix 2** to this report.

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Strategic Plan 2022-2025 Priorities and Integrated Children's Services Plan: outcomes will be delivered in alignment with both plans;-

1. LOCAL OUTCOME 3 - CHILDREN & YOUNG PEOPLE – the quality of services to children at risk of harm, including delivery of the improvement areas identified in the Action Plan, has a direct impact on delivery of LOIP 3.

4.2 Frontline Service to Customers – improved communication and processes for children and young people.

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – None.

4.5 Financial Implications – None

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None.

4.10 Sustainability – None.

4.11 Other – None.

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The inspection process seeks to assess practice in relation to the leadership, management and delivery of statutory services delivered by a number of Community Planning Partnership partners. The finding offer assurance that these processes are currently robust and identifies area for further development.

5.2 Failure to deliver service to children at risk of harm effectively may negatively impact the safety, health and wellbeing of our children and young people.

6.0 IMPACT

6.1 **STATUTORY DUTY** – Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006 set out the provisions for undertaking inspection of those providing Children's Services.

6.2 **EAST DUNBARTONSHIRE COUNCIL** – None

6.3 **NHS GREATER GLASGOW & CLYDE** – None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction required.

7.0 POLICY CHECKLIST

7.1 There are no policy implications**.**

8.0 APPENDICES

8.1 **Appendix 1 -** ED Joint Inspection CARH Report
8.2 **Appendix 2 -** ED CARH Action Plan

Report of a joint inspection of services for children and young people at risk of harm in East Dunbartonshire community planning partnership

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

18 April 2023

Education Scotland Foghlam Alba

Healthcare Improvement Scotland

HMICS Improving Policing Across Scotland

HAPPY TO TRANSLATE

Contents

Introduction

Our remit

At the request of Scottish Ministers, the Care Inspectorate is leading joint inspections of services for children and young people at risk of harm. The remit of these joint inspections is to consider the effectiveness of services for children and young people up to the age of 18 at risk of harm. The inspections look at the differences community planning partnerships are making to the lives of children and young people at risk of harm and their families.

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

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

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

The terms that we use in this report

- When we say **children at risk of harm**, we mean children up to the age of 18 years who need urgent support due to being at risk of harm from abuse and/or neglect. We include in this term children who need urgent support due to being a significant risk to themselves and/or others, or who are at significant risk in the community.
- When we say **young people**, we mean children aged 13 - 17 to distinguish this age group from younger children.
- When we say **parents** and **carers**, we mean those adults with parental responsibilities and rights and those who have day-to-day care of the child (including kinship carers and foster carers).
- When we say **partners**, we mean leaders of services who contribute to community planning.
- When we say **staff**, we mean any combination of people employed to work with children, young people and families in East Dunbartonshire.

Appendix 2 contains definitions of some other key terms that we use.

Key facts

Total population: 108,900 people on 13 July 2021

This was an increase of 0.1% from 2020. Over the same period, the population of Scotland increased by 0.3%.

NRS Scotland

In 2021, there were estimated to be 22,022 children and young people aged 0 - 17 in East Dunbartonshire. This was 20.22% of the total population, which was higher than the national average of 18.67%.

NRS Scotland

In 2020, 3.85% of East Dunbartonshire data zones were in the 20% most deprived in Scotland. Only two other mainland local authorities had a lower proportion.

Local Government Benchmarking Framework

In 2021, it was estimated that 8.3% of children aged under 16 were living in relative low income families. This was well below the national estimate of 15.1%.

SCOTTISH GOVERNMENT

East Dunbartonshire had 62 incidents per 10,000 population of domestic violence recorded by Police Scotland in 2020/21. This was lower than the national average of 119.

In 2020/21, East Dunbartonshire had a rate of 1.2 per 1,000 children aged under 16 on the child protection register, lower than the Scottish average of 2.3. The rate of child protection investigations was 9.8 per 1,000 children aged under 16. This was also lower than the Scottish average of 12.8.

SCOTTISH GOVERNMENT

Our approach

Inspection teams include inspectors from the Care Inspectorate, Healthcare Improvement Scotland, His Majesty's Inspectorate of Constabulary in Scotland and Education Scotland, as well as associate assessors. Associate assessors are professionals with significant practice or management experience in children's services who bring up-to-date knowledge to joint inspections. Teams also include young inspection volunteers, who are young people with direct experience of care or child protection services. Young inspection volunteers receive training and support and contribute to joint inspections using their knowledge and experience to help us evaluate the quality and impact of partners' work.

We take a consistent approach to inspections by using the quality framework for children and young people in need of care and protection, published in August 2019[1]. Inspectors collect and review evidence against all 22 quality indicators in the framework to examine the four inspection statements. We use a six-point scale (see Appendix 1) to provide a formal evaluation of quality indicator 2.1: impact on children and young people.

How we conducted this inspection

The joint inspection of services for children at risk of harm in the East Dunbartonshire community planning partnership area took place between 26 September 2022 and 16 March 2023. This included a three-week break over the Christmas and new year period. It covered those partners in the area that have a role in meeting the needs of children and young people at risk of harm and their families.

- We received survey responses from 25 children and young people at risk of harm and 24 from parents and carers.
- We spoke with 20 children and young people and 9 parents and carers to hear their views and experiences. This included face-to-face meetings and telephone calls.
- We reviewed practice by reading a sample of records held by a range of services for 60 children and young people at risk of harm.
- We reviewed a position statement provided by the partnership, supported by a wide selection of accompanying documents.
- We carried out a staff survey and received 492 responses from staff who have a role in meeting the needs of children and young people at risk of harm and their families. 424 of these (86%) fully completed the survey.
- We met with around 100 staff members who work with children, young people and families.
- We met with members of senior leadership teams, committees and boards that oversee work with children at risk of harm and their families.

We are very grateful to everyone who talked to us as part of this inspection.

[1] : The Quality framework for children and young people in need of care and protection was updated in November 2022. However, the version published in August 2019 was the one in place at the time this inspection was announced.

As the findings in this joint inspection are based on a sample of children and young people, we cannot assure the quality of service received by every single child and young person in East Dunbartonshire who may be at risk of harm.

Key messages

1. Initial concerns were being responded to timeously and effective collaborative practice was helping to keep children and young people safe from harm.
2. Risks to children and young people at risk of harm were being reduced by consistent assessment and care planning, and by the support that services delivered in response.
3. A range of services and initiatives were supporting children and young people at risk of harm. Some of these were recently introduced and partners were not yet able to see the difference they were making for children and young people.
4. Children and young people at risk of harm felt valued and supported by staff to contribute to decisions about their lives. Along with their parents and carers, they were also being involved in key processes.
5. Service improvements had been influenced by the views of children and young people. Hearing directly from those who were at risk of harm was nevertheless an area for development.
6. The partnership had a clear vision, aims and priorities, and was focussed on delivering effective services for children and young people at risk of harm.
7. Management information was being effectively scrutinised to identify areas for service improvement.
8. The partnership were not fully benefitting from evaluation of services. They had scope to develop a greater understanding of the difference they were making to the lives of children and young people at risk of harm.

Impact of the Covid-19 pandemic

The joint inspections of East Dunbartonshire's services for children and young people at risk of harm and their families took place between September 2022 and March 2023. Like all other partnerships across Scotland, East Dunbartonshire had faced the unprecedented challenge of both the Covid-19 pandemic and the subsequent recovery over the previous two years. We appreciated the partnership's co-operation and support for the joint inspection of services at this time.

We scrutinised the records of children at risk of harm for a two-year period between September 2020 and September 2022. When we consulted staff, children, young people and families, we encouraged them to consider that period when sharing their experiences. As all of the practice in our inspection period was at least in part affected by the Covid-19 pandemic, all messages should be interpreted as relating to practice during that time.

