East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair

East Dunbartonshire HSCP

Performance Audit & Risk Committee Meeting

Thursday 28th September 2023 at 2pm
Meeting will be held virtually via MS Teams

AGENDA

Item	Lead	Description	Update	For Noting/ Approval
STANDING ITEMS				
1.	J Forbes	Welcome and Introductions	**Verbal**	**Noting**
2.	J Forbes	Minutes of Last Meeting – 20th June 2023	**Paper**	**Noting**
3.	G McConnachie	Internal Audit Report to August 2023	**Paper**	**Noting**
4.	G McConnachie	PAR Committee Self-Assessment	**Paper**	**Noting**
5.	J Campbell	HSCP Delivery Plan 2023-24 Update	**Paper**	**Noting**
6.	J Campbell	HSCP Corporate Risk Register 2023-24	**Paper**	**Noting**
7.	D Pearce	Care Inspectorate – Care at Home (CAH) Inspection May 2023	**Paper**	**Noting**
8.	J Campbell	Records Management Plan Interim Update – Progress Update Review (PUR) Outcome	**Paper**	**Approval**
9.	J Campbell	HSCP PAR Agenda Planner	**Paper**	**Noting**
10.	J Forbes	AOCB	**Paper**	**Noting**
11.	J Forbes	Date of next meeting – tbc January 2023	**Verbal**	**Noting**

Minutes of
East Dunbartonshire HSCP Performance, Audit & Risk Committee Meeting
Date: Tuesday 20 June 2023 at 2pm
Location: Via MS Teams

Present:	Calum Smith (Chair)	**CSm**	Jacquie Forbes	**JF**
	Caroline Sinclair	**CS**	Ketki Miles	**KM**
	Jean Campbell	**JC**	Gillian McConnachie	**GMcC**
	David Aitken	**DA**	Derrick Pearce	**DP**
	Alison Willacy	**AW**	Gillian Healey	**GH**
	Karen Lamb	**KL**	Tom Reid	**TR**
	Karen Donnelly	**KD**		

Minutes : Jacqueline Hughes

No.	Topic	Action by
1.	**Welcome and Apologies**	**CSm**
	Chair welcomed the Committee members to the meeting. Apologies submitted from: Ewan Patterson, Ishana Singh, Ian Ritchie, Claire Carthy.	
2.	**Minutes of Last Meeting – Extraordinary Performance, Audit and Risk Committee Meeting of 21st March 2023.**	**All**
	The minutes of the meeting on the 21st March 2023 were accepted as accurate and approved.	
3.	**Mazars - Audit Strategy Memorandum for Year Ending 31st March 2023**	**TR**
	TR reported from the Mazars Audit Strategy Memorandum for the year ending 31st March 2023. Points highlighted: • Section 4: Significant Risks and Other Key Judgement Areas regarding Management Override Controls being a significant risk. • Section 5: Wider Scope & Best Value that highlights the framework for wider scope work and approach. • Section 8, Materiality and misstatements, the summary of the materiality thresholds. **No questions were asked.** **It was resolved:** • The content of the Annual Audit Plan for the IJB was noted.	
4.	**Unaudited Annual Accounts 2022-23**	**JC**
	JC reported from the unaudited Annual Accounts. Points highlighted: • 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.

- 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.

JC highlighted underspend can ab attributed to recruitment difficulties and an error made in charges to ED HSCP that have been paid back.

Questions:
JF raised a query regarding the position of being ahead with the contingency amount, would this have to be used rather than additional funding sources.
JC responded that the contingency was only slightly over. Going into next year there are significant risks in Scotland. There is the pay uplift, provider market risks and the possibility of the HSCP making transitionary payments in order to deliver the Strategic Plan.

JF asked about the unfilled vacancies, would they impact the performance indicator and if it could be earmarked rather than go to general reserves.
JC responded that all HSCP's are the same and rather than earmark it gives the ability to manage and respond to risks.
CS added there is a broad observation line between recruitment and performance. For an example an area of transformation would be developing a rehab focussed service, however it is difficult to provide an enhanced service when covering the basic. There has been recruitment engagement, creative ways to recruit. The challenge being, everyone is recruiting from the same talent pool.

KM noted they were happy to approve and raised that sustainability should be made clear by the IJB and recorded with the auditors.

It was resolved:

- The Unaudited Accounts for 2022/23 were noted and approved.
- The Annual Governance Statement included within the Unaudited Accounts was approved.
- The local code of governance against which the IJB will measure itself in the Annual Governance Statement for 2022/23 was approved.
- The self-assessment against the Scottish Government's best value framework were noted and approved.
- The assessment of compliance for the IJB against the requirements of the CIPFA Financial Management code were noted and approved.

5.	**Mazars – Audit of East Dunbartonshire IJB's Financial Statements for the year ending 31 March 2023**	**GMcC**
	GMcC reported the questionnaire was part of the audit process and with JC it has been prepared under International Standards for Auditing (ISA) relating to fraud, laws and regulations, litigation and claims. **No questions were asked.** **It was resolved:** • The response to Mazars questionnaire, 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 was approved.	
6.	**HSCP Annual Performance Report 2022/23**	**AW**
	AW explained 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. Points highlighted: • Achievements and good practice were highlighted and staff praised for their efforts. • There were corrections in the CAMHS data, P34 & P36 the percentage of children was 74.1% were seen in the 18 weeks target. P56, 3rd bullet point has been amended to reflect children who have been seen in 18 weeks. **Questions:** KM & JF noted thanks for the work on the new report. JF asked about the performance of care homes as a couple are not achieving scores that would be liked and what could be done to support. GH confirmed there is care home support from HSCP and Clinical Commissioning Partnership. JF extended offer of support. **It was resolved:** • The HSCP Annual Performance Report 2022-23 was noted.	
7.	**HSCP Annual Internal Audit Report to June 2022**	**GMcC**
	GMcC reported on the 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. Points highlighted: • 1 remaining high risk, 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. • Target date is in a few months, aim is next PAR will be business as usual. **No questions were asked.** **It was resolved:** • The Annual Audit Report for 2022/23, including the Internal Audit Opinion for 2022/23 was considered and approved.	

	• 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 was agreed and approved. • 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 was considered and approved. • The Chief Finance & Resources Officer to submit performance monitoring reports detailing progress against Plan and audit results to future meetings of the Committee was considered and requested.	
8.	**HSCP Delivery Plan 2022-23 Update**	**JC**
	JC confirmed the position of the HSCP Delivery Plan with 31 projects and the majority being achieved. Points highlighted: • 81% of projects achieved. • 5 projects in red status. • Outstanding projects will be carried forward to 2023-24 Delivery Plan. • Savings plan was achieved with the exception of £10,000. **Questions:** JF noted thanks for the detailed information and the excellent work & savings. JF queried the format of the report as it is a 1 year report that has actions that can span 2-3 years. Also noted was the projects in exception and felt more clarity was needed. JC explained there were limits on the reporting software and will investigate ways to make the information clearer. JC explained that some projects do take years but the reporting was on that years particular part of the project is put in the action plan for that year **It was resolved:** • The update to the HSCP Delivery Plan for 2022/23 was noted.	
9.	**HSCP Risk Management Policy and Corporate Risk Register Update**	**JC**
	JC gave an overview of the HSCP Risk Management Policy and updates to the Corporate Risk Register. Points highlighted: • Corporate Risk Register will be brought to all PAR meetings. • Risk Management Policy updated with minor changes following Governance Audit and reflects NHS Board changes. • 14 risks in the Risk Register. • Positive financial position was noted. **Questions:** JF noted appreciation for the work completed and raised a query regarding a risk including recruitment of GP's, as the HSCP cannot influence the recruitment of GP's and does not see that it should be noted as a risk. JC explained it impacts the HSCP as the board may need to step in and run a practice. A surgery was given as an example that could not deliver services or recruit GP's and the HSCP supported them in this time. DP confirmed if a GP practice hands their contract back then the HSCP needs to run the practice. JF thanked for the information.	

	KM expressed thanks for the work in the report and noted great progress and offered it would be beneficial to show trends. **It was resolved:** • The updated HSCP Risk Management Policy was considered and approved. • The Corporate Risk Register attached was considered and approved.	
10.	**HSCP Directions Log Update**	**JC**
	JC reported the Directions Log is 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. Points highlighted: • 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 • 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 • 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 **No questions were asked.** **It was resolved:** • The content of the Report was noted. • It was noted the report will be remitted to the IJB.	
11.	**Mental Welfare Commission's Findings in relation to Mental Health and Specialist Children's Services**	**CS**
	CS summarised the findings from the Mental Welfare Commission in relation to Mental Health and Specialist Children's Services. Points highlighted: • Skye House, 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. 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. • Ward 4, 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. 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. **No questions were asked.** **It was resolved:** • The content of the Report was noted; and • 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 were approved.	
12.	**Accounts Commission Report – Integration Joint Boards Financial Analysis 2021/22**	**JC**
	JC noted for the representative's information the 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. Points highlighted: **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. **No questions were asked.** **It was resolved:** • The contents of the Accounts Commission report on Integration Joint Boards Financial Analysis 2021/22 were noted.	
13.	**Joint Inspection of Services for Children at Risk of Harm – Inspection Report and Action Plan**	**CC**
	CS reported for CC, it is proposed the report is brought to this forum 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. Points highlighted: • Overall good inspection. • 1 area requiring attention - delivery of advocacy services could have a more strategic approach. • CARH plan in place until June 2024, with positive feedback of confident delivery. CSm noted thanks for the additional work to everyone involved. **No questions were asked.** **It was resolved:** • The publication of the Joint Inspection of Services for Children at Risk of Harm Inspection Report was noted; • The Action Plan for delivery • 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 was noted.	
14.	**PAR Committee Agenda Planner**	**CS**
	CS provided the planner for the PAR Committee Agenda. **It was resolved:** • The planner was agreed.	
15.	**A.O.C.B**	
	None	
16.	**Date of next meeting – 28th September 2023**	**ALL**

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 3.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**28th SEPTEMBER 2023**
REPORT REFERENCE:	**PERF/280923/03**
CONTACT OFFICER:	**GILLIAN MCCONNACHIE, CHIEF INTERNAL AUDITOR, 0141 574 5642**
SUBJECT TITLE:	**INTERNAL AUDIT UPDATE TO AUGUST 2023**

1.0 PURPOSE

1.1 The purpose of this report is to update the Committee on internal audit work completed in the period since the last Committee.

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 the these committees, this report provides details on the ongoing audit work, for information, to the H&SCP Performance, Audit & Risk Committee and to allow consideration from the perspective of the H&SCP.

2.0 RECOMMENDATIONS

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

2.1 Note the contents of the report and

- 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 BACKGROUND/MAIN ISSUES

3.1 In the period since the last committee update, the Internal Audit Team finalised and reported on the outputs as shown in Table 2 below. The table below represents a continuation of the reporting on the Internal Audit work for 2023/24, with Outputs 1 to 3 having previously been completed and reported to committee.

Table 2 – Analysis of Internal Audit Outputs June 2023 to August 2023

	Audit Area and Title	Areas Noted	High Risk	Medium Risk	Low Risk
	Systems				
4	HSCP Governance – Workforce Planning	**2**	-	2	-
5	HSCP Bad Debt Provision	**4**	-	1	3

3.2 Two outputs were completed in the period, representing a year-to-date cumulative achievement of 5 outputs or 50% completion of the 10 outputs planned for the year 2023/24, at 42% through the year.

3.3 The audit plan is progressing as expected and there are no concerns about the completion of the audit plan at this stage.

3.4 Auditors have provided the following summary of the audit output completed since the last monitoring report for Members.

HSCP Governance – Workforce Planning

3.5 The overall objective of the audit was to review the arrangements put in place by the HSCP to ensure that there is a sound system of Workforce and Succession Planning.

3.6 Auditors recognise that the HSCP operates in a highly challenging environment due to financial constraints and the organisational uncertainty relating to the forthcoming National Care Service.

3.7 Nonetheless, the ability to manage both the current and future workforce requirements is crucial to the ability to effectively deliver services and meet the strategic aims and objectives of the organisation. Workforce planning involves the careful review of both the quantity of the staff required to deliver the aims of the organisation, as well as the possession of the necessary skills to do so.

3.8 The HSCP, as required by the Scottish Government has developed and published a workforce plan, covering the period of 2022-25. This sits alongside developments such as the National Workforce Strategy, published by the Scottish Government in 2022 and the Health and Social Care Staffing Act of 2019, where the provisions of such will come into effect in April 2024. The legislation and strategies reflect the importance of ensuring there is a system of robust workforce planning.