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

Key messages

- Effective information sharing and collaborative working between services were helping to keep children and young people in East Dunbartonshire safe from harm.
- There was an effective and timely multi-agency response to initial concerns about children and young people who were at risk of harm. This standard was maintained in the follow-up to those concerns.
- Despite the timeliness of the initial response, some subsequent inter-agency referral discussions (IRDs) undertaken through the North Strathclyde Partnership Scottish Child Interview Model project, were delayed.
- Responses to young people at risk of harm were being enhanced. Care and risk management guidance was being piloted alongside work to address other risks and vulnerabilities. There was opportunity to align these into a single coherent approach.
- Staff were confident of their knowledge and skills to recognise and report child abuse, neglect and exploitation, and assess and analyse risks. They were supported by planned learning and development opportunities and regular supervision.

Prevention and early identification of risks

A strong multi-agency approach to collaborative working, information sharing and the provision of early intervention services was helping to keep children and young people at risk of harm in East Dunbartonshire safe. Protecting children and young people from harm and ensuring that their wellbeing needs were met had been a key priority for leaders during the period of Covid-19 restrictions. The continuity of collaborative working between agencies throughout that time was evaluated as good or better in most of the records we read.

The partnership's approach to early and effective intervention was helping to prevent or reduce incidences of abuse, neglect, and exploitation. Most respondents to our staff survey were confident that there were effective intervention processes in place to address these. Existing early and effective intervention procedures, which were refreshed in 2021, had led to multi-agency screening groups being established. These were helping to ensure those children in need of additional support were identified at the earliest stage. Teams, involving school staff, social workers and community support workers, worked closely together often providing high levels of contact, including out of hours. The resettlement team, responsible for supporting Ukrainian refugees, had received training and guidance from children's services as well as inputs from others including housing, health, and education.

Preventative measures were developed and implemented by multi-agency groups in response to emerging concerns, such as children and young people who go missing, and child sexual exploitation (CSE) and trafficking. For example, the missing persons

steering group had launched a multi-agency protocol, derived from the national missing person's framework, to provide local guidance on prevention, response and support when children and young people go missing. A trafficking and exploitation sub-group had helped to raise awareness of the significant risks associated with these areas and provided guidance and advice on the public protection website. Overseen by the vulnerable pregnancy liaison group, an unborn babies protocol was supporting staff to recognise and identify pre-birth concerns.

Through their active scrutiny of data, partners had identified areas for further exploration and intervention. For example, a review of referrals and in particular the number where domestic abuse was a factor, had led to the introduction of the Safe and Together model. Key factors in relation to neglect, such as high rates of poor oral health, weight, mental health and alcohol use, had been identified. An assessment of care toolkit was subsequently implemented and staff reported seeing benefits in relationship building with families, particularly as it provided a visual means of recording and seeing change. It was too soon though to see if it had been effective in reducing more formal interventions.

A recent learning review had highlighted several areas for development in understanding neglect of disabled children and young people. It covered thresholds of concern, roles and responsibilities, recognition of neglect and cumulative harm. An action plan and training programme had been developed to improve identification of, and response to, signs of neglect of disabled children and young people. Opportunities remained though to analyse the full learning from the review to further improve this area of practice. Additional training sessions were planned and had been amended following responses to earlier presentations.

The police took a whole systems approach to children who came to their attention. Officers had recognised the need to be trauma informed and look at each child in their wider context. Measures were in place to reduce risk and prevent escalation and there had been a reduction in both referrals and re-offending. The police-led community alcohol partnership (CAP) was launched in June 2022. It followed a large-scale survey of young people about their alcohol use. It aimed to reduce under-age drinking, prevent alcohol related harm for young people and improve the quality of life within the community. As well as diversionary activities such as street football, it also focussed on educating young people and retailers. Community campus police officers and youth workers were working directly with young people and their intervention had been positively received. Evaluation evidence was not yet available though about the difference that these approaches had made.

Response to identification of concerns

The partnership responded timeously to initial concerns about children and young people who were at risk of harm. Most staff who responded to our survey were confident that local child protection arrangements ensured an effective and timely response to reports of child abuse, neglect and exploitation. In almost all the records we read, there was evidence that the named person, or person acting as the professional point of contact in universal services, was notified about the concerns at an early stage. These were also shared without delay with police or social work, and actions were clearly recorded in all cases. In most records, the quality of the initial response was rated as good or better. Our evidence concurred with the partnership's own positive analysis from its use of the national child protection minimum dataset.

In nearly three-quarters of the cases where an inter-agency referral discussion (IRD) was held, it was carried out within expected timescales, as were investigations where these were subsequently required. IRDs that were held were found to be very effective and clear decisions were made and recorded about the next steps in all cases. Almost all IRDs were attended by health, social work and police colleagues. Procedural changes also meant that education colleagues were now more often involved. Health staff were able to access records from a number of different health databases to contribute information to the discussions. Where necessary, immediate actions were taken to keep the child and other children safe. Analysis of the data from the records we read suggested that the quality of the multi-agency response to referrals received for 6- to 12-year-olds was likely to be better than for younger or older age groups.

Where the threshold for an IRD was not met, the reasons for this were recorded by all agencies. Most records showed appropriate consideration of the need for medical examinations, joint investigative interviews, and in all cases where there had been an IRD, emergency protective action or legal measures. Partners had ensured that there was a process in place for IRDs should a concern arise out of hours, including the availability of an on-call paediatrician child protection consultant. The out of hours service, which was delivered in conjunction with neighbouring authorities, received comparatively fewer referrals from East Dunbartonshire. The service suggested that this may be due to the effectiveness of the early intervention and prevention work being undertaken.

Nevertheless, in a minority of records we read, no IRD was held where one could have been expected. In just over a quarter of records where an IRD was held, it was not carried out within the expected timescales. Data from the wider North Strathclyde Partnership Scottish Child Interview Model (SCIM) pilot, of which East Dunbartonshire was a member, indicated that over the whole pilot area, delays averaged three days from the notification of concern. More detailed information was needed about the length of, or reasons for, delays locally. The partnership acknowledged the need to improve IRD practice and was working to bring it in line with national guidance. For example, whereas non-familial incidents, or cases already open to statutory services, may not have previously led to an IRD, one would now be considered.

The partnership's approach to young people at risk of harm was an area for development. Whilst welcomed, some staff suggested that other areas were ahead of East Dunbartonshire in responding to this group of young people. Similar to the IRD process, the vulnerable young people protocol was a multi-agency response to those aged 12 - 16. It had been introduced in 2018 before the Covid-19 pandemic and was being reviewed alongside the introduction of the Care and Risk Management (CARM) process. Training had recently been delivered for CARM and was being piloted initially in six schools. The intention was to review the protocol following the pilot with the aim of tackling wider vulnerabilities and risks such as missing, exploitation and trafficking and contextual safeguarding.

Staff engagement

Staff in East Dunbartonshire were supported in their practice by clear single and multi-agency procedures, policies and guidelines. A working group was in place to update current West of Scotland child protection procedures to comply with the 2021

national guidance. Staff received regular communication, including 7-minute briefings, about changes in practice.

Those who completed the staff survey were confident in their knowledge, skills and abilities. Almost all felt able to recognise and report signs of child abuse, neglect and exploitation. A similar high proportion were confident that they could assess and analyse risks and needs and understood the implications of these for those that they worked with. Comparable numbers also felt supported to be professionally curious with the aim of keeping children and young people safe.

Staff across all services, including the third sector and panel members, had access to multi- and single-agency training opportunities through the training calendar maintained by the child protection committee. This included both specific and generic child protection training. Almost all staff who responded to the survey felt that the learning and training they had participated in had increased their confidence and skills in working with children and young people at risk of harm. Most also agreed that participation in regular local multi-agency training and development opportunities had strengthened their contribution to joint working. Almost all were confident that they knew the standards of practice that were expected of them and were encouraged through supervision to achieve these. Most also agreed that they received regular supervision or opportunities to speak with a line manager that supported and challenged them to achieve high standards of practice.

Impact on children and young people

The partnership was being effective in reducing risk for children and young people. Almost all the children and young people who answered our survey felt safe where they now lived. This had not been affected by the Covid-19 pandemic. During the subsequent restrictions, the effectiveness of the partnership's response to ensuring children were protected from harm and their wellbeing needs met was assessed as good or better in most of the records we read. Most of those responding to the staff survey agreed that children and young people were being protected from abuse, neglect, harm or exploitation. A majority of parents we surveyed told us that staff had responded quickly to concerns about their children.

The North Strathclyde Partnership Scottish Child Interview Model (SCIM) pilot was working effectively. Feedback from young people was that they felt more supported because of the model's relationship-building aspect with staff. Overall data for the partnership had shown an increase both in the number of joint investigative interviews and in resulting disclosure rates. This supported the use of the SCIM and its beneficial consequence for children and young people. However, data from the pilot provided insufficient detail for local partners to fully understand its impact for them. This was an area that was being further developed.

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

Key messages

- Most children and young people and their families benefitted from compassionate, caring, trusting and sustained relationships with staff. This created a positive environment to support the improvement of outcomes for them.
- Services were effectively reducing risks of harm to children and young people. This had been sustained throughout the period of the Covid-19 pandemic.
- Assessment and care planning for children and young people at risk of harm were being well applied. The quality of chronologies was more variable.
- Many services had been introduced to address the increase in children and young people requiring early support for emotional wellbeing and mental health needs.
- Provision of services for children and young people with moderate and severe mental health problems, including for those with suicidal ideation, was less well addressed. Long waiting lists for child and adolescent mental health services (CAMHS) were affecting outcomes for those needing this support, although performance had improved more recently.

Sustained, loving and nurturing relationships

We observed strong, caring and compassionate relationships between staff and children and young people. Staff knew children well and responded to their needs through individualised plans. Nearly three-quarters of staff felt that children and young people were thriving as a result of sustained, loving and nurturing relationships. In most of the records we read, there was evidence that the child or young person had had the opportunity to develop a relationship with a key member of staff, as had the majority of parents and carers. Importantly, for most of those whose records we read, the quality of this contact was maintained throughout the period of the Covid-19 pandemic. Of those we spoke with or who answered our survey, most children and young people experienced positive relationships with professionals that kept them safe and protected from further harm; something that most but not all parents and carers we heard from also agreed with.

Performance across regulated care services, such as adoption, fostering and residential care, had been high over recent years, ensuring a positive experience for children and young people. Foster carers we spoke with were positive about the support they had received from all services within East Dunbartonshire. Children and parents reported having had opportunities to maintain relationships and contact with each other, their brothers and sisters and wider family.

Effective planning and support for children and young people at risk of harm

We noted empowering and child-focussed language across both strategic plans and in conversations with staff. They were keen that children and young people should be heard, have their views acted on, and be as involved as possible in all aspects of their care and service provision. Children, young people and their parents and carers told us about staff who were committed and caring, with many examples of individual workers being involved with the same child or family over long periods of time, creating the right environment for building relationships of trust. However, just half of staff responding to the survey felt that children and young people were living in the right environment to experience the care and support they needed.

How well both children and young people, and their parents and carers were listened to in key processes such as assessment and planning was evaluated as good or better in the majority of records we read. By contrast, how well parents or carers were involved was evaluated slightly better than that for children and young people. Evidence from parents and carers who responded to our survey and who we spoke with demonstrated that, in the main, they felt involved, valued and respected in a range of child protection meetings. The partnership themselves had had similar feedback from their own audit work.

The getting it right for every child (GIRFEC) approach was well-embedded in East Dunbartonshire. Most staff were confident that it was having a positive impact on the lives of those children and young people at risk of harm that they were working with. Staff displayed knowledge of a range of both statutory and third sector services. They spoke consistently about effective collaborative planning between agencies to address needs and risks. Three-quarters of respondents to our survey agreed that children and young people who had experienced abuse and neglect were being helpfully supported to recover. A comprehensive protocol was in place to support disabled young people at the point of transition from school to receiving support from adults' services.

There was a range of both longstanding and more recently established services in place to support children and young people at risk of harm. For example, the well-embedded and evaluated nurture approach in schools in East Dunbartonshire had been augmented by a significant investment in support for children and young people presenting with anxiety and depression. A compassionate distress response service, operated by Glasgow Association for Mental Health (GAMH) on behalf of the East Dunbartonshire health and social care partnership, had been introduced for older young people aged up to 25 years, or 26 if care experienced. Investment had also been made in other areas, such as provision of local area co-ordinators for young people with autism to plan support through and after leaving school. There were other good examples of services for older young people at risk of harm. For example, the role of police campus officers within secondary schools, and the House project that provided tailored support to older young people leaving care to reduce the risks that they faced. Whilst there was an absence of evidence gathered over time of their impact, staff involved were able to give anecdotal information about positive outcomes for individual children and young people, as well as positive learning for themselves.

The delivery of services that were trauma informed and responsive was supported by a commitment to staff training and supervision. Staff in the children's residential service were trained in trauma informed practice. Our young inspection volunteers

noted their consequent commitment and passion to putting young people first and sustaining consistent relationships with them. Nevertheless, staff we spoke with believed that more resources were required to support the children and young people they were working with, particularly for mental health and support for those who had experienced trauma.

Effective work to reduce risk or neglect

Evidence from the records we read showed that services in East Dunbartonshire were effectively reducing risks to children and young people and that this had been sustained throughout the period of the Covid-19 pandemic. In over two-thirds of the records we read, services were rated as good or better at reducing risks of abuse or neglect to the child, or arising from parents or carers' circumstances and behaviours. Nearly all of the small number of records where risks were associated with the child harming themselves or others, or arising from circumstances within the community, were similarly evaluated. The partnership's effectiveness in ensuring that children and young people who they were supporting during the Covid-19 pandemic were protected from harm and had their needs met was rated as good or better in over three-quarters of the records we read.

Although some staff suggested that it may be due to a greater awareness of mental health, rather than a greater prevalence, the numbers of children seeking support with their mental health and emotional wellbeing had increased following the Covid-19 pandemic. Staff recognised that the effects on children of the lack of socialisation during this time will take some years to work through. Imaginative responses, such as the employment of a primary school teacher in a secondary school to support those with unmet needs to make the transition, were being made to tackle this. There were other positive and well-received initiatives in place to support children and young people's mental health and emotional wellbeing. Counselling services, including for home schooled children, and support programmes such as Motivation, Commitment and Resilience (MCR) pathways, were available within schools. Mental health first aid training had been provided, including for staff in the third sector. Services, such as 'We are with you', had been expanded to support young people with their problematic substance use, and trauma informed practice was being rolled out. The chief officers group had responded to data that showed that mental health and wellbeing was becoming a significant issue in the area by identifying mental health framework monies to target further support. Partners had also engaged with the Schools Health and Wellbeing Improvement Research Network (SHINE) programme at Glasgow University to get a better understanding of young people's needs and to be better able to respond to them.

In spite of this, services faced challenges in responding to children and young people with moderate to severe mental health needs consistently and in a timely manner. Compared to improvements in physical health outcomes, staff who responded to our survey were less likely to agree that children's mental health outcomes were improving. Services for young people experiencing more acute issues, such as suicidal ideation and those at risk of suicide, were less available than services to address lower-level concerns. Those children and young people who required an input from CAMHS faced long delays, especially in the west area of East Dunbartonshire. In 2021 - 2022, performance in achieving the national referral to treatment target of seeing 90% of young people within 18 weeks of referral to

CAMHS had slipped from 61% in quarter 2 to 40% in quarter 4. Evidence suggested that performance had improved more recently, though would need time to see if this could be sustained.