3.9 The HSCP recognises in its Workforce Plan that the Social Care recruitment marketplace is impacted by the widely varying rates of pay and differing terms and

conditions that are available across the sectors. These differentials are not an issue when recruiting NHS staff as there are standard remuneration packages available across NHS Scotland providers. It is hoped that the proposed National Care Service will standardise the salaries available to staff in a positive manner.

3.10 Internal Audit concluded that the arrangements in operation for Workforce Planning with regards to the HSCP are sound with no high risks being identified during the review. Nonetheless, Auditors identified some areas of improvement in relation to the content of the existing Workforce Plan, in particular the outlining of future workforce requirements with respect to both the quantity needed and the skills required. Succession planning could be strengthened as well as further detail to support the action plan.

3.11 The HSCP followed National Guidance when formulating the Plan and creating the Action Plan. As part of its review of the HSCP's Workforce Plan the Scottish Government supplied feedback regarding the content of the Plan. As this feedback was received just prior to the Plans publication (October-22, published November-22), there was limited time to formally review and action the feedback points. Therefore, it is important that these are fully addressed in future iterations of the Workforce Plan.

3.12 Supporting the feedback from the Scottish Government, Internal Auditors have highlighted a few key areas where improvements could be made. These include:

- Further detailing of the future workforce required,
- Succession and Scenario Planning, and;
- Action Plan – to be supported by more detailed service level action plans and costing.

3.13 The agreed action plan commits to a review of Scottish Government feedback as part of the update of future iterations of the workforce plan. In addition, detailed work will be progressed through the Workforce Planning Group to determine indicative future workforce requirements within each service area linked to an action plan including financial impacts. Succession and scenario planning considerations will be also be strengthened within the next iteration of the Workforce Plan.

HSCP's Bad Debt Provision

3.14 Auditors have concluded a review of the HSCP's Bad Debt Provision.

3.15 The debts relating to HSCP activity are legally Council debtors, with contracts in place between the Council and the service users. However, any change in the balance sheet of HSCP related debtors affects the HSCP's Income and Expenditure.

3.16 Debtors are recorded on the Council's ASH Debtors system with recovery processes and procedures are administered by the Council's Corporate Debt Team.

3.17 Internal Audit concluded that the controls in place with respect to the calculation of the HSCP's Bad Debt Provision are sound. Improvements have been identified with respect to the reporting on and monitoring of the HSCP Bad Debt Provision and in relation to the write-off process.

3.18 Auditors found no material issues with respect to the recovery of HSCP Debts, being administered in accordance with the Council's Debt Recovery procedures.

3.19 It should be noted that Auditors, as part of the Self-Directed Support Overpayments audit in 2022/23, considered risks around the timely raising of invoices and actions are being progressed in line with the findings in that report.

EAST DUNBARTONSHIRE COUNCIL INTERNAL AUDIT PROGRESS

3.20 Work on the Council's Internal Audit Plan continues. Audit work to date has included work on IT backups of potential interest to the PAR in terms of crossover risks - this audit sought to verify that the Council is aligned with best practice with respect to the backing up of data. This includes lessons learned following a cyber-attack on SEPA in 2020 and assurance that issues identified in the 2021 SEPA Report have been addressed. Auditors concluded that Council adherence to back-up best practice is generally reasonable but should be subject to further improvement actions to enhance assurances within the area. No high risks were noted during the review, and auditors noted that the Council has made recent improvements. Further enhancements will be progressed with the creation of a formal back-up policy, outlining the testing arrangements in place.

NHSGGC INTERNAL AUDIT PROGRESS

3.21 An update on the NHSGGC's internal audit activity has been received by Internal Audit. An audit of Public Protection Arrangements was carried out and Azets found that substantial improvement is required. Eight actions have been agreed, with Auditors finding that the adult protection documentation is not as robust as the child protection documentation, the staff training processes should be improved and that the standard forms could be amended to more clearly evidence lessons learned. In addition, governance arrangements were found to be in a transition stage as adult protection measures were being aligned to those established for children and young people.

3.22 An audit of Property Transaction Monitoring did not identify any actions, with Auditors providing an 'Effective' rating.

4 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan – 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 Corporate Parenting – None

4.11 Other – None.

5 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 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 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

None

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 4.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**28th SEPTEMBER 2023**
REPORT REFERENCE:	**PERF/280923/04**
CONTACT OFFICER:	**GILLIAN MCCONNACHIE, CHIEF INTERNAL AUDITOR, 0141 574 5642**
SUBJECT TITLE:	**PERFORMANCE, AUDIT & RISK COMMITTEE SELF-ASSESSMENT**

1.0 PURPOSE

1.1 This report requests that Members consider the results of the self-assessment exercise, detailed in the attached report, which assesses the effectiveness of the Performance, Audit & Risk Committee, and approve any actions required to enhance compliance with best practice for this Committee.

2.0 RECOMMENDATIONS

2.1 The Performance, Audit & Risk Committee is asked to:

a) Consider the results of the self-assessment exercise

b) Approve the actions detailed in the report.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND / MAIN ISSUES

3.1 At the 21st March 2023 meeting of the Performance, Audit & Risk (PAR) Committee a summary of audit work, reviewing corporate governance arrangements was presented. As part of this work, Internal Audit recommended the completion of a Performance, Audit & Risk Committee Self-Assessment.

3.2 A self-assessment is designed to assist audit committees in evaluating how well they are executing their responsibilities. This helps to identify any ongoing goals for the Committee and ensure that responsibilities are being fulfilled, which adds to the practice of good governance. To this end, the Chief Internal Auditor has drafted the attached templates for consideration to assist with the self-assessment.

3.3 Two sources of best practice guidance have been considered – the Scottish Government and the Chartered Institute of Public Finance and Accountancy (CIPFA).

3.4 The Scottish Government have issued IJB Financial Guidance and this specifies the Scottish Government's expectations with regards to IJB Audit Committees. The Scottish Government has also issued generic guidance for public sector Audit Committees.

3.5 The draft self-assessment against Scottish Government guidance answers 'Yes' to being compliant in all instances, with one minor area for improvement identified. However, in some instances, the draft self-assessment against CIPFA guidance is 'No' in terms of compliance but there is no recommendation. This is because the CIPFA guidance is primarily aimed at local authorities and so a 'comply or explain' approach has been taken where full application of the guidance may be deemed to be disproportionate for an IJB audit committee.

3.6 The self-assessment has concluded that the committee generally conforms with best practice. Nonetheless, some areas for improvement have been identified as follows:

- The terms of reference of the Performance, Audit and Risk Committee should be reviewed and updated to ensure that they remain fit for purpose.
- As part of the review of the terms of reference, consideration should be given as to whether it would enhance governance arrangements to provide the PAR Committee with rights of access and formal engagement with the HSCP Strategic Planning Group.

4 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan; - None.

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 Corporate Parenting – None

4.11 Other – None.

5 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 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 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 – Self Assessment against Scottish Government Guidance

8.2 Appendix 2 – Self Assessment against CIPFA Guidance

Appendix 1
HSCP Performance, Audit & Risk Committee
Self-Assessment

Qun No.	Objective Source	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
1	**Scottish Government – IJB Financial Guidance**	The Integration Joint Board should make appropriate and proportionate arrangements, for consideration of the audit provision and annual financial statements, which are compliant with regulations and good practice governance standards in the public sector. This should include any reports from internal audit, external audit and the annual accounts. For example this may be an audit committee which meets before the main Integration Joint Board meeting two or three times per year.	✔				Performance, Audit and Risk (PAR) Committee has been established. It has within its remit consideration of internal and external audit work and financial statements. It meets a minimum of twice a year, although in practice more frequently.
2	**Scottish Government – IJB Financial Guidance**	It will be the responsibility of the Integration Joint Board to agree the membership having regard to the agreed remit, skills and good practice for a public sector audit committee. It is anticipated that members of the Integration Joint Board will serve in this capacity.	✔				The membership has been agreed and includes members of the IJB. Good practice for a public sector audit committee is further considered in Appendix 2, against CIPFA guidance.

Qun No.	Objective Source	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
3	**Scottish Government Guidance on Audit Committees**	The AC should have written terms of reference from the Board, which encompass all the assurance needs of the Board and Accountable Officer[1]. Within this, the Audit Committee (AC) should have particular engagement with the work of Internal Audit, the work of the External Auditor and with financial reporting issues;	✔				The PAR Committee has written terms of reference which were agreed by the PAR in June 2018. The HSCP Board received minutes of the PAR Committee which were noted by the Board. The Terms of Reference for the PAR Committee include reference to the work of Internal Audit, External Audit and the accounts. It is good practice to periodically review and update the terms of reference of committees to ensure that these remain fit for purpose. **Recommendation 1** (Low risk) The terms of reference of the Performance, Audit and Risk Committee should be reviewed and updated to ensure that they remain fit for purpose.
4	**Scottish Government Guidance on Audit Committees**	The AC should Support the Board and Accountable Officer by reviewing the scope, reliability and integrity of the assurances provided to them;	✔				The PAR committee reviews assurances provided by both internal and external audit and other sources such as Care Inspectorate inspections.

[1] The Chief Officer will be the accountable officer of the Integration Joint Board in all matters except finance.

Qun No.	Objective Source	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
5	**Scottish Government Guidance on Audit Committees**	Highlight those aspects of risk management, governance and internal control that are functioning effectively and, just as importantly, those that need to be improved;	✔				The PAR committee reviews reports by Internal and External audit including assurances over risk management, governance and internal control. This includes areas where improvement is required.
6	**Scottish Government Guidance on Audit Committees**	• Have at least three non-executive members, under the chairmanship of a non-executive member who should be someone other than the Chair of the public body or of any other sub-committee of the Board; • Own corporately an appropriate skills mix to allow it to carry out its overall function. At least one of the Committee members should have recent and relevant financial experience; • Have a Chair whose role goes beyond chairing meetings - this is key to achieving Committee effectiveness. The additional workload should be taken into account in the appointment of the Chair; • Have a Chair who is involved in the appointment of new Committee	✔				The PAR Committee is composed of the six voting members of the Partnership Board. The PAR Committee is chaired by the Vice-Chair of the Partnership Board. This is in line with Scottish Government expectations specific to IJBs that the audit committee comprises IJB members.

Qun No.	Objective Source	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
		members, including providing advice on the skills and experience being sought by the Committee, and is responsible for ensuring that the work of the Audit Committee is appropriately resourced;					
7	**Scottish Government Guidance on Audit Committees**	Be independent and objective; in addition each member should have a good understanding of the objectives and priorities of the organisation and of their role as an Audit Committee member; Encourage the Accountable Officer, Head of Internal Audit and Director of Finance to attend meetings (though not as members of the Audit Committee);	✔				Committee members are objective and 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. The Chief Officer and the Chief Finance and Resources Officer together with other members of the Senior Management Team and Internal and External auditors all regularly attend meetings to present and answer questions on reports.

Qun No.	Objective Source	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
8	**Scottish Government Guidance on Audit Committees**	Should have regular and on-going liaison with External Auditors; and	✔				The PAR Committee has regular engagement with External Auditors who regularly attend meetings so that they can answer any questions on their reports.
9	**Scottish Government Guidance on Audit Committees**	Should ensure it has effective communication with the Board and Accountable Officer, the Head of Internal Audit, the External Auditor, and other stakeholders. In addition, the role of the Chair and provision of appropriate secretariat support are important elements in achieving Audit Committee effectiveness.	✔				Communication to the Board is via the presentation of minutes of the Committee and the answering of any questions in relation to these. The Chief Internal Auditor (Council's Audit & Risk Manager), and the External auditor regularly attend and present their reports to the committee. Communication is two way, with good questions and discussion taking place at committee. The Chair is the Vice Chair of the Board and secretariat support is provided for the production of the agenda and the taking of minutes.
10	**Scottish Government Guidance on Audit Committees**	The role of the Audit Committee in relation to Internal Audit should include advising the Board and Accountable Officer on: • The Audit Strategy and periodic Audit Plans, forming a view on how well they support the Head	✔				The PAR Committee communicates to the Board via the presentation of minutes of the Committee and the answering of any questions in relation to these. The work of internal audit is considered by the committee

Qun No.	Objective Source	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
		of Internal Audit's responsibility to provide an annual opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes; • The results of Internal Audit work and the management response to Internal Audit findings; and • Internal Audit coverage.					including the Audit Plan, Charter, results and coverage. The committee provides suitable scrutiny on both the work of internal audit and management's response to internal audit findings.