Assessment, planning and reviewing processes

Almost all staff who responded to our survey were confident of their ability to assess the risks and needs of children and young people at risk of harm. They also felt able to analyse those risks and needs and to understand the implications for those that they were working with. In turn, a majority felt able to develop an outcomes focussed care plan that would aim to reduce risks and meet the child or young person's needs. Three-quarters of respondents were confident that effective plans for children and young people were produced in a timely way. These encouraging self-assessments were supported by our reading of children's records. Performance was positive across a range of measures. For example, almost all records included an assessment that considered needs, protective concerns and risks, with most also containing a plan to address these. Of the assessments we read, over three-quarters were evaluated as good or better, with two-thirds of plans being similarly rated.

The partnership had recognised through its own audit work that improvements were required to ensure that multi-agency chronologies were better able to inform planning and decision making for children and young people at risk of harm. A revised chronology framework had been developed and recently implemented, with further training to be provided. The need for this was confirmed by our records reading as although all those we read contained a single or multi-agency chronology, the quality of these was weaker and in clear contrast to that of assessments and plans. Over half were evaluated as less than good, with one rated as unsatisfactory.

Our analysis, supported by evidence in the health and social care partnership's quarterly performance report, showed that most plans were reviewed regularly and within expected timescales. The quality of most of them was evaluated as good or better. For a few records that we read though there was no evidence of a review being held.

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

Key messages:

- Children and young people at risk of harm were being helped to express their views, had their rights explained to them and felt valued. Staff were making efforts to involve them in meetings, plans and decisions, including using age appropriate means.
- Parents and carers views were being considered during protection processes and they were contributing to multi-agency meetings. Some parents and carers felt less involved and not given sufficient opportunity to participate.
- A range of independent advocacy services was on offer. Partners lacked a strategic approach though to ensure that they were available and accessible throughout the area to children and young people at risk of harm, as well as their parents and carers.
- Partners were committed to creating opportunities for children and young people to influence policy, planning and service development. There was evidence to demonstrate the ways in which their voices had been heard.
- Senior leaders supported children and young people's involvement in developing strategic plans and influencing change. Compared with hearing from care experienced young people, particularly through the champions board, opportunities were limited for leaders to hear from children and young people at risk of harm.

Children and young people's involvement in decisions about their lives

Children and young people at risk of harm were being listened to and involved in decisions about their lives. Almost all of the children and young people who responded to our survey said that they had a trusted adult to talk to about things that were important to them, particularly if they felt unsafe. Most also felt that their views and opinions were listened to. In our staff survey, over three-quarters agreed that children and young people at risk of harm were able to participate meaningfully in decisions about their lives. Staff we spoke with expressed their confidence that services in general were getting better at hearing the voice of children and families. They felt that the supportive nature of the SCIM model had helped to build relationships with children and young people and enabled them to become more informed and involved. These positive reflections were supported by evidence from our records reading. In almost all those that we read, the views and experiences of children were considered during child protection processes, whilst in a majority the child or young person had contributed to multi-agency planning meetings. We evaluated the ways that children and young people were listened to, heard and involved by staff working with them as good or better in over two-thirds of the records we read. Only in a few cases was this rated as weak and in one case unsatisfactory.

Age appropriate and flexible methods were being used to support children and young people to participate meaningfully in assessment, planning and meetings, including through the use of talking mats, the Mind of my own (MoMo) application, and 'Having Your Say' forms. Young people were helping to train staff in their use. An independent worker had recently been employed to hear young people's views after their involvement in meetings and to check their understanding of what had happened. We heard examples of young people directly influencing planning decisions about their lives, including where they were to live and who they should have contact with. Staff acknowledged the positive benefits of involving them in their own meetings, including helping them to more readily understand young people's needs and the risks that they faced. Creative means were used to maximise the opportunities for young children or those without verbal communication to express their views about what they wanted.

Most children and young people responding to our survey agreed that they had been helped to express their views. A majority agreed that someone had explained their rights to them, although a few were less sure of whether they had been given this support. A range of advocacy services, including Partners in Advocacy, Children 1st and Who Cares? Scotland, as well as services based in neighbouring local authorities, was available to children and families within East Dunbartonshire. It was clear though that knowledge of them, including how to access them, was not well developed. Parents and carers who responded to our survey were uncertain about whether they had had an opportunity to speak with an advocacy worker. Just under half of staff who responded to our survey agreed that independent advocacy support was routinely made available to children and young people at risk of harm. Importantly though, nearly a third were unaware of this. Staff we spoke with described the provision of advocacy as a complicated landscape and acknowledged that it needed to be better co-ordinated. One consequence was that advocates supporting young people at children's hearings were sometimes not involved early enough in the process and were unprepared at the time of the hearing. This was being addressed through the Better Hearings Group, the multi-agency group working to implement the service standards for children's hearings. From our discussions with staff, it was also clear that many felt able to advocate on behalf of young people directly, without the need for the independent advocacy services that were available. Although this was appropriate for some young people, for others it meant that it was difficult for them to challenge decisions where the professional advocating on their behalf may not agree with their views.

Parents and carers involvement in decisions about their children's lives

Parents and carers who responded to our survey were not as positive about their involvement in key decisions as children and young people were. A majority did not feel listened to, or that their views had contributed to decisions about their children. Even when they were included in meetings, some parents felt that they were not always given sufficient information about what would happen to be able to contribute. Others said that they were not given sufficient time to read and understand the necessary paperwork in advance of meetings. These comments were in contrast to evidence from the partnership, the staff survey, and our records reading. Telephone questionnaires with parents and carers following their involvement in child protection meetings found that most felt they had opportunities to express their views and that they had been treated with respect. Nearly three-quarters of respondents to our staff

survey were confident that families contributed to plans for their children. Our records reading tended to support the partnership's findings and the views of staff. This showed that in a majority of cases, parents and carers views were considered during protection processes and that they had contributed to multi-agency meetings. The way that they had been listened to, heard and included by staff was evaluated as good or better in over three-quarters of cases we read.

Means of engaging parents and carers were evolving. Telephone contact with parents and carers following child protection meetings and other options for providing feedback were being developed. This included the use of a survey rather than a phone call, which had been valued by parents. Translation and interpretation facilities were available for parents and carers whose first language was not English. Foster carers we spoke with confirmed that they and the children and young people placed with them had had opportunities to contribute their views and to be involved in planning processes.

Children, young people and families influence on service planning and improvement

Senior leaders were committed to ensuring the views of children and young people were reflected in their plans and that these influenced service developments. Largely as a consequence of the champions board, a forum for care experienced young people to meet and share their views, many staff we spoke with were very aware of how young people had been involved in service developments. For instance, in the successful application for the House project.

Good practice example: East Dunbartonshire House project

The East Dunbartonshire House project was considered to be a good practice example as it reflected a collaborative approach taken by partners working directly with young people. Although long-term benefits were yet to be seen, the inspection team learned of significant differences that the project had already made to the lives of some of the young people who had been involved.

The project was launched in February 2021, with funding from the Life Changes Trust and as part of the National House project. It responded to a gap in the support and preparation for young people leaving care that increased the risks that they faced due to challenges such as isolation and struggling to sustain tenancies. It was a good example of listening to young people and hearing their views about their needs and the risks they faced. It offered an innovative way for young people to take control of their future and to support them to gain the skills and experiences to live independently whilst developing lifelong communities of support. Young people were involved directly in the development and submission of the bid for funding for the project. They were closely involved in the way that it was run and the responsibilities that each of them had towards its success.

From its launch it supported 10 young people into their own homes. In October 2021, another 10 young people joined the House project. They had also been involved further afield, including in a peer evaluation of other House projects as well as presenting a pitch in-house for funding to support activities promoting mental health and wellbeing. The House project was making a clear difference for the young people who had been involved. There was strong positive feedback from both the young people and the staff. High-quality, warm and caring relationships were

observed that contributed to giving young people confidence and awareness that their views can bring about change.