HSCP Performance, Audit & Risk Committee
Self-Assessment against CIPFA Position Statement 2022

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
1	The committee has oversight of both internal and external audit together with the financial and governance reports, helping to ensure that there are adequate arrangements in place for both internal challenge and public accountability.	✔				The Performance, Audit and Risk (PAR) Committee has within its remit consideration of internal and external audit work and financial statements.
2	The audit committee should be established so that it is independent of executive decision making and able to provide objective oversight.	✔				The PAR is independent of the HSCP Board, the executive decision making body. This allows it to provide objective oversight.
3	It is an advisory committee that has sufficient importance in the authority so that its recommendations and opinions carry weight and have influence with the leadership team and those charged with governance.	✔				The PAR reports into the HSCP Board (those charged with governance) and is attended by and supported by Senior Management. This provides weight and influence to the PAR Committee.
4	The committee should: a) be directly accountable to the authority's governing body b) be independent of both the executive and the scrutiny functions c) have rights of access to and constructive engagement with other committees/functions, for example scrutiny		✔			a) Yes- the PAR Committee is directly accountable to the HSCP Board b) The PAR is independent of the executive. However, the PAR also provides a scrutiny function over performance. This may be considered reasonable, given the size of the organisation.

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
	and service committees, corporate risk management boards and other strategic groups d) have rights to request reports and seek assurances from relevant officers e) be of an appropriate size to operate as a cadre of experienced, trained committee members. Large committees should be avoided					c) No formal access to other committees. However, scrutiny and risk are part of the remit of the PAR. **Recommendation 2:** Consideration to be given as to whether it would enhance governance arrangements to provide the PAR committee with rights of access and formal engagement with the HSCP Strategic Planning Group. d) The relevant officers may be employed by the partner organisations – arrangements are therefore in line with the integration agreement rather than formally documented in the terms of reference. In practice, the committee has been able to request relevant reports and explanations. e) The PAR Committee is composed of the six voting members of the Partnership Board. The PAR Committee is chaired by the Vice-Chair of the Partnership Board. This is in line with Scottish Government expectations specific to IJBs that the audit committee comprises IJB members.
5	The audit committees of local authorities should include co-opted independent			✔		The PAR Committee is composed of the six voting members of the Partnership Board.

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
	members in accordance with the appropriate legislation. Where there is no legislative direction to include co-opted independent members, CIPFA recommends that each authority audit committee should include at least two co-opted independent members to provide appropriate technical expertise. The appointment of co-opted independent members on the committee should consider the overall knowledge and expertise of the existing members.					The PAR Committee is chaired by the Vice-Chair of the Partnership Board. As above, this is in line with Scottish Government expectations specific to IJBs that the audit committee comprises IJB members. The CIPFA guidelines go further than the Scottish Government guidance in this respect, recommending at least two independent members. There does not appear to be an immediate need for independent members on the PAR as the current membership demonstrates the required skills. If it was felt that there were gaps in the skills or knowledge of the committee that could not be address through training then independent members could be considered.
6	Maintenance of governance, risk and control arrangements a) Support a comprehensive understanding of governance across the organisation and among all those charged with governance, fulfilling the principles of good governance. b) Consider the effectiveness of the authority's risk management arrangements. It	✔				a) These governance aspects are considered via the monitoring of the work of internal and external audit and the governance statement as included in the annual accounts. b) The PAR oversees the HSCP's risk management arrangements including oversight of the corporate risk register.

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
	should understand the risk profile of the organisation and seek assurances that active arrangements are in place on risk-related issues, for both the body and its collaborative arrangements. c) Monitor the effectiveness of the system of internal control, including arrangements for financial management, ensuring value for money, supporting standards and ethics and managing the authority's exposure to the risks of fraud and corruption.					c) The system of internal control is monitored via the work of internal audit, which is reported to and overseen by the committee.
7	Financial and governance reporting a) Be satisfied that the authority's accountability statements, including the annual governance statement, properly reflect the risk environment, and any actions required to improve it, and demonstrate how governance supports the achievement of the authority's objectives. b) Support the maintenance of effective arrangements for financial reporting and review the statutory statements of account and any reports that accompany them.	✔				a) The draft accounts which include the governance statement are approved by the committee. This includes specific approval of the governance statement, in line with best practice. b) The statutory accounts are reviewed and approved by the PAR Committee in support of effective financial reporting arrangements.

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
8	Establishing appropriate and effective arrangements for audit and assurance: a) Consider the arrangements in place to secure adequate assurance across the body's full range of operations and collaborations with other entities. b) In relation to the authority's internal audit functions: oversee its independence, objectivity, performance and conformance to professional standards c) support effective arrangements for internal audit d) promote the effective use of internal audit within the assurance framework. e) Consider the opinion, reports and recommendations of external audit and inspection agencies and their implications for governance, risk management or control, and monitor management action in response to the issues raised by external audit. f) Contribute to the operation of efficient and effective external audit arrangements,	✔				a) These elements are covered by the terms of reference of the committee and in practice with the PAR committee overseeing both internal and external audit and other forms of assurance. This extends to information on the internal audit activity of the partner organisations. b) The internal audit service is provided by East Dunbartonshire Council's Internal Audit Service. Whilst the Council's Audit & Risk Management Committee oversees the internal audit service, the PAR Committee oversees the internal audit service that is provided to the HSCP. c) The PAR Committee supports effective arrangements by reviewing the internal audit plan, progress against this plan and the results of individual assignments. d) The PAR Committee considers the work of internal audit in the context of other sources of assurance, such as Care Inspectorate Reports, performance information and progress against strategic plans. e) The opinion, reports and recommendations of relevant bodies such as internal audit, Mazars, the Care Inspectorate are considered. Follow up

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
	supporting the independence of auditors and promoting audit quality. g) Support effective relationships between all providers of assurance, audits and inspections, and the organisation, encouraging openness to challenge, review and accountability.					on previously raised actions is also monitored by the committee. f) External auditors are supported by the committee, including their independence by allowing them to report directly to the committee. g) The committee supports the providers of assurance working together.
9	A membership that is trained to fulfil their role so that members are objective, have an inquiring and independent approach, and are knowledgeable.	✔				Committee members are independent and objective and 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.
10	A membership that promotes good governance principles, identifying ways that better governance arrangement can help achieve the organisation's objectives.	✔				The PAR Committee oversees the implementation of internal and external audit recommendations for improvements to the governance arrangements to help the HSCP achieve its objectives.

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
11	A strong, independently minded chair, displaying a depth of knowledge, skills, and interest. There are many personal skills needed to be an effective chair, but key to these are: • promoting apolitical open discussion • managing meetings to cover all business and encouraging a candid approach from all participants • maintaining the focus of the committee on matters of greatest priority. The committee membership should display the following: • Willingness to operate in an apolitical manner. • Unbiased attitudes – treating auditors, the executive and management fairly. • The ability to challenge the executive and senior managers when required. • Knowledge, expertise and interest in the work of the committee.	✔				The Chair ensures all business is covered and reports are presented to the committee, with discussion thereafter allowing an open environment. The Chair and other committee members focus on higher risks areas and priorities, with a good level of discussion on these.

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
12	To discharge its responsibilities effectively, the committee should: a) meet regularly, at least four times a year, and have a clear policy on those items to be considered in private and those to be considered in public b) be able to meet privately and separately with the external auditor and with the head of internal audit c) include, as regular attendees, the chief finance officer(s), the chief executive, the head of internal audit and the appointed external auditor; other attendees may include the monitoring officer and the head of resources (where such a post exists). These officers should also be able to access the committee members, or the chair, as required d) have the right to call on any other officers or agencies of the authority as required; e) support transparency, reporting regularly on its work to those charged with governance	✔				a) The committee has in its Terms of Reference that it will meet at least twice a year. However, in practice it meets around four times a year. b) There is no statement as to items to be considered in private. In practice all items are considered in public. If there was an item of a sensitive nature, for example relating to a commercially sensitive transaction, then this would be considered in private. The terms of reference states that there is the option of meeting privately with the internal and external auditor. c) The Chief Officer and the Chief Finance and Resources Officer together with other members of the Senior Management Team and Internal and External auditors all regularly attend meetings to present and answer questions on reports. d) The Audit Committee may ask any other officers from the Health & Social Care Partnership, East Dunbartonshire Council and NHS Greater Glasgow & Clyde to attend to

Qun No.	OBJECTIVE	YES	PARTLY	NO	N/A	Comment
	f) report annually on how the committee has complied with the position statement, discharged its responsibilities, and include an assessment of its performance. The report should be available to the public.					assist it with its discussions on any particular matter. e) Communication to the Board is via the presentation of minutes of the Committee and the answering of any questions in relation to these. f) This self-assessment represents such a report and can be refreshed annually.
13	The committee should evaluate its impact and identify areas for improvement.	✔				This self-assessment represents an opportunity for the committee to evaluate its impact and identify areas for improvement.

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 5.

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

DATE OF MEETING:	**28th SEPTEMBER 2023**
REPORT REFERENCE:	**PERF/280923/05**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER, TELEPHONE NUMBER, 0141 232 8216**
SUBJECT TITLE:	**HSCP DELIVERY PLAN 2023/24 UPDATE**

1.0 PURPOSE

1.1 The purpose of this report is to update the Committee on the performance of the HSCP Delivery Plan for 2023/24.

2.0 RECOMMENDATIONS

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

2.1 Note the update to the HSCP Delivery Plan for 2023/24.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The HSCP Board agreed the HSCP Delivery Plan 2023/24 at the IJB meeting on the 23rd March 2023. 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.

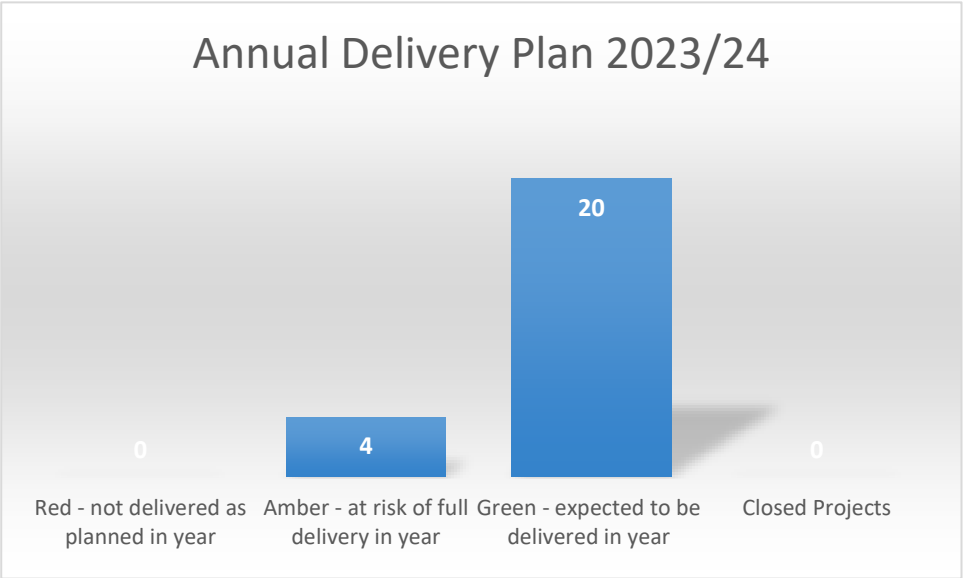
HSCP Delivery Plan 2023/24

3.4 The dashboard setting out progress on delivery of the projects to be delivered during 2023/24 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 2023/24 included as part of the Budget 23/24 is indicating a shortfall of £0,731m at the year end, as reported through the IJB 0n the 14th September 2023. This means the HSCP expects to achieve £3.163m of savings against a target of £3.894m during 2023/24. A smoothing reserve of £0.594m was created at the time of setting the budget for 23/24 in expectation that some savings will take time to implement and bed in – the unachieved savings are beyond the reserve available at this stage in the financial year. A copy of the financial implications of projects approved as part of the Budget 2023/24 are included as **Appendix 3.**

3.6 There are a total of 24 projects to be delivered within the Delivery Plan for 2023/24:-

- 20 are considered at Green status with an expectation that these will be delivered as planned in year.
- 4 are considered Amber status (at risk) – work is underway with some risk or delay to delivery.
- 0 are considered Red status – not delivered as planned in year.



3.7 The projects identified as at risk of full delivery in year relate to:

- Review of accommodation services for adults with learning disabilities
- No One Dies Alone (Compassionate East Dunbartonshire)
- Mental Health / Alcohol and Drug Recovery Commissioned Service Review
- Modern Facilities Development

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 2023/24 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 2023/24 September 2023
8.2 Appendix 2 – HSCP Delivery Plan Highlight Report 2023/24 September 2023
8.3 Appendix 3 – HSCP Savings Update 2023/24 September 2023

APPENDIX 1

HSCP TRANSFORMATION PROGRAMME 2023/2024								
Programme overview				**Summary of RAG Status**				
Projects **24**				On Track **20**		At Risk **4**		In Exception **0**
Priority	Project Name	Previous Status	Current Status	Progress	Reason for RAG Status	Original Project End Date	Forecast Project End Date	Risk/Exception Details
n/a	Digital Solutions Development			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Trauma Informed			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Learning Disability Day Services			40%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Social Support for Older People			35%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Child Protection Procedures			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Children at Risk of Harm: Inspection Response			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Learning/Intellectual Disability Strategy			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Children's House Project			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	MAT Standards			40%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Tier 1 and 2 Services for Children			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.

APPENDIX 1

n/a	Review of Accommodation Service for Adults with Learning Disabilities			25%	At risk	31-Mar-2024	31-Mar-2024	**Two-year plan and landscape has changed since the project and LD Review was originally commissioned. Risks in terms of provider resilience, financial risk, recruitment challenges, capacity etc have emerged and whilst original aspirations laudable there is a requirement to 'regroup' and re-evaluate the scope of the project.**
n/a	Workforce and Organisational Development			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Public Health Strategy			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Community-Led Support			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	No-One Dies Alone			10%	At risk	31-Mar-2024	31-Mar-2024	**There have been delays in agreeing officer capacity to drive the Compassionate East Dunbartonshire project - now resolved. There**

								have been associated delays in agreeing the scope of the programme and engaging with third sector partners to deliver.
n/a	Mental Health/Alcohol and Drug Recovery Commissioned Service Review			25%	At risk	31-Mar-2024	31-Mar-2024	**Developing risks to the project's success in terms of capacity and potential financial risk.**
n/a	Specialist Children's Services			100%	Complete	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Workforce Review			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Joint Unscheduled Care Plan			55%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Quality Management Framework			45%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Public Dental Service			35%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Medium Terms Financial and Strategic Planning			25%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Primary Care Improvement			50%	On track	31-Mar-2024	31-Mar-2024	There are no decisions required.
n/a	Modern Facilities Development			30%	At risk	31-Mar-2024	31-Mar-2024	**Securing appropriate accommodation within Milngavie will be challenging given timescales**

								and priorities. Lack of Capital Team resource may pause programmes. Lack of funding made available via NHSGG&C Capital funding may result in need to look at HSCP-funded sources.

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**	**RAG Status**
HSCP-23-01-TRA Digital Solutions Development			50%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2024	31-Mar-2024	16-Jun-2023

Project Description
Development of digital solutions to support digitally enabled workforce, digitally enabled service users - Home monitoring, analogue to digital implementation.

Project Sponsor	Project Manager
Jean Campbell; Andy Craig	Jean Campbell; Elaine Marsh

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Outcome of digital maturity assessment for East Dunbartonshire now available • Development of local HSCP Digital Strategy underway • Digital projects including analogue to digital progressing as planned.	• Conclude development of draft HSCP Digital Strategy, undertake a process of consultation & engagement to inform final strategy for approval through IJB. • Continue progress of digital projects including analogue to digital for community alarm service users.

Reason for RAG Status
Project delivery is expected by Mar-24.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**
N/A	N/A	N/A

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**	**RAG Status**
HSCP-23-02-TRA Trauma Informed				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	22-Jun-2023			
Project Description					
Continue to develop as a Trauma Informed organisation.					
Project Sponsor		**Project Manager**			
Claire Carthy; Andy Craig		Alex O'Donnell			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Working with stakeholders to raise profile of Trauma Informed Organisation. • Presentations to HSCP Strategic Leadership Group and ED SLT.		• Continue training need analysis for all roles. • Continue with communications.			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	• Trauma informed workforce			
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**	**RAG Status**
HSCP-23-03-TRA Learning Disability Day Services				40%	Green - Project on track
Original Project End Date	**Forecast Project End Date**		**Date of last project board**		
31-Mar-2024	31-Mar-2024		N/A		
Project Description					
Development of community-based services, employability, volunteering and community-based model of support.					
Project Sponsor			**Project Manager**		
David Aitken; Andy Craig			Richard Murphy; Gayle Paterson; David Radford		
HIGHLIGHT REPORT					
Actions completed within the last reporting period			**Actions planned in the Next Reporting Period**		
• Redesign of day services to create wider model of support which builds on transition to new Allander which was completed in March 2023.			• Establishment of Working Group reporting to Learning Disability Strategic Review Group. • Consolidation of existing community-based development to support opening of new Allander. • Continued development lead by Registered Services and Homecare Fieldwork Manager of community support, employment and volunteering services.		
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	• Enhanced community-based support for adults with learning/intellectual disabilities. • Establishment of capacity within ED to meet complex/ challenging needs which have been met outside ED in the past. • Enhanced choice and personalisation.			
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**	**RAG Status**
HSCP-23-04-TRA Social Support for Older People				35%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	04-May-2023			
Project Description					
Implement the 23/24 actions of the Social Support for Older People Strategy.					
Project Sponsor		**Project Manager**			
Andy Craig; Derrick Pearce		Kelly Gainty; Richard Murphy			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Individual care management meetings have taken place with all customers and carers who wished to take these up (2 did not). In principle, choices have been intimated for future provision but significant concerns remain from customers/carers re re-provisioning of Milan Day Centre. Service specification for future building-based day care provision at final draft stage.		• Continue/Complete negotiations with providers for delivery of 2 centre-based services from April 2024. • Determine future option choices for Milan service users • Progress transition planning			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-05-TRA Child Protection Procedures				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	22-Jun-2023			
Project Description					
Update and implement new Child Protection Procedures.					
Project Sponsor		**Project Manager**			
Claire Carthy; Andy Craig		Michelle Dearie; Lorraine Campbell			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Draft CP Guidance presented to CPC on 22/08/23 for discussion on implementation plan.		• Agree implementation and comms plan.			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	• Increase skills and knowledge in relation to child protection.			
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**	**RAG Status**
HSCP-23-06-TRA Children at Risk of Harm: Inspection Response				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	22-Jun-2023			
Project Description					
Respond to the outcome of the Children at Risk of Harm Inspection.					
Project Sponsor		**Project Manager**			
Claire Carthy; Andy Craig		Suzanne Greig			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Action plan progressing on track, reporting to DCYPP, CPC, HHC Forum.		• Produce advocacy pathway on website.			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	• Children at risk of harm are receiving improved services.			
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**	**RAG Status**
HSCP-23-07-TRA Learning/Intellectual Disability Strategy				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Refresh HSCP Learning/Intellectual Disability Strategy.					
Project Sponsor		**Project Manager**			
David Aitken; Andy Craig		Alan Cairns; Gayle Paterson			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Learning Disability Locality Strategy to be updated by Project Lead for 2023-26.		• Strategy has been updated and will be presented to HSCP Board in September for approval. • Communication and engagement plan will be implemented for a 90 day consultation period. • Equality Impact Assessment will be completed.			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	• Strategy will set out commitment to develop and improve services.			
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**	**RAG Status**
HSCP-23-08-TRA Children's House Project				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	22-Jun-2023			
Project Description					
Ongoing implementation of Children's House Project model.					
Project Sponsor		**Project Manager**			
Claire Carthy; Andy Craig		Claire Carthy; Raymond Walsh			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Progress into Year 3.		• Plan Cohort 4 • Plan for sustainability in longer term.			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
£200,000	£400,000	• Evidence commitment to Corporate Parenting.			
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**	**RAG Status**
HSCP-23-09-TRA MAT Standards				40%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Delivery of Medically Assisted Treatment Standards 6-10.					
Project Sponsor		**Project Manager**			
David Aitken; Andy Craig		Lynsay Haglington			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Additional posts to support the work of the Alcohol and Drug Partnership and delivery of MAT Standards have been recruited to. These posts report directly to the ADP Coordinator. • Further additional operational posts have been approved and are in the process of being recruited to support delivery of MAT Standards. These include Peer Support Worker posts, Occupational Therapy and Band 6 and Band 5 nurses. Peer support posts will support delivery of experiential element of MAT Standards.		• Implementation Group to review progress against MAT 1-6. • Support from NHS GGC board wide implementation group (consistent for all partnerships) now in place to ensure consistency of reporting and recording. • ADP Strategy will be updated to reflect new national priorities including MAT Standards.			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	• Enhanced care and treatment options for those affected by problematic alcohol/drug use. • Reduced deaths due to problematic drug use.			
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**	**RAG Status**
HSCP-23-10-TRA Tier 1 and 2 Services for Children				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	22-Jun-2023			
Project Description					
Continue to develop tier 1 and tier 2 service for children.					
Project Sponsor		**Project Manager**			
Claire Carthy; Andy Craig		Vivienne Tennant			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Year 3 funding agreed. Working with Commissioning Team to extended projects CDR, Lifelink, Creatorvators.		• Steering group to plan for the year 3 spend. • Evaluate impact.			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	• Improved access to Tier 1 and 2 services for CYP to improve mental health and wellbeing.			
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**	**RAG Status**
HSCP-23-11-TRA Review of Accommodation Service for Adults with Learning Disabilities			25%	Amber- Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2024	31-Mar-2024	N/A

Project Description
Review and redesign of accommodation-based support services for adults with learning/intellectual disabilities to ensure that services continue to meet the needs of our community and the expectations set out within the Scottish Government Strategy 'Coming Home'. Note that this is a two-year plan.

Project Sponsor	Project Manager
David Aitken; Andy Craig	Gillian Healey; Stephen McDonald; Richard Murphy; Gayle Paterson

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Project plan developed.	• Two year project. • Engagement with Council SMT to agree scope / remit of review, and identify where there were common approaches required and possible involvement directly within Strategic Group. • Briefing paper to HSCP Chief Officer being prepared to take forward discussions with Council. • Needs Assessment to be completed in advance of next Strategic Review Meeting.

Reason for RAG Status
Two-year plan and landscape has changed since the project and LD Review was originally commissioned. Risks in terms of provider resilience, financial risk, recruitment challenges, capacity etc have emerged and whilst original aspirations laudable there is a requirement to 'regroup' and re-evaluate the scope of the project.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**
N/A	N/A	• Enhanced planning arrangements for transitions from children's to adult services.

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**	**RAG Status**
HSCP-23-12-TRA Workforce and Organisational Development			50%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2024	31-Mar-2024	N/A

Project Description
Development of recruitment strategy and delivery of measures to support staff well-being.

Project Sponsor	Project Manager
Andy Craig; Tom Quinn	Lisa Walsh

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Undertaken Recruitment Radio Advertising campaign • Revised recruitment strategy included within the 2023-24 Workforce Action Plan • Staff Wellbeing Survey launched - asking staff for their ideas for wellbeing activity (closes 30 August 2023)	• Create a "Wellbeing Action Plan" based on the Staff Wellbeing Ideas Staff survey. • Promote the positive responses about wellbeing supports from recent iMatter survey • Review and reflect on the success of the Garden Competition and the self-reflection open air events.

Reason for RAG Status
Project delivery is expected by Mar-24.

Benefits	

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits
N/A	N/A	N/A

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**	**RAG Status**
HSCP-23-13 Public Health Strategy				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Implement the Public Health Strategy.					
Project Sponsor		**Project Manager**			
Andy Craig; Derrick Pearce		David Radford			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Strategy drafted. • Discussions ongoing re governance with decision to me made whether Strategy is HSCP specific or a Community Planning Partnership document. • Associated implementation plan drafted for adoption upon approval of draft strategy - work that related to the business of the HSCP and specifically the work of the HSCP Public Health Improvement Team is live and underway.		• Decision to be taken between CO and EDC CExec re governance. • Strategy to be presented for sign off to CPP and/or IJB • Progress implementation of year 1 action plan			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-14 Community-Led Support				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	04-May-2023			
Project Description					
Pilot a community-led support approach within a locality, working through community planning partners.					
Project Sponsor		**Project Manager**			
Andy Craig; Derrick Pearce		Kelly Gainty; James Johnstone; David Radford			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Officers meeting has taken place to further explore our approach to CLS - paper to SMT/ leadership discussion to follow to agree local vision. • Small projects funding agreed - level and allocations process to be determined • Excellent work in Twechar community continues with focus on: considering the outcome of the needs assessment, right care, right place patient education, exploring options for community led support in the community etc.		• Progress engagement with SMT and Leadership Group to determine vision and principles to form local action plan. • Progress analysis of needs assessment in Twechar • Agree level of funding for small projects fund and agree process for application/allocation			
Reason for RAG Status					
Project delivery is expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-15 No-One Dies Alone				10%	Amber - Project at risk
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Implementation of Compassionate ED model - 'No One Dies Alone'.					
Project Sponsor		**Project Manager**			
Leanne Connell; Andy Craig; Derrick Pearce		Kathleen Halpin; David Radford			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Awaiting confirmation to progress role within existing structures		• Agree officer capacity and appoint associated backfill post • Finalise project scope and set up Project Board • Engage 3rd sector and initiate plan for NODA operational delivery.			
Reason for RAG Status					
There have been delays in agreeing officer capacity to drive the Compassionate East Dunbartonshire project - now resolved. There have been associated delays in agreeing the scope of the programme and engaging with third sector partners to deliver.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-16 Mental Health/Alcohol and Drug Recovery Commissioned Service Review			25%	Amber - Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2024	31-Mar-2024	N/A

Project Description
Redesign services for adult mental health and alcohol and drugs services to develop a recovery focused approach.