The project was linked to other initiatives including East Dunbartonshire's response to The Promise, and was overseen by a multi-agency steering group including representatives from education, employability, elected members, community justice, police, Who Cares? Scotland, housing and homelessness services.

Our young inspection volunteers were impressed by the Cinderella video that the House project residents had produced as a powerful way to portray voices of young people that was accessible for everyone. The House project was seen as a comfortable and safe place, although for some its location had raised some safety concerns. The project had recognised the need to promote its success more effectively as similar projects reported that this contributed to a better understanding of the approach and supported them to be embedded in wider services.

In another example, care experienced young people had sought changes to the way that they were able to access leisure services so that they could attend unaccompanied by their carer. Changes had also been made to the records that young people were able to access following one individual's concerns about the amount of the records that were redacted. Work was underway with young people through the child protection committee communications subgroup to review the paperwork associated with key processes to ensure that they were written from a young person's perspective and context. Young people had participated in training for panel members for the children's hearing and were to be involved in future interviews for new members. Two videos produced by young people had been widely used in training staff in the area and across the wider health board, to better understand the place of trauma informed practice.

The consequential benefit of these developments for children, young people, families and carers was less clear and there was no immediate evidence available to show the difference that they were making. This meant the partnership was limited in its ability to demonstrate the impact these and wider examples of involvement had had on children and young people's lives. The impetus created by the partnership's response to The Promise had shown them how they may achieve this. They had, for example, measured themselves against The Promise's call to action and were confident of their progress in subsequently being able to demonstrate their effectiveness.

Partners had upheld the principles of the United Nations Convention of the Rights of the Child (UNCRC) and evidence of this was clearly on display. Work in schools was ongoing to make children and young people aware of their rights and more confident about having them respected. Prior to the pandemic, there had been plans for consultation with young people in connection with the integrated children's services plan (ICSP). The engagement of senior leaders and elected members with children and young people was not as strongly embedded. It was not clear for example, how senior leaders, and indeed elected members, hear from children and young people who are, or have been, at risk of harm. There was an over-reliance on the champions board as the vehicle for engaging with them, even though the primary focus of this group was care experienced young people. This group had also had to be recently relaunched following the lifting of Covid-19 restrictions.

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

Key messages

- Leaders had a strong vision for the delivery and improvement of services for children and young people at risk of harm. They were visible and in touch with their staff, and their aims and priorities were clearly articulated.
- The partnership had been adaptive and responsive to change throughout the Covid-19 pandemic. Structures introduced to manage that period were evolving in response to the new challenges that it faced to ensure continuous improvement.
- Partners were committed to using management information and self-evaluation to develop services for children and young people at risk of harm and their families.
- Processes were not always in place to capture the evidence, both from newer services and longstanding ones, that would demonstrate the difference that they were making to the lives of, and outcomes for, children and young people at risk of harm.

Leadership of vision, values and aims

Most staff said leaders had a strong vision for the delivery and improvement of services. Although there were some minor variations, a single vision statement 'our children and young people are safe, healthy and ready to learn', itself linked to the local outcomes improvement plan (LOIP), was evident in a number of key documents. The aims and priorities within key plans, such as the integrated children's services plan (ICSP), were aligned to that vision.

Leadership of strategy and direction

The response to Covid-19 had been timely and effective through the creation of the public protection leadership group (PPLG). It had overseen the work of other groups, including the child protection committee and adult protection committee, managed data requests from Scottish government, and responded to changes in legislation and guidance. The PPLG reviewed trends in new referrals, including children and young people reported missing, and was able to make real-time changes. For example, its analysis suggested that with schools closed there were fewer community-based referrals than could have been expected. Consequently, an effective public awareness campaign was instigated to remind communities that 'its everyone's job' to look out for children at risk of harm or neglect. This led to more referrals being received.

The PPLG had maintained a risk register on behalf of the chief officers group throughout the period of the Covid-19 pandemic with matters escalated to the group as required. This enabled the chief officers group to be better sighted on areas it needed to focus on. For example, data presented to the group on pre-birth activity led to it commissioning a pre-birth pathway and support for mothers with vulnerable

babies. Both the PPLG and the chief officers group's risk register were being retained to respond to new and emerging risks, such as those associated with the cost of living crisis or the arrival of asylum seekers and refugees.

The child protection committee met regularly with an agenda clearly related to its improvement plan. It had functioned well and continuously throughout the Covid-19 restrictions. It had responded imaginatively to online meetings by using breakout rooms to analyse data or other pertinent business allocated by the chair before discussion in the wider meeting. This was reported to have worked well, ensured that all voices were heard, enabled participants to feel more engaged, and for the committee to cover its business more efficiently and effectively.

Although there was crossover in membership between key strategic groups such as the chief officers group, the child protection committee and the delivering for children and young people partnership (DCYPP), leaders saw this as supporting good communication, joined up working, oversight of several workstreams and accountability. Minutes of meetings of these groups showed an appropriate attendance, representation and discussion. There were plans to move on from the structures introduced in response to the Covid-19 pandemic and increase future participation at these meetings.

Although multi-agency plans, such as the local outcomes improvement plan, the child poverty plan and the integrated children's services plan outlined clear priorities, they did not always make clear responsibility for actions or how outcomes would be measured. For example, although a further iteration of the integrated children's services plan was due to be produced later in 2023, the current version did not specify how actions would be achieved. Similarly, the child protection committee's business plan contained detailed actions but no outcomes, measurement of progress or responsibilities.

A comprehensive strategic needs assessment had been produced in March 2022. It was being used by the DCYPP to identify areas for service development. Within the context of strategic planning, partners had recognised prevalent issues relating to neglect, such as mental health and alcohol use, and their cumulative effect. The consequence of the Covid-19 pandemic, as well as the cost of living crisis, was influencing strategic planning. There was evidence of a range of third sector services for children and young people at risk of harm. Some of these participated in the inspection and underlined the contribution that they were making. They noted the challenges that they faced with recruitment, where statutory services were often able to pay higher salaries, and their over-reliance on short-term funding, which was not always aligned to the longer-term nature of their work. Partners were not necessarily making best use of information to understand the effect of their strategic planning decisions, or of the difference that commissioned services, particularly longstanding ones, were making.

Elected members and integration joint board members were aware of key issues facing services for children and young people at risk of harm. Some individuals were involved with particular initiatives, whilst occasional thematic seminars allowed them opportunity to examine key areas. However, by contrast to their approach to corporate parenting and awareness of issues relating to care experienced young people, elected members' role in relation to children at risk of harm was less well developed. This limited their ability to provide scrutiny and oversight.

Leadership of people and partnerships

Evidence from the staff survey suggested that leaders were in touch with their staff, and highly visible, and communicated regularly with them at all levels. Most thought that leaders knew the quality of work that the workforce was able to deliver. This was supported by the results of the local IMatters staff survey and the regular staff bulletins published throughout the period of the Covid-19 pandemic. Amongst those we met, there was positive support for the leadership that senior management had provided throughout this time. They had adopted a 'caring for people' approach and ensured that staff had access to guidance and PPE very quickly. In turn, managers cited the response of staff during the period of Covid-19 restrictions, including the speed of their adaptation, as a significant achievement.

Leaders were responsive to the changing needs of the workforce and their local communities. A joint adult protection committee and child protection committee multi-agency communications group had been established to keep them informed about new and emerging issues relating to risk and harms. This had included the use of display screens in leisure centres to convey public information messages. A comprehensive learning and development framework was in place. It relied on a 'training the trainers' approach, to ensure a sustainable model by building up individual skills within all agencies to deliver training. Participation was open to all statutory and voluntary partners and attendance rates were reported to have increased when it went largely online during the Covid-19 pandemic. Feedback was mostly positive. Site specific child protection training had been provided for groups such as panel members, taxi-drivers, and care at home teams. Training for frontline staff, including groups such as buildings staff and school cleaners, had improved their understanding of trauma and adversity. Further presentations were planned in response to the recent learning review.

In 2020, UNISON made the Care Inspectorate aware of its concerns about staff low morale, continued vacancies in key posts and the actions of some managers in the children's social work service. UNISON considered there to have been an unacceptable delay by East Dunbartonshire council in completing an investigation into these concerns. At that time, the Care Inspectorate had discussions with the council's chief executive. Information on the progress and outcome of the council's investigation was shared with the Care Inspectorate through the allocated link inspector. The investigation was completed in December 2021 with an action plan outlining the necessary improvements, overseen by the council's chief executive. Whilst some key leadership posts remained temporary or interim at the time of the inspection, responses to our survey were broadly positive in terms of staff confidence in their managers and in how effectively they were leading change. Concerns about low morale in the children's social work service were not reflected in any of the activities carried out in the course of this inspection.

There was contrasting evidence in relation to workforce issues such as staff supervision and oversight, and recruitment and retention. On the one hand the integration joint board's quarterly performance reports noted low rates of annual staff appraisals across the health and social care partnership, possibly due to fewer being recorded during the Covid-19 restrictions rather than them not taking place. By contrast, staff we met with reported receiving regular supervision and frontline managers told us they used team meetings and supervision to brief staff with important information, such as from the child protection committee.

Information from panel members and regulated care inspections suggested that there was a relatively high turnover of staff in certain teams, such as one community support team, with a negative consequence for some children and families. Although the number of health visitors was determined by a national allocation model, until recently, vacancies in the service were adding to higher than average caseloads. By contrast, other staff and some families said that they had benefited from the continuity of having longstanding and consistent relationships with the same workers. Some professionals reported that maintaining contact with the same families over time meant that they were more able to identify and reduce the incidence of inter-generational neglect.

Managers described how recruitment rather than retention was more of a challenge, particularly as neighbouring areas reportedly paid higher salaries. East Dunbartonshire attempted to compensate for this by providing a supportive environment with greater visibility of senior leaders, as well as enhancing career pathways through job rotation and post-graduate qualifying opportunities.

Leadership of improvement and change

Effective and collaborative inter-agency working was supporting practice improvements. Staff suggested that working more flexibly during the Covid-19 pandemic, when services, including the third sector, were able to support each other, had enhanced already good working relationships. Whilst social workers and health visitors had maintained home visits within guidance, hubs had been established in schools to support those most at risk, and third sector agencies had provided practical and emotional support to families.

Children and young people were beginning to influence service development and contribute to change. Young people were being included in locality plan consultations, whilst initiatives such as the community alcohol partnership and the House project were showing how young people's opinions could lead to solutions. Leaders suggested that hearing the voices of children and young people was embedded in the culture of East Dunbartonshire and increasingly explicit in strategic documents. They were aware though of the need for wider consultation mechanisms to be developed as there was an over-reliance on the champions board. They were keen to benchmark their practice against other areas.

The partnership had demonstrated that it was adaptive to change. For example, a new public protection website, designed to be a 'one stop shop' and including a 'getting in touch' button to make easy contact, had recently been launched. Numbers accessing the website were being monitored and a test of change was being used to ensure that it was relevant and accessible to all. The recent learning review had led to the introduction of practitioner forums to promote awareness of issues such as domestic abuse and neglect and a trauma co-ordinator had been appointed to embed trauma informed practice throughout the partnership. Again, it was not clear how the effect of these improvements would be reviewed in order to understand the difference they had made.

A majority of respondents to the staff survey said that leaders ensured there was necessary capacity to meet the needs of children at risk of harm. However, a relatively high proportion of respondents were less clear about this. Balancing the budget was clearly a challenge for the integration joint board, which had responsibility for delegated children's services. Although leaders across the

partnership were evidently alert to the demands placed on children's services as a whole and recognised the importance of early intervention, financial pressures in the wider public sector meant that plans were more tightly aligned to the key strategic priorities of the community planning partnership and the NHS Board.

The management information and self-evaluation (MISE) subgroup of the child protection committee was driven by a learning and improvement framework. It managed audit activity on the committee's behalf and maintained oversight of the child protection minimum dataset. The MISE subgroup's role had been expanded both by the increased interest in and analysis of data during the Covid-19 pandemic and by the adoption of the dataset. An audit of domestic abuse referrals, for example, had been prompted by an analysis that had highlighted peaks in referrals during the Covid-19 restrictions. Rather than relying on national projections, local data was closely reviewed to understand this. However, the effect of the introduction of the Safe and Together model on such referrals did not appear to have been considered. A project steering group had been established to take this work forward.

Areas for audit or closer scrutiny were proposed by individual agencies or by the child protection committee itself. There was evidence that such analysis was informing a better understanding of practice and areas for improvement, such as conversion rates through the various stages of the child protection process, or rates of attendance at child protection meetings. MISE had also reviewed data for both de-registration and re-registration and continued to monitor this regularly. An analysis of re-registrations, for example, highlighted that although overall numbers were relatively small, neglect was a common factor, a finding that contributed to practice improvement in this area. A pre-birth audit was undertaken following changes in patterns of activity and findings led to changes in the way that professionals worked together and a review of the pre-birth/SNIPS (special needs in pregnancy service) protocol. A perinatal mental health steering group had developed a collaborative approach and a tiered response to support mothers and families' wellbeing and mental health in the perinatal period, including specialist counselling from the Bluebell service. Within social work, service managers, team managers and frontline staff used the 'How Good is our Service' approach to review consistency of performance in relation to child protection investigations. The delivering for children and young people partnership also analysed a wide range of quantitative and qualitative data to inform its strategic priorities. As noted though, evaluation was not always being used to consider the impact of particular initiatives or services.

Evaluation of the impact on children and young people - quality indicator 2.1

For these inspections we are providing one evaluation. This is for quality indicator 2.1 as it applies to children at risk of harm. This quality indicator, with reference to children at risk of harm, considers the extent to which children and young people:

- feel valued, loved, fulfilled and secure
- feel listened to, understood and respected
- experience sincere human contact and enduring relationships
- get the best start in life

Evaluation of quality indicator 2.1: Good

In East Dunbartonshire, there were a number of important strengths that clearly outweighed the areas for improvement in relation to the impact of services on children and young people at risk of harm.

Therefore, we evaluated quality indicator 2.1 'impact on children and young people' as good.

The important strengths that were having a significant positive impact on the experiences of children and young people at risk of harm.

- Many children and young people said that they got the right help to make and keep loving relationships with those they cared about. We saw how some were being supported to maintain relationships with brothers and sisters, as well as with parents.
- Support for children's wellbeing, planning of care and provision of good nurturing relationships was rated as good or better in regulated care inspections.
- Almost all children and young people told us they felt safe where they lived all or most of the time. Asylum seeking young people felt well supported, safe and helped to maintain cultural links. Interpreters were provided for individual children or parents.
- Young people were being listened to about what mattered to them, felt involved and were aware of their rights. Many children and young people had the opportunity to develop consistent and enduring relationships with key staff.
- Children and young people had been directly engaged in service developments such as the House project. In other examples, including record keeping, they were influencing changes in practice.
- Staff we spoke with demonstrated a child-centred approach to providing services to improve the wellbeing of children and young people.
- Statutory and voluntary agencies were working well together to provide practical support for children, young people and their families. A range of services from pre-birth to teenage, provided early and effective intervention in response to emerging concerns.
- Children and young people had benefitted from their safety and wellbeing having been a key priority for leaders throughout the Covid-19 pandemic.

We noted that improvement was required to ensure consistency in experience and outcomes for children and young people at risk of harm and their families.