Project Sponsor	Project Manager
David Aitken; Andy Craig	Sharon Gallacher; Lynsay Haglington; Gillian Healey

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Options Paper/Proposal finalised - currently subject to final agreement/implementation plans	• Review meeting scheduled for September 2023 HoS / Strategic Commissioning Manager to agree priorities to take forward project • Complete Options Paper. • Make decision re future commissioning model. • Provider engagement

Reason for RAG Status
Developing risks to the project's success in terms of capacity and potential financial risk.

Benefits	

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	Other Intended Benefits
£30,000	£30,000	• Integrated commissioning pathway for MH/A&D services • Strengthen collaborative commissioning approach

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**	**RAG Status**
HSCP-23-17 Specialist Children's Services				100%	Project Complete
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Realign Specialist Children's Services from the current dispersed management arrangements in to a single hosted management arrangement.					
Project Sponsor		**Project Manager**			
Andy Craig; Caroline Sinclair		Alan Cairns			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• All outstanding actions in the SCS Realignment of Management Structure project plan are complete and an end of project report has been shared with NHSGGC CMT.		N/A			
Reason for RAG Status					
Project has been completed.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-18 Workforce Review				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Review and refresh workforce plans to ensure capacity to see and treat children and young people.					
Project Sponsor		**Project Manager**			
Andy Craig; Karen Lamb		Julie Metcalfe			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Specialist Children's Services (SCS) workforce group in partnership with staff side TOR agreed. • Governance process agreed for workforce change or requests. • CAMHS Workforce Group continues to plan suitable workforce to deliver for Mental Health Recovery & Renewal & Referral To Treatment requirements. • Planning continues to construct an overall SCS Workforce plan and identify any actions to be taken to comply with the safe staffing legislation.		• Continue to construct an overall SCS Workforce plan and identify any actions to be taken to comply with the safe staffing legislation (April 2024). • Aim to meet the 18 week Referral To Treatment by Quarter 2 of 2023/24 to ensure children and young people are seen in less than 18 weeks.			
Reason for RAG Status					
Project delivery expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-19 Joint Unscheduled Care Plan				55%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Implement actions set out within the GGC Joint Unscheduled Care Plan for EDC for 2023/24.					
Project Sponsor		**Project Manager**			
Andy Craig; Derrick Pearce		Fiona Munro; Alison Willacy			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Frailty group and meeting schedule established • Action plan for frailty / Driver Diagram developed • Third frailty practitioner for GGC wide post recruited to • Benchmark current service delivery models against Hospital at Home delivery model completed		Consultation on frailty Driver Diagram Develop work plan which enables the delivery of the aspirations of the frailty Driver Diagram			
Reason for RAG Status					
Project delivery expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-20 Quality Management Framework				45%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Implementation of the Quality Management Framework.					
Project Sponsor		**Project Manager**			
Leanne Connell; Andy Craig		Alan Cairns			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Learning system exercise rolled out to all teams via Strategic Leadership Group with further presentation at Strategic Leadership Community early Sept. • Casefile audit in planning stage. High level scan programmed in for end Sept. Commencing preparatory work for ASP inspection.		• Commence self-evaluation high level scan of selected adult services following CI/HIS Quality Improvement Framework methodology. • Undertake joint casefile audit of adult services • Commence preparation for ASP inspection			
Reason for RAG Status					
Project delivery expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-21 Public Dental Service				35%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Implementation of the recommendations from the Public Dental Service review Programme Board.					
Project Sponsor		**Project Manager**			
Andy Craig					
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Short life working groups reconvened • Programme Manager recruitment undertaken - no appointment made		• Review of SLWGs to recommence September, 2023 • Programme Manager position to be advertised September, 2023 Continue to work on actions from the PDS review			
Reason for RAG Status					
Project delivery expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	• Improved patient pathways and outcomes resulting in positive feedback or reduced complaints. • Improved referral pathways for General Dental Practitioners. • Improved staff morale - demonstrated through iMatter feedback.			
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**	**RAG Status**
HSCP-23-22 Medium Terms Financial and Strategic Planning				25%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Engage with public in relation to financial position to inform future priorities.					
Project Sponsor		**Project Manager**			
Jean Campbell; Andy Craig		Fiona Shields			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Budget consultation for HSCP will align to Council timescales / format. Draft engagement document developed with feedback from SMT.		• Continue engagement with Council Communications on final brief for HSCP consultation and firm up timescales following Council budget consultation process in Sept / Oct 2023.			
Reason for RAG Status					
Project delivery expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-23 Primary Care Improvement				50%	Green - Project on track
Original Project End Date	**Forecast Project End Date**	**Date of last project board**			
31-Mar-2024	31-Mar-2024	N/A			
Project Description					
Continue implementation within financial envelope, for Primary Care Implementation Plan.					
Project Sponsor		**Project Manager**			
Andy Craig; Derrick Pearce		James Johnstone; Dianne Rice			
HIGHLIGHT REPORT					
Actions completed within the last reporting period		**Actions planned in the Next Reporting Period**			
• Following the successful recruitment of 3 x Band 5 Treatment Room Nursey, planned service provision in the Bearsden & Milngavie cluster will commence by end of September, early October 2023.		• Planning for Bishopbriggs & Auchinairn Accommodation • Recruitment of CTAC Non-clinical staff for Bishopbriggs & Auchinairn cluster			
Reason for RAG Status					
Project delivery expected by Mar-24.					
Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**			
N/A	N/A	N/A			
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**	**RAG Status**
HSCP-23-24 Modern Facilities Development			30%	Amber - Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2024	31-Mar-2024	21-Aug-2023

Project Description
Progression of Property Strategy - revisit Business Case for Integrated Health and Care Facility in the West Locality.

Project Sponsor	Project Manager
Jean Campbell; Andy Craig	Vandrew McLean

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Upgrades to two rooms in KHCC, will provide modernised Treatment Rooms for Community Treatment and Care Service and Alcohol and Drug Recovery Service - completion late 2023. • Funded via HSCP Capital Allocation, Acc Reserve and MH funding.	• Begin plan for BC for Integrated Health & Social Care facility within West Locality. Seek advice from NHSGG&C Capital Team • Complete HSCP Property Strategy - approval via HSCP IJB meeting 14.09.23. • Progression of capital projects within Milngavie/Bearsden - submission of business case via NHSGG&C forum in late 2023. • Bishopbriggs Retail Unit - project should start after 04.09.23. Project Board required. • Progression of capital works feasibility and re-modelling for improvements - Woodlands and Milngavie paused due to Capital team resource. Anticipate pick up late 2023. • Completion of two Tr Rooms at KHCC funded via HSCP Capital • Progress KHCC feasibility and remodelling proposals for ground floor

Reason for RAG Status
Securing appropriate accommodation within Milngavie will be challenging given timescales and priorities. Lack of Capital Team resource may pause programmes. Lack of funding made available via NHSGG&C Capital funding may result in need to look at HSCP-funded sources.

Benefits		
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**Other Intended Benefits**
N/A	N/A	N/A

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✘	✔	✘	✔	✘	✔

East Dunbatonshire HSCP

Financial Planning 2023/24 - Savings Programme **APPENDIX 3**

Workstream	Action	Lead	Full Year Savings Target 23/24	Actual Savings Anticipated 23/24	Savings Un Achieved 23/24	Smoothing Reserve 23/24
	Community Health & Care					
Policy	Development of a Charging Policy for Telecare	Derrick				
Service Change	Review of Older People Day Supports	Derrick	30,000		30,000	30,000
Service Change	Health Improvement Redesign	Derrick				
Efficiency	Demographic Growth	Derrick	-			
Service Change	Review of Continuing Care	Derrick	1,043,746	1,043,746	-	
Service Change	Review of PDS funding from Carers	Derrick	277,000	277,000	-	
			1,470,746	1,320,746	-	
	Mental Health, Learning Disability & Addictions					
Efficiency	Impact of New Investment on Mainstream budgets	David	136,000	136,000	-	
Efficiency	Increased turnover due to delays / difficulties in recruitment	David				
Service Change	Cessation of review Team function	David	250,000	250,000	-	
Service Change	Review of Pineview / move to 2 bedded unit	David	338,356	148,356	190,000	
Efficiency	Budgets for Adult Services in line with Fair Access policy and access to resources	David			-	
Service Change	New Allander Daycare opportunties	David	407,000	190,900	407,000	407,000
Service Change	Review of Voluntary Sector / MH / Addicitions Commissioning	David		190,900		
			1,131,356	826,156	597,000	
	Childrens Services					
Service Change	Continuance of House Project model	Claire	500,000	500,000	-	
			500,000	500,000	-	
	Strategic & Resources					
Efficiency	Review of Planning & Commissioning funding	Jean	157,000	83,079	73,921	157,000

Efficiency	Management Efficiencies	Jean	313,000	313,000		
	Total Savings Programme 23/24		470,000 3,894,417	396,079 3,163,496	73,921 730,921	594,000

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 6.

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

DATE OF MEETING:	**28th SEPTEMBER 2023**
REPORT REFERENCE:	**PERF/280923/06**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER (07583902000)**
SUBJECT TITLE:	**HSCP CORPORATE RISK REGISTER UPDATE**

1.0 PURPOSE

1.1 The purpose of this report is to 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 Consider and approve the Corporate Risk Register attached as **Appendix 1**.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The Corporate Risk register reflects the HSCP Board's Commitment to a culture of improved performance in the management of Corporate Risks.

3.2 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.

3.3 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.

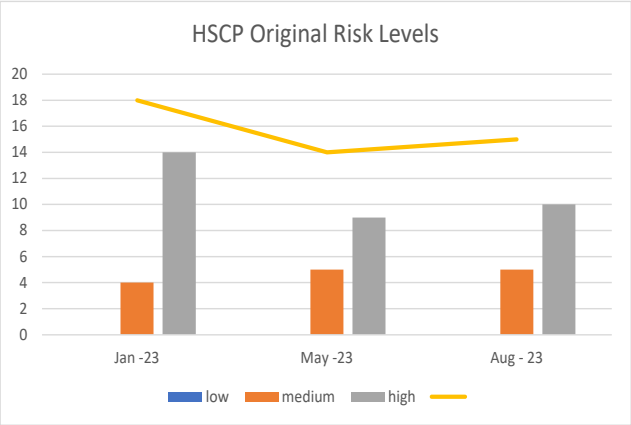
3.4 The Risk Register provides full details of all current risks, in particular high level risks, and the control measures that are in place to manage these. The risks associated with the Covid pandemic have been incorporated into the wider HSCP Corporate risks where they are considered to have an ongoing impact beyond the Covid pandemic and will remain relevant for the duration of 2023 - 24.

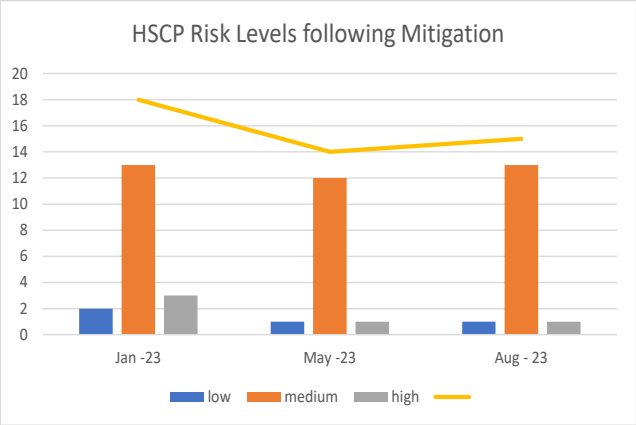
3.5 There are a total of 15 risks included within the HSCP Corporate Risk register. This represents an increase in the number of risks for the HSCP of one from that previously reported. This movement relates to the addition of a risk escalated from the Oral Health Directorate risk register.