- A range of advocacy services was available, but they were less developed for children and young people at risk of harm and were not always consistently accessible throughout the area. The value of independent advocacy in hearing their voices within protective processes was less understood by staff more generally.
- Opportunities for children and young people's voices to influence wider strategic planning were less established for those at risk of harm than for those who were care experienced.
- By comparison to other key processes, the weaker quality of chronologies was limiting their contribution to assessment of risk and need for individual children and young people at risk of harm, and the planning of services for them.
- Not all children and young people were being adequately supported in relation to their mental health. By contrast to the range of services that provided early support for emotional wellbeing and mental health needs, CAMHS services had only recently benefitted from extra funding to address the unprecedented levels of need. Although there was evidence that performance was improving, they had been subject to long waiting times and geographical imbalance within the area.
- Partners were working to develop evaluations of interventions to ensure that these were clearly measured. They were not yet able to demonstrate the outcomes that services were achieving for individual children and young people at risk of harm, as well as the overall impact that they were having.

See appendix 1 for more information on our evaluation scale.

Conclusion

The Care Inspectorate and its scrutiny partners are confident that partners in East Dunbartonshire have the capacity to make changes to service delivery in the areas that require improvement.

This is based on the following factors.

- Evidence of strong partnership working, and staff and leaders being committed to improving outcomes for children, young people and families.
- High levels of confidence from staff in their knowledge and abilities, supported by evidence from our records reading.
- Similar levels of support from staff about their leaders' ability to continue to drive change and make improvements.
- Well-developed management information and self-evaluation practice capable of identifying areas for improvement and further action.
- Collaborative inter-agency practice, including the role of the third sector, providing services to children at risk of harm and their families.
- Recent commitments to changes in practice, including the introduction of the Safe and Together model, and an emphasis on trauma informed practice.
- The partnership's own self-evaluation had already identified many of the areas for improvement found by the inspection team, which showed that they knew themselves well and had a solid foundation to make improvements.

What happens next?

The Care Inspectorate will request that a joint action plan is provided that clearly details how the partnership will make improvements in the key areas identified by inspectors. We will continue to offer support for improvement and monitor progress through our linking arrangements.

Appendix 1: The quality indicator framework and the six point evaluation scale

Our inspections used the following scale for evaluations made by inspectors outlined in the quality framework for children and young people in need of care and protection:

- **6 Excellent** - Outstanding or sector leading
- **5 Very Good** - Major strengths
- **4 Good** - Important strengths, with some areas for improvement
- **3 Adequate** - Strengths just outweigh weaknesses
- **2 Weak** - Important weaknesses – priority action required
- **1 Unsatisfactory** - Major weaknesses – urgent remedial action required

An evaluation of **excellent** describes performance that is sector leading and supports experiences and outcomes for people that are of outstandingly high quality. There is a demonstrable track record of innovative, effective practice and/or very high-quality performance across a wide range of its activities and from which others could learn. We can be confident that excellent performance is sustainable and that it will be maintained.

An evaluation of **very good** will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement. Those that do exist will have minimal adverse impact on people's experiences and outcomes. While opportunities are taken to strive for excellence within a culture of continuous improvement, performance evaluated as very good does not require significant adjustment.

An evaluation of **good** applies to performance where there are a number of important strengths that, taken together, clearly outweigh areas for improvement. The strengths will have a significant positive impact on people's experiences and outcomes. However, improvements are required to maximise wellbeing and ensure that people consistently have experiences and outcomes that are as positive as possible.

An evaluation of **adequate** applies where there are some strengths, but these just outweigh weaknesses. Strengths may still have a positive impact but the likelihood of achieving positive experiences and outcomes for people is reduced significantly because key areas of performance need to improve. Performance that is evaluated as adequate may be tolerable in particular circumstances, such as where a service or partnership is not yet fully established, or in the midst of major transition. However, continued performance at adequate level is not acceptable. Improvements must be made by building on strengths while addressing those elements that are not contributing to positive experiences and outcomes for people.

An evaluation of **weak** will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect peoples' experiences or outcomes. Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met. Weak performance requires action in the form of structured and planned improvement by

the provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

An evaluation of **unsatisfactory** will apply when there are major weaknesses in critical aspects of performance that require immediate remedial action to improve experiences and outcomes for people. It is likely that people's welfare or safety will be compromised by risks that cannot be tolerated. Those accountable for carrying out the necessary actions for improvement must do so as a matter of urgency, to ensure that people are protected, and their wellbeing improves without delay.

Appendix 2: Key terms

NB. More key terms that we use in inspections are available in The Guide.

Asylum seeking young people are young people under 18 years of age or who, in the absence of documentary evidence establishing age, appear to be under that age who are applying for asylum in their own right and are separated from both parents and not being cared for by an adult who by law or custom has responsibility to do so.

Care and risk management (CARM) are processes which are applied when a child between the ages of 12 and 17 has been involved in behaviours which could cause serious harm to others. This includes sexual or violent behaviour which may cause serious harm. CARM processes are also applicable when an escalation of behaviours suggests that an incident of a seriously harmful nature may be imminent.

Champions boards allow young people to have direct influence within their local area and hold their corporate parents to account. They also ensure that services are tailored and responsive to the needs of care experienced young people and are sensitive to the kinds of vulnerabilities they may have as a result of their experiences before, during and after care. Young peoples' views, opinions and aspirations are at the forefront in this forum and are paramount to its success. Champions boards build the capacity of young people to influence change, empower them by showing confidence in their abilities and potential, and give them the platform to flourish and grow.

Chief officers group (COG) is the collective expression for the local police commander and chief executives of the local authority and NHS board in each local area. Chief officers are individually and collectively responsible for the leadership, direction and scrutiny of their respective child protection services and their child protection committees.

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

Child protection committee (CPC) is a locally-based, inter-agency strategic partnership responsible for child protection policy and practice across the public, private and third sectors. Working on behalf of chief officers, its role is to provide individual and collective leadership and direction for the management of child protection services in its area.

Chronology sets out key events in sequential date order, giving a summary timeline of child and family circumstances, patterns of behaviour and trends in lifestyle that may greatly assist any assessment and analysis. They are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration, investigation and assessment.

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

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

Inter-agency referral discussion (IRD) is the start of the formal process of information sharing, assessment, analysis and decision making following reported concern about abuse or neglect of a child or young person under the age of 18 years, in relation to familial and non-familial concerns. This may include discussion of concern relating to brothers and sisters, or other children within the same context, and can refer to an unborn baby that may be exposed to current or future risk. They may also be known as initial referral discussions or initial referral tripartite discussions.

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

Integration joint board (IJB) plans and commissions integrated health and social care services in their areas. Integration joint boards are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. They are responsible for overseeing the local health and social care partnership and managing social care and health services in their area.

Learning review brings together agencies, individuals and families in a collective endeavour to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect children and young people. The process is underpinned by the rights of children and young people as set out in the United Nations Convention on the Rights of the Child (UNCRC). Until the updated national guidance for child protection was published in 2021, the term 'significant case review' (see below) was more commonly used.

Local outcomes improvement plan (LOIP) is a requirement of the Community Empowerment (Scotland) Act 2015. It is produced to outline how community planning partners will work with communities to improve outcomes for individuals, families and communities. The LOIP is not an aspirational statement for the future but a document that takes into account the needs of communities.

Minimum Dataset for Child Protection Committees in Scotland has been developed by CELCIS in partnership with Scotland's child protection committees, Scottish Government, Care Inspectorate, Police Scotland, NHS Scotland and Scottish Children's Reporter Administration. It is a package of data collation, presentation, analysis, scrutiny questions and reporting. It aims to deliver robust datasets to support child protection improvement, develop a national resource for advice on using child protection data for local planning and service development, and to expand analytical capacity.

Multi-agency risk assessment conference (MARAC) is a regular, local meeting where information about domestic abuse victims at risk of the most serious levels of harm (including murder) is shared between representatives from a range of local agencies to inform a co-ordinated action plan to increase the safety of the victim and their children.

National Guidance for Child Protection 2021 describes responsibilities and expectations for all involved in protecting children in Scotland. The Guidance outlines how statutory and non-government agencies should work together with parents,

families and communities to prevent harm and to protect children from abuse and neglect. Everyone has a role in protecting children from harm.

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

Safe and Together provides a model for practitioners to consider and discuss concerns, challenges and solutions for families. It is a way of working that aims to create systems and practice change that is child-centred and keeps children safe and together with the protective parent. Its effectiveness is measured by how domestic violence informed agencies make this occur as much as possible and how child welfare systems and practitioners respond to the issue of domestic abuse.

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

United Nations Convention on the Rights of the child (UNCRC) is a widely ratified international statement of children's rights.

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EAST DUNBARTONSHIRE COMMUNITY PLANNING PARTNERSHIP
JOINT INSPECTION OF SERVICES FOR CHILDREN AND YOUNG PEOPLE AT RISK OF HARM
ACTION PLAN - APRIL 2023

The inspection report was published on 18 April 2023 and can be accessed Joint inspections of services for children and young people (careinspectorate.com)
The areas for development identified through the inspection process and the actions agreed to address these are set out below .

1. Advocacy
a) A range of advocacy services was available, but they were less developed for children and young people at risk of harm and were not always consistently accessible throughout the area.
b) The value of independent advocacy in hearing their voices within protective processes was less understood by staff more generally.

Action and Cross Referencing	Lead & Reporting Route	Timescale	Progress
1 a) Part 1 - The NHSGGC wide advocacy strategy is currently being refreshed for 2022 – 2026.	NHSGGC Board led by Glasgow City HSCP via a Review Group (Kelly Gainty is ED rep)	Publication 31 July 2023	In consultation stage – comments by 26 May 2023
Part 2 - A local implementation plan will be developed for East Dunbartonshire.	David Aitken reporting to EDIJB	16 November 2023	To follow completion of above
1 b) Part 1 - Mapping of advocacy which is currently available – to be completed as part of production of NHSGGC advocacy strategy 2022 - 2026	DCYPP members	26 May 2023	In progress

Part 2 - Promotion of awareness across the workforce. Web site links to services refreshed, and advocacy poster produced Part 3 - Ensure the views of children and young people about their use of advocacy is captured, as part of capturing wider views on their experience	CPC through development of the Communication, Participation and Engagement Framework, on CPC 2022 – 2025 Business Plan. Also for inclusion in next iteration of the ICSP	31 August 2023 31 June 2024	In progress In progress
2. Voices of Children & Young People at Risk of Harm **Opportunities for children and young people's voices to influence wider strategic planning were less established for those at risk of harm than for those who were care experienced.**			
Action and Cross Referencing	**Lead & Reporting Route**	**Timescale**	**Progress**
2. Develop and Implement CPC Communication, Participation and Engagement Strategy to: - Widen the number of ways in which we can gain feedback from children, young people, parents and professionals in a focussed way using a number of accessible tools, including MOMO, online survey and telephone consultation. - Information gathered provides us with evidence to inform improvement.	CPC – led by Public Information and Communication sub group	31 June 2024	In progress
3. Chronologies			

By comparison to other key processes, the weaker quality of chronologies was limiting their contribution to assessment of risk and need for individual children and young people at risk of harm, and the planning of services for them.			
Action and Cross Referencing	**Lead & Reporting Route**	**Timescale**	**Progress**
3. Chronology framework to launch and embed: - Implement Learning and Development Evaluation Framework to support this. - Multi-agency training is available in the Joint Learning and Development calendar. - 7- minute briefing to be used in team meetings and supervision to evidence and understand how chronologies are being used to further inform improvements in this area. - Make changes to agenda for Child Protection Planning and Review Meetings and core groups to include the provision of a multi-agency chronology. - Accessible resources available on the website.	CPC – led by Management Information and Self-Evaluation Sub Group	31 June 2024	In progress
4. CAMHS (Child and Adolescent Mental Health Services) **Not all children and young people were being adequately supported in relation to their mental health. By contrast to the range of services that provided early support for emotional wellbeing and mental health needs, CAMHS services had only recently benefitted from extra funding to address the unprecedented levels of need. Although there was evidence that performance was improving, they had been subject to long waiting times and geographical imbalance within the area.**			
Action and Cross Referencing	**Lead & Reporting Route**	**Timescale**	**Progress**

4 a) The workforce plan for CAMHS will be reviewed to establish where there are gaps specifically in relation to case holding capacity. 4 b) Recruitment will continue to allow greater case holding capacity and to meet the 18 week waiting times standards. 4 c) The realignment of SCS in to a single management arrangement will allow for a channelling of resource to focus on areas of longest waiting. This will also allow for recruitment to be channelled to the teams with the greatest demand. This will support delivery of the waiting times standards. 4 d) CAMHS will strengthen links with East Dunbartonshire Delivering for Child and Young People's Partnership planning for a to ensure more integrated pathways are being developed and to advice on future service developments to support children young people and their families while they await CAMHS	Karen Lamb – Reporting via the NHSGGC Mental Health Recovery and Renewal Programme Board Performance reporting to NHSCMT and Board and EDIJB	31 December 2023	In progress
5. Analysis and demonstration of outcomes and impact of services **Partners were working to develop evaluations of interventions to ensure that these were clearly measured. They were not yet able to demonstrate the outcomes that services were achieving for individual children and young people at risk of harm, as well as the overall impact that they were having.**			
Action and Cross Referencing	**Lead**	**Timescale**	**Progress**
Implement Frameworks which support evidencing evaluation and impact: 5 a) Learning and Improvement Framework	CPC – led by various Sub Groups	31 June 2024	In progress

- Supported by themed audit activity throughout the academic year for targeted areas for improvement from previous learning from audit activity. - This is developed and supported by the MISE Action Plan 5 b) Learning and Development Strategy - Multi-agency workforce development which continues to be influenced by themes derived from audits/ Learning Reviews. 5 c) Monitoring and Evaluation Framework - Supported and driven by Multi-agency and L and D subgroup and will be live via the new learning management system, Moodle. This will be further scrutinised by our annual training report. 5 d) Communication, Participation and Engagement Strategy - Widening the number of ways in which we can gain feedback from children, young people, parents and professionals in a focussed way using a number of accessible tools, including MOMO, online survey and telephone consultation. - Information gathered provides us with evidence to inform improvement. - Promote awareness of impact, outcomes etc through CPC annual report and seven minute briefings			

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair

Agenda Item Number: 14.

East Dunbartonshire HSCP Performance, Audit & Risk (PAR) Committee Agenda Planner
Meetings
September 2022 – September 2023

Updated 21/03/22

Standing items (every meeting)
Minutes of last meeting (JC)
Internal Audit Update (GMcC)
Committee Agenda Planner (JC)
HSCP Annual Delivery Plan Update (JC)
Care Inspectorate Reports as available
Relevant Audit Scotland reports as available
HSCP Committee Agenda Items – October 2022 (Special Meeting to approve Annual Accounts 2021/22)
Final Audited Annual Accounts 2021/22 (JC)
Audit Scotland Annual Audit Report (PL)
HSCP Committee Agenda Items – January 2023
Internal Audit Update (GMcC)
Interim Internal Audit Follow Up Report (GMcC)
Performance Management Update Qtr2 22/23 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update
HSCP Committee Agenda Items – March 2023

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair

Agenda Item Number: 14.

Internal Audit Plan 2023/24 (GMcC)
Performance Management Update Qtr3 22/23 (AC / AW)
HSCP Board Agenda Items – June 2023
Annual Internal Audit Report (GMcC)
Annual Audit Plan – External Audit (Mazars)
Internal Audit - Audit Plan 2023/24
Final Internal Audit Follow Up Report (GMcC)
Unaudited Annual Accounts 2022/23 (JC)
SW Contracting Update (GH)
Performance Management Update Qtr4 22/23 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update
HSCP Board Agenda Items – September 2023
Performance Management Update Qtr1 23/24 (AC / AW)
Final Audited Annual Accounts 2022/23 (JC)
Audit Scotland Annual Audit Report (PL)