3.6 There is 1 new risk included related to the failure to deliver oral health services without proper commissioning and testing of equipment because the project has not been signed off by an Infection Control Doctor (ICD), significantly reducing service capacity.

3.7 Following a review there has been no change to risk scores with a number of actions continuing to mitigate risks across the register.

3.8 Of the 15 risks identified within the Corporate Risk register, 10 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 continues to relate 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.





3.9 A copy of the HSCP Corporate Risk Register is included as **Appendix 1**.

3.10 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

3.11 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 74(32) live/active risks associated with these registers. The increase is attributed to introduction of our new governance processes with a focus on improving risk management across the HSCP and reporting of risks through the service risk registers.

3.12 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 Corporate Risk Register September 2023

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Completed by	**Jean Campbell**	**Date created/ updated**	**Updated September 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 @ 20th September 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 / cessation ; potential risk of poor service / harm to individuals; inability to offer competitive rates to service providers with potential loss of provider / risk to provider sustainability locally; cuts to staffing numbers 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 incorporating 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. Reserves Strategy in place.	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; inability to progress service reviews / redesign to meet budget requirements for savings	Service Delivery	Engaged in Board wide process to ensure proportionate allocation. Chief Officer attends constituent body CMT / SMT meetings.	3	3	9	3	Tolerate	Ongoing 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 recruitment 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 and wider cost of living crisis, capacity implications due to Scottish Living Wage (SLW) / benefit cap), Increasing Care Inspectorate /Public Health demands, limits on public sector finances to meet uplifts in provider costs.	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 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 Established	3	4	12	2	Treat	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.	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

IJB Corporate Risk Register @ 20th September 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
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, prioritisation of current funding allocation to core contractuasl commitments where apropriate	2	4	8	3	Derrick Pearce, Head of Health & Community Care	Chief Officer
HSCP 13	Inability to secure apropriate accommodation in the West Locality to deliver effective integrated health and social work services in that area.	Lack of capital funding available to progress development of an integrated solution, competition / prioritisation of need across NHSGGC and other HSCP priorities taking precedence, inability to effectively evidence need in context of NHSGGC priority matrix ie deprivation. Options for refurbishement / extension across HSCP and GP premises in the area very limited due to nature and location of current estate.	Lack of intergated working and limited service delivery offering due to lack of available space to accommodate all service demand, lack of delivery on key strategic priorities eg PCIP, GPs remain in dated premises with little / no options for expansion to accomodate increasing demand related to housing / care home developments in the area, risk of GP Practice closure due to nature of tenure within the area with no ability of HSCP to respond. Lack of sapce to accommodate acute functions movbing into the community eg Plebotomy.	Service Delivery	NHSGG&C Primary Care Property Strategy under development which will set out board priorities for primary care accommodation, ED HSCP Property Strategy in place and regular engagement with colleagues within the Council / NHS board to scope options for progressing strategic priorities, GG&C HSCP Captioal Planning Group established to review board wide HSCP priorities.	3	4	12	2	Treat	Progression of actions within ED HSCP Property Strategy and in particular revisit the business case for an Integrated Health & Care Centre in the West Locality, continue to apply pressure locally and with the NHS Board for re-prioitisation of this option, explore opportunities for creation of capital funding within the HSCP and in collaboration with partners. Explore alternative solutions to address capacity within HSCP accommodation.	2	3	6	3	Jean Campbell, CFRO	Chief Officer
HSCP 14	Failure to secure an alternative system to Carefirst for Social Work case mangement and provider financial payments	Completion of business case, reliance on Council prioritisation of project in context of competing prioriites across other Council services, lack of resources within the HSCP and Council support functions to progress implementation.	Current system not fit for purpose to meet the needs of system users. New cloud based systems in development and industry moving on leaving HSCP with out of date system and no opportunity for any further development. Lack of support in the event system malfunctions as system becomes obsolete. Limits opportunity for service redesign and efficiencies in working practices.	Service Delivery	Business case in development to support new system solution for SW caseload management and financial payments to care providers. Carefirst Steering Group in place to support collaborative working across HSCP and Council services and promote importance and requirement for new system. Continued enagement with current system provider to ensure continued support available.	3	4	12	2	Treat	Escalation of business case to ensure prioritised for progression, planning of resource requirements through carefirst steering group.	2	4	8	3	Jean Campbell, CFRO. HOS	Chief Officer
HSCP 15 - new	Oral Health services cannot be delivered without proper commissioning and testing of equipment because the project has not been signed off by an Infection Control Doctor (ICD). This means that new ventilation and air handling/exchange equipment installed in dental surgeries cannot be turned on, significantly reducing capacity	ICD postholder stood down from role in April 2022 and not replaced. Service has not been allocated to another ICD.; in addition, service advised that Infection Prevention Control Nurse (IPCN) was unable to provide advice. Existing and new ventilation works including upgrades to air handling units within PDS sites are being installed but cannot be signed off without review from an ICD; any water testing required cannot be undertaken without review from an ICD. Service advised if advice required from Microbiology/ICD they must arrange this themselves.	Existing and new ventilation works including upgrades to air handling units within PDS sites cannot be signed off without review from an ICD. Required water testing to ensure safe service provision cannot be undertaken without review from an ICD/Microbiologist.	Service Delivery	Issue escalated at various Regional Services/East Dunbartonshire HSCP forums e.g. clinical governance, capital planning meetings, Acute Infection Control Committee. ICD issue escalated to Director for Regional Services and Chief Officer for East Dun HSCP as well as Prof Angela Wallace and Sandra Devine for input. SBAR tabled for Directiors meeting with COO	4	4	16	2	Treat	CO to raise within board wide forums to secure a solution	2	4	8	4	Caroline Sinclair, CO	

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 7.

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

DATE OF MEETING:	**28th SEPTEMBER 2023**
REPORT REFERENCE:	**PERF/280923/07**
CONTACT OFFICER:	**DERRICK PEARCE, HEAD OF COMMUNITY HEALTH AND CARE SERVICES, 07813752285**
SUBJECT TITLE:	**CARE INSPECTORATE - CARE AT HOME SERVICE INSPECTION MAY 2023**

1.0 PURPOSE

1.1 The purpose of this report is to appraise members of the outcome of the Care Inspectorate Inspection of the internal Care at Home (Homecare) Service in May 2023.

2.0 RECOMMENDATIONS

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

2.1 Note the outcome the inspection and the published inspection report;

2.2 Note the continuous significant improvements observed by the Care Inspectorate at a time of extreme pressure for this frontline service.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The HSCP in-house care at home service was inspected by the Care Inspectorate over five days in May 2023. This was an unannounced inspection. The dimensions that were inspected are noted below, along with the corresponding grades and descriptors awarded by the Care Inspectorate.

3.2 Dimensions and Grades - main theme areas:

- How well do we support people's wellbeing? **5** - **Very Good**
- How good is our leadership? **5** – **Very Good**
- How good is our staff team? **5** - **Very Good**
- How well is our care and support planned? **5** – **Very Good**

3.3 The overall grades above recognise the main grade for each thematic area, with the overall grade for each area always being aligned to the lowest score awarded. The service was inspected on six specific areas and achieved overall 6 x **Very Goods.**

- People experience compassion, dignity and respect **5 - Very Good**
- People get the most out of life **5 - Very Good**
- People's health and wellbeing benefits from their care and supports **5 - Very Good**
- Quality assurance and improvement is led well **5 – Very Good**
- Staff have the right knowledge, competence and development to care for and support people **5 - Very Good**
- Assessment and personal planning reflects people's outcomes and wishes **5 – Very Good**

3.4 The inspection outcome **(Appendix 1)** represents an improvement on the previous inspection in June 2022 and a continuation of improvement in all areas since the full strategic service review, completed in 2019. The context for this inspection, and the evidence and quality assurance information, which was scrutinised during the process, was based on performance during the 2022/23 winter pressure crisis, experienced by all care at home providers in Scotland. This placed severe pressures on staffing and recruitment for in house and on the internal and external care at home providers in East Dunbartonshire.

3.5 After the 2022 inspection the service was awarded 5 Very Goods a Good and an adequate over 7 areas of inspection. The main theme areas were graded as 2 x Very Good, a Good and an Adequate.

3.6 Key messages from the 2023 inspection identified by the Care Inspectorate were:

- Significant strengths were highlighted across all the main theme areas.
- Staff were identified as being well trained and feeling well supported.
- Very effective joint working and reablement support with health services was observed.
- There was a high level of user and family satisfaction with the service.
- Care given was noted to be flexible, responsive and person-centred.
- Evidence indicated that Carers engaged with relatives in a supportive manner.
- Quotes from customers and their relatives included statements such as:

'they're incredibly respectful, compassionate and caring, always cheerful'

'putting the bounce in the ball. I can see the positive change in my wife's mood once the carers have been in'

'lifeline to me, mum and my family'

3.7 Two areas of improvement were identified:

3.8 The provider should notify the Care Inspectorate of all relevant incidents under the correct notification heading and within the required timeframe. This in the main referred to outbreak notifications to the Care Inspectorate who have a different reporting criterion than that of Public Health Scotland. This was remedied at the point of inspection when clarity was achieved on the reportable incidents to the care inspectorate, and:

3.9 The service should complete, or have scheduled, training for staff involved with direct care or assessments in terms of dementia training to skilled level. This related to some front-line staff and training was already planned, in person and via online training resources.

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

Care at Home services contribute to the delivery of all HSCP Strategic Plan objectives.

4.2 Frontline Service to Customers – Inspection allows us to continually reflect on the quality of support provided and levels of satisfaction of customers

4.3 Workforce (including any significant resource implications) – Inspection supports the eliciting of feedback from frontline workforce. There are no new workforce implications.

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 There are no new risks arising from this report

6.0 IMPACT

6.1 **STATUTORY DUTY –** No new impact noted

6.2 **EAST DUNBARTONSHIRE COUNCIL** – No new impact noted

6.3 **NHS GREATER GLASGOW & CLYDE** – No new impact noted

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

7.0 POLICY CHECKLIST

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** – Inspection Report May 2023

[DRAFT]

Home Care Services - Mainstream Team
Housing Support Service

Kirkintilloch Health Care Centre
10 Saramago Street
Kirkintilloch
G66 3BF

Telephone: 01415 782 101

Type of inspection:
Unannounced

Completed on:
26 May 2023

Service provided by:
East Dunbartonshire Council

Service provider number:
SP2003003380

Service no:
CS2004082079

About the service

Home Care Services - Mainstream Team provides care at home services to people living in the East Dunbartonshire local authority area. The service provides support to people with a range of needs including physical and mental health conditions, dementia and palliative care. It also has a small reablement team providing short term support, mainly to people discharged from hospital to maximise their independence. At time of inspection they were providing a service to 466 people.

Their aims and objectives state that they will work alongside people and their family/friends to work out what people want/ need and develop a support plan which details how the carers will achieve the outcomes identified and support independence.

About the inspection

This was an unannounced inspection which took place on 22, 23 and 24 May 2023. The inspection was carried out by 3 inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with 29 people using the service and 20 of their family/friends/representatives
- spoke with 14 staff and management -
- observed practice and daily life -
- reviewed documents
- spoke with 3 visiting professionals

Key messages

There were warm, supportive relationships between staff and people using the service. Support plans were in place, which focussed on outcomes. People felt that they were also mentally stimulated by staff and not purely task focussed. The reablement team was very effective in terms of people returning to normal activities of daily living. There were clear, established links with health care professionals.

All support plans sampled in people's homes and digital copies viewed were in date and regular reviews were taking place. New staff were in place to support reviews and with quality assurance across the service. The service have improved how they record and learn from accidents, incidents and complaints. However, the service were not always making the required notifications to us about these occurrences.

Staff spoken to all felt well supported and confirmed that supervision, team meetings and observations were taking place regularly. Training levels were good and a recruitment drive was underway. The service should increase the levels of staff who are trained to skilled level in dementia.

People and relatives were involved in reviews and these were regular. Support plans had details of people's wishes and outcomes. There was input from relevant health professionals. However, the service should improve their communication with people who have their care moved to private providers.

From this inspection we evaluated this service as:

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

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

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

How well do we support people's wellbeing? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes - for people, therefore we evaluated this key question as very good. -

There were warm, compassionate and supportive relationships between staff and people using the service. - People interviewed commented that they were treated with dignity and respect, and this was witnessed - during interactions and in support plan detail. Evidence of people's wishes and preferences were being - recorded in support plans and had been acted upon. Many people told us that that they enjoyed 'banter' - with the staff, and that having regular faces made all the difference. There were some comments that - weekend staffing was variable, but people were understanding about this and we could see there was a - recruitment drive to improve this area. -

The support plans that were in place focussed on outcomes and meant that people were being supported to - get the most out of life. People felt that they were also mentally stimulated by staff and not purely task - focussed on health or personal care needs. People's interests, history and what was important to them - were all noted in the plans. Independence was encouraged and tasks were done with people, not for people. - Care given was flexible, responsive and person-centred. Carers also engaged with relatives in a supportive - manner and we heard how families felt the benefit as well as people receiving the care. Relatives were - confident that they could step back from their care-giving role and that staff were competent and able. -

Several people told us that the care staff were proactive in suggesting equipment that would be beneficial, - or had noted health or welfare concerns that led to improved outcomes for people. -

People told us: -

'they are patient and fun' -
'first class, nothing is too much trouble. Staff certainly do treat me well' -
'it means my daughter is my daughter again' -

Relatives told us: -

'they're incredibly respectful, compassionate and caring, always cheerful' -
'putting the bounce in the ball. I can see the positive change in my wife's mood once the carers have been - in' -
'lifeline to me, mum and my family' -

As well as ongoing home care, there was a provision for people who were leaving hospital. The reablement - team was very effective in terms of people returning to normal activities of daily living, and had statistics - that showed 86% of people went on to require no further home care. There were clear, well-established - links with health care professionals. The service had developed effective joint working with relevant - professionals to provide guidance, technical support and training regarding falls, medicines and pressure - ulcers. The external professionals we spoke to about the service were very positive about the care and - support being provided. Any health or wellbeing concerns were promptly raised and actioned. This meant - that people's health and wellbeing benefitted form their care and support. -

How good is our leadership? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for people, therefore we evaluated this key question as very good.

Since last inspection, the service has employed a monitoring and review officer to undertake quality assurance work and additional staff to assist with care plans reviews. All support plans sampled in people's homes and digital copies viewed were in date and regular reviews were taking place. People and their relatives confirmed that this was the case. Thorough care plan audits were taking place and we saw contributions from people, family members and relevant health and social care professionals.

The service had tracking systems in place to record reviews, staff supervision, team meetings and direct observations of staff practice. We could see that all of these were up to date and that the tracking was effective at identifying where possible issues could arise and proactive steps taken. The staff observations were thorough and covered staff practice, professionalism and IPC (Infection Prevention and Control).

Any accident / incident forms were well recorded with appropriate details regarding clear timelines, actions and outcomes. There were referrals being made and additional staff training being put in place where identified. The service have also introduced this in terms of complaints received and lessons learned from these. However, the service have not been making all of the required notifications to us, and sometimes not keeping us up to date. This meant that our scrutiny work was not always well informed. **(see area for improvement)**

The service had received positive feedback from a survey completed in June 2022 and was preparing to send another out this year. Staff were also consulted and issues raised were actioned. This lead to additional training, new resources and a new rota system.

There was a service improvement plan in place which identified digital technology, recruitment, falls and behaviour support training. All areas were rated green for on track and had detailed progress noted. Overall, we could see that this meant that quality assurance and improvement was well led.

Areas for improvement

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

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

How good is our staff team? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for people, therefore we evaluated this key question as very good.

The additional staff that have been employed to monitor quality assurance and care plan reviews have been effective. A further recruitment drive was taking place with a particular focus on weekend staff. There had also been a recent reduction in staff absence and an internal bank staff had been recruited. Any agency staff that were used were always as part of a two to one pairing with an existing staff member.

Staff we spoke to all felt well supported and confirmed that supervision, team meetings and observations were taking place regularly. We could see that tracking systems were in place to support the management of these. Staff supervision recording was effective and covered key areas including training, professional registration, customer concerns, own health and wellbeing and had action plans in place.

Team meetings were taking place regularly and actions and outcomes were followed through. One regional team was noted to be a good example of these as meetings were opened with a positive agenda item to support staff engagement and celebrate successes.

Direct observations of staff were effective and thorough and included all necessary areas including medication, confidentiality and IPC (Infection Prevention and Control). All areas were discussed with staff and were a mix of positive reinforcement and constructive comments. Plans and dates were in place across the paperwork used.

Training levels were good across the staff team, other than dementia skilled training. However, we did note that the service were actively pursuing this already. The service had very strong links with social work and health teams who were able to provide training, guidance and best practice guidelines for many areas. The service made full use of these resources to ensure that their staff had the right knowledge, competence and development to care for and support people.

Areas for improvement

1. The service should complete, or have scheduled, training for staff involved with direct care or assessments in terms of dementia training to skilled level.

This is to ensure care and support is consistent with the Health and Social Care Standards which state 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14).

How well is our care and support planned? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for people, therefore we evaluated this key question as very good.

Assessments were regular in terms of reviews and people and their relatives were involved. Other relevant health and social care professionals had input into the care planning process where required. This included district nursing, moving and assisting assessments and pressure ulcer prevention. There was expert support on hand with regards to falls and medication. Pathways for raising health concerns were very well established. The reablement team had focus on specific needs and very effective support resulting in 86% of people using that service went on to require no further home care.

Support plans had details of people's wishes and outcomes. One page profiles were in place which gave a good overview of people using the service. People and their relatives felt that the plans were an accurate reflection of them and their needs. These plans were thoroughly reviewed on a regular basis and were updated following any changes in circumstances. There were effective tracking systems in place and additional staff to ensure that these reviews took place.

People's likes, dislikes and routines were clear. Plans covered all of the relevant areas concerning health and wellbeing. Support plans were detailed and reflected social inclusion and relationships as well as physical health. People and relatives told us that the staff were caring and attentive to their needs. We heard about staff engaging people by joining with their singing and supporting them with their interests.

The service did appropriately action any adult support and protection concerns that arose and were thorough in their recording and reporting of these to social work, but they should ensure that the relevant notification to us is made. However, we could see that the management team were raising concerns where needed.

There have been two recent complaints about people being moved to private providers without due notice, and a complaints inspection has recently taken place. The service had since produced an updated information booklet about the service which details that moves to private care providers may happen. The service should ensure that they always let people know about any planned moves and they have given assurances to us that this will happen. Two people we spoke to told us that they had been informed that they were moving to private providers, but that the service had respected their wishes and not gone ahead with the move.

Overall, we were assured that assessment and personal planning reflects people's outcomes and wishes.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 30 September 2022 to ensure that people experience care and support that is safe and right for them, the provider must ensure that individuals' personal plans are: • reviewed on a six-monthly basis, or more frequently as required • reviews capture the views and preferences of people and, where appropriate, their family members • include the views of relevant others, for instance, health care staff and, where appropriate, care staff. This is to ensure care and support is consistent with and in order to comply with: This is to comply with Regulation 5 of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) Regulation 5 - a requirement for a plan of care. This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15).

This requirement was made on 23 June 2022.

Action taken on previous requirement

Action plan submitted in 2022. Also supplied at current inspection. All support plans sampled in people's homes and digital copies viewed were in date and regular reviews taking place. People confirmed that this was the case. Review paperwork has been sampled and evidence of contributions from people and/ or family members. Could see input from relevant others via moving and assisting assessments, pressure ulcer prevention and other areas. Nursing colleagues very positive about joint working. Now have additional review officers in place and a care at home monitoring and review officer in place.

Met - outwith timescales

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

Areas for improvement

Previous area for improvement 1

The provider should consider how it records routine records like complaints, incidents and accidents. This should be with a view to detail, where appropriate, what lessons might be learned and what actions might be implemented to improve outcomes for people. This is to comply with Health and Social Care Standards (HSCS) which state: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

This area for improvement was made on 23 June 2022.

Action taken since then

Service provided an action plan in 2022 and also made plan available at this inspection. Viewed paper copies of accidents, incidents and complaints plus online overview and both corresponded. Forms now thorough and clear including timeline, actions and learning with signatures and dates. There is now a monitoring & review officer keeping oversight of these documents and trends.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations -

How well do we support people's wellbeing?	5 - Very Good
1.1 People experience compassion, dignity and respect	5 - Very Good
1.2 People get the most out of life	5 - Very Good
1.3 People's health and wellbeing benefits from their care and support	5 - Very Good

How good is our leadership?	5 - Very Good
2.2 Quality assurance and improvement is led well	5 - Very Good

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

How well is our care and support planned?	5 - Very Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	5 - Very Good

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ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

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East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 08.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**28th SEPTEMBER 2023**
REPORT REFERENCE:	**PERF/280923/08**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER, TELEPHONE NUMBER 0141 232 8216**
SUBJECT TITLE:	**RECORDS MANAGEMENT PLAN INTERIM UPDATE – PROGRESS UPDATE REVIEW (PUR) OUTCOME**

1.0 PURPOSE

1.1 The purpose of this report is to provide an update to Performance, Audit & Risk Committee members on the findings of a Progress Update Review (PUR) on our EDHSCP Records Management Plan (RMP) to meet the requirements of the Public Records (Scotland) Act 2011.

2.0 *RECOMMENDATIONS*

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

2.1 Consider the content of the Report: and

2.2 Approve the findings of the East Dunbartonshire HSCP Records Management Plan PUR, giving approval that this can now be formally accepted to the Keeper of the Records of Scotland by 30th September 2023 and published on the National Records of Scotland website.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 Following the agreement of our authority's Records Management Plan (RMP) in December 2021, the Assessment Team for National Records Scotland offered East Dunbartonshire Integrated Joint Board the opportunity to provide a Progress Update Review (PUR) on our records management provisions.

3.2 This is a voluntary scheme; there is no obligation under the Act for authorities to submit a PUR and there is no legal requirement or expectation on authorities to do so.

3.3 The Progress Update Review (PUR) mechanism is intended to help authorities demonstrate their continuing compliance with s.5(1)(a) of the Public Records (Scotland) Act 2011 (the Act) to keep their RMPs under review.

3.4 It is also an opportunity for authorities to highlight and share any advances being made in the provision of their records management services and to receive impartial feedback and advice on those advances by the Assessment Team.

3.5 In March 2023 the IJB were asked to approve the update and submission of the East Dunbartonshire HSCP Records Management Plan PUR, by 31st March 2023.

3.6 All PUR submissions are assessed by the Public Records (Scotland) Act Assessment Team rather than by the Keeper. The resulting PUR assessment reports express the opinion of the Assessment Team about the submitted updates and they will not change the Keeper's statutory assessment of an authority's RMP as agreed under the Act.

3.7 The assessment provides an informal indication of what marking an authority might expect should it submit a revised RMP to the Keeper under the Act. In this way the PUR mechanism offers authorities a "health-check" on the developments and modifications in their records management provisions since agreement of their RMP.

3.8 This PUR mechanism does not affect the statutory right to submit a revised RMP at any time for assessment and agreement by the Keeper under s.5(6) of the Act.

3.9 The Assessment Team have now reviewed our submitted PUR and provided a draft report on their findings. **(Appendix 1).** The IJB is asked to consider the findings and respond by 30th September 2023 to the assessment. Once agreed the final report will be sent to the IJB and is published on the National Records Scotland website.

3.10 The draft report will be shared with East Dunbartonshire Council and NHSGG&C Information Governance Leads.

3.11 There are 15 areas assessed under the PUR which are given outcomes under a Red, Amber and Green Status (RAG).

3.12 The report found that 11 areas were found to be at Green Status (The Assessment Team agrees this element of an authority's plan).

3.13 3 areas had elements assessed as being Amber Status (The Assessment Team agrees this element of an authority's progress update submission as an 'improvement model'. This means that they are convinced of the authority's commitment to closing a gap in provision and will request that they are updated as work on this element progresses). Of these 3 areas elements related to work that is required to be supported

by East Dunbartonshire Council or NHSGG&C, the Keeper has determined that an IJB's plan cannot be given a RAG status superior to that of the partner body responsible for managing the IJB records.

4.0 IMPLICATIONS

The implications for the Board 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

4.2 Frontline Service to Customers – None.

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

4.4 Legal Implications – The legal requirements are embedded within the Public Records (Scotland) Act 2011.

4.5 Financial Implications – Potential financial implications for the organisation if the Act is not administered as it will lead to fines.

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 None.

6.0 IMPACT

6.1 **STATUTORY DUTY –** Integration Joint Boards (IJBs) are required to submit a Records management Plan (RMP) to the Keeper of the Records of Scotland. The RMP sets out

how East Dunbartonshire IJB's records will be created and managed in line with national policy. This is a responsibility which all public bodies must comply with.

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The HSCP will be relying on East Dunbartonshire Council for the delivery of sound information governance in support of delivery of a robust records management approach and delivery of the HSCP Records Management Plan.

6.3 **NHS GREATER GLASGOW & CLYDE** – The HSCP will be relying on NHSGG&C for the delivery of sound information governance in support of delivery of a robust records management approach and delivery of the HSCP Records Management Plan.

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 – Records Management Plan PUR

The Public Records (Scotland) Act 2011

East Dunbartonshire Integration Joint Board

Progress Update Review (PUR) Draft Report by the PRSA Assessment Team

date

Contents

1. Public Records (Scotland) Act 2011

The Public Records (Scotland) Act 2011 (the Act) received Royal Assent on 20 April 2011. It is the first new public records legislation in Scotland since 1937 and came into force on 1 January 2013. Its primary aim is to promote efficient and accountable record keeping by named Scottish public authorities.

The Act has its origins in *The Historical Abuse Systemic Review: Residential Schools and Children's Homes in Scotland 1950-1995* (The Shaw Report) published in 2007. The Shaw Report recorded how its investigations were hampered by poor recordkeeping and found that thousands of records had been created, but were then lost due to an inadequate legislative framework and poor records management. Crucially, it demonstrated how former residents of children's homes were denied access to information about their formative years. The Shaw Report demonstrated that management of records in all formats (paper and electronic) is not just a bureaucratic process, but central to good governance and should not be ignored. A follow-up review of public records legislation by the Keeper of the Records of Scotland (the Keeper) found further evidence of poor records management across the public sector. This resulted in the passage of the Act by the Scottish Parliament in March 2011.

The Act requires a named authority to prepare and implement a records management plan (RMP) which must set out proper arrangements for the management of its records. A plan must clearly describe the way the authority cares for the records that it creates, in any format, whilst carrying out its business activities. The RMP must be agreed with the Keeper and regularly reviewed.

2. Progress Update Review (PUR) Mechanism

Under section 5(1) & (2) of the Act the Keeper may only require a review of an authority's agreed RMP to be undertaken not earlier than five years after the date on which the authority's RMP was last agreed. Regardless of whether an authority has successfully achieved its goals identified in its RMP or continues to work towards them, the minimum period of five years before the Keeper can require a review of a RMP does not allow for continuous progress to be captured and recognised.

The success of the Act to date is attributable to a large degree to meaningful communication between the Keeper, the Assessment Team, and named public authorities. Consultation with Key Contacts has highlighted the desirability of a mechanism to facilitate regular, constructive dialogue between stakeholders and the Assessment Team. Many authorities have themselves recognised that such regular communication is necessary to keep their agreed plans up to date following inevitable organisational change. Following meetings between authorities and the Assessment Team, a reporting mechanism through which progress and local initiatives can be acknowledged and reviewed by the Assessment Team was proposed. Key Contacts have expressed the hope that through submission of regular updates, the momentum generated by the Act can continue to be sustained at all levels within authorities.

The PUR self-assessment review mechanism was developed in collaboration with stakeholders and was formally announced in the Keeper's Annual Report published on 12 August 2016. The completion of the PUR process enables authorities to be credited for the progress they are effecting and to receive constructive advice concerning on-going developments. Engaging with this mechanism will not only maintain the spirit of the Act by encouraging senior management to recognise the need for good records management practices, but will also help authorities comply with their statutory obligation under section 5(1)(a) of the Act to keep their RMP under review.

3. Executive Summary

This Draft Report sets out the findings of the Public Records (Scotland) Act 2011 (the Act) Assessment Team's consideration of the Progress Update template submitted for East Dunbartonshire Integration Joint Board. The outcome of the assessment and relevant feedback can be found under sections 6 – 8.

4. Authority Background

The East Dunbartonshire Integration Joint Board (the IJB) was established under the Public Bodies (Joint Working) Scotland Act 2014. The IJB is a body corporate (a separate legal entity). It is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a major function of management and, therefore, a responsibility placed upon the appointed members and officers of the Board.

The Health & Social Care Partnership pursues the principles of sound corporate governance within all areas of its affairs. Its Audit Committee is an essential component of the governance of the Health & Social Care Partnership Board detailed within its Financial Regulations.

The IJB consists of six voting members appointed in equal number by the NHS Board and the Council, with a number of representative, non-voting members who are drawn from the third sector, independent sector, staff, carers and service users. The IJB is advised by a number of professionals including the Chief Officer, Chief Finance & Resources Officer, Clinical Director, Chief Nurse and Chief Social Work Officer.

For the purposes of the Public Records (Scotland) Act, the Board (scheduled as the East Dunbartonshire Integration Joint Board) is the scheduled authority rather than the 'Health & Social Care Partnership'.

East Dunbartonshire Health and Social Care Partnership Board | East Dunbartonshire Council

5. Assessment Process

A PUR submission is evaluated by the Act's Assessment Team. The self-assessment process invites authorities to complete a template and send it to the Assessment Team one year after the date of agreement of its RMP and every year thereafter. The self-assessment template highlights where an authority's plan achieved agreement on an improvement basis and invites updates under those 'Amber' elements. However, it also provides an opportunity for authorities not simply to report on progress against improvements, but to comment on any new initiatives, highlight innovations, or record changes to existing arrangements under those elements that had attracted an initial 'Green' score in their original RMP submission.

The assessment report considers statements made by an authority under the elements of its agreed Plan that included improvement models. It reflects any changes and/or progress made towards achieving full compliance in those areas where agreement under improvement was made in the Keeper's Assessment Report of their RMP. The PUR assessment report also considers statements of further progress made in elements already compliant under the Act.

Engagement with the PUR mechanism for assessment cannot alter the Keeper's Assessment Report of an authority's agreed RMP or any RAG assessment within it. Instead the PUR Final Report records the Assessment Team's evaluation of the submission and its opinion on the progress being made by the authority since agreeing its RMP. The team's assessment provides an informal indication of what marking an authority could expect should it submit a revised RMP to the Keeper under the Act, although such assessment is made without prejudice to the Keeper's right to adopt a different marking at that stage.

Key:

G	The Assessment Team agrees this element of an authority's plan.	**A**	The Assessment Team agrees this element of an authority's progress update submission as an 'improvement model'. This means that they are convinced of the authority's commitment to closing a gap in provision. They will request that they are updated as work on this element progresses.	**R**	There is a serious gap in provision for this element with no clear explanation of how this will be addressed. The Assessment Team may choose to notify the Keeper on this basis.

6. Progress Update Review (PUR) Template: East Dunbartonshire Integration Joint Board

Element	Status of elements under agreed Plan 09DEC21	Status of evidence under agreed Plan 09DEC21	Progress review status <date>	Keeper's Report Comments on Authority's Plan 09DEC21	Self-assessment Update as submitted by the Authority since 09DEC21	Progress Review Comment <date>
1. Senior Officer	G	G	G	Update required on any change to senior staff member identified as holding corporate responsibility for records management. The *RMP* also includes the following action against this element "Further Development IJB Records Management Procedure, which identifies roles and responsibilities, will be produced once the RMP has been approved." **This is a welcome idea and the Keeper requests that he is provided with a copy of this guidance if it is developed.**	No change during interim period since December 2021. For East Dunbartonshire Council there has been no change, and updates to the East Dunbartonshire Council Records Management Plan has been postponed due to the migration over to Microsoft 365 project which will feed into a brand new suite of policies, procedures and new Records Management Plan based on those. The plan to further develop IJB Records Management Procedure identifying roles and responsibilities will progress in line with East	The Assessment Team thanks you for this update, and confirmation that East Dunbartonshire integration Joint Board continues to follow East Dunbartonshire Council's lead when developing its procedures in line with East Dunbartonshire Council's Records Management Plan (RMP). It is also acknowledged that the implementation of M365 will have implications to the Plan as well as adjacent policies and procedures. The Team look forward to further updates as the project progresses.

					Dunbartonshire Council RMP.	
2. Records Manager	G	G	G	Update required on any change.	No change during interim period since December 2021. Remains Karen Watt, East Dunbartonshire Council Information and Records Manager with responsibility for IJB records held by EDC.	The Assessment Team thanks you for this update. The Act requires that each authority identifies an individual staff member as holding operational responsibility for records management and that this individual has appropriate corporate responsibility, access to resources and skills. The Keeper has agreed that, due to the partnership nature of an integration joint board, two individuals may be identified under this element. The Assessment Team will continue to list Vandrew McLean, HSCP Corporate Business Manager, and Karen Watt, East Dunbartonshire Council Information and Records Manager, as East Dunbartonshire Integration Joint Board's Key Contacts.
3. Policy	G	G	G	Update required on any change.	No change during interim period since December 2021.	Update required on any future change.
4. Business Classification	A	G	A	The *RMP* commits the authority to "Continue to review IJB records to ensure adherence to the BCS." (page 10). This is welcome. **However, the *NHS Greater Glasgow and Clyde Records***	M365 has progressed for NHSGG&C however work is still ongoing to	Thank you for letting the Assessment Team know that work on M365 implementation and review of records

				***Management Plan* has been graded with an amber for this element (a full business classification scheme has not yet been imposed on the organisation's records management system). The Keeper has determined that an IJB's plan cannot be given a RAG status superior to that of the partner body responsible for managing the IJB records.** **Therefore, the Keeper's agreement against this element will be on an amber 'improvement model' basis while the health board finalise their business classification and implements it on their new records management structure, which the Keeper understands will be a M365 solution.**	implement new records management procedure. NHSGGC have fully incorporated two electronic Information Assets Registers covering Personal Assets and Business Assets. The Board has a designated, Information Governance Officer with the day to day responsibility of managing the Information Asset Register. The management of the IAR is now a standing item on the Information Governance Steering Group Agenda.	management procedures is ongoing. It is good to hear that there is now a combined IAR with both personal and business assets, and that there is an Information Governance Officer with responsibility for managing this and reporting back to the IG Steering Group. This Element will remain at Amber until the improvement actions have been completed by the partner body responsible for managing the IJB records. Update required on any future change.
5. Retention Schedule	**G**	**G**	**G**	Update required on any change.	No change during interim period since December 2021.	Update required on any future change.
6. Destruction Arrangements	**G**	**G**	**G**	Update required on any change.	No change during interim period since December 2021.	Update required on any future change.
7. Archiving and Transfer	**G**	**G**	**G**	Update required on any change.	No change during interim period since December 2021.	The Assessment Team thanks you for letting us know that there have been no major updates to this Element.

					For East Dunbartonshire Council there has been no change, and updates to the East Dunbartonshire Council Records Management Plan has been postponed due to the migration over to Microsoft 365 project which will feed into a brand new suite of policies, procedures and new Records Management Plan based on those.	See Element 13 for comments on RMP update and review.
8. Information Security	**G**	**G**	**G**	Update required on any change.	No change during interim period since December 2021.	Update required on any future change.
9. Data Protection	**G**	**G**	**G**	Update required on any change.	No change during interim period since December 2021. Data Protection | East Dunbartonshire Council Data Protection & Privacy - NHSGGC	Thank you for letting us know there have been no major changes to East Dunbartonshire IJB's Data Protection Arrangements. The Assessment Team also acknowledges the publicly-available linked data protection statements with thanks. Update required on any future change.
	A	**G**	**A**	The Keeper has previously agreed the business continuity arrangements in NHS Greater Glasgow and Clyde and in East Dunbartonshire Council.	No change during interim period since December 2021.	Thank you for letting us know there have been no changes to the Council's procedures,

10. Business Continuity and Vital Records				**However, the Keeper's agreement of this element of the council's RMP was under improvement model terms. At the time of their submission, East Dunbartonshire Council were developing a *Business Continuity Plan* that would encompass all its services. The objective of creating, rolling out and publishing a comprehensive plan was a target in the Records Management Improvement Action Plan. The agreement is conditional on him being provided with a copy of the *Business Continuity Plan* when it had been approved by the relevant governance groups in the Council. However, this has not yet been provided.** **As with element 4 above, the Keeper has determined that an IJB's plan cannot be given a RAG status superior to that of the partner body responsible for managing the IJB records.** **Therefore, the Keeper agrees this element of East Dunbartonshire Integration Joint Board's Records Management Plan under the same improvement model terms applied to that of East Dunbartonshire Council.**	For East Dunbartonshire Council there has been no change, and updates to the East Dunbartonshire Council Records Management Plan has been postponed due to the migration over to Microsoft 365 project which will feed into a brand new suite of policies, procedures and new Records Management Plan based on those.	and for confirming that the Council's Business Continuity Plan (which would encompass the Integration Joint Board) is not yet available. For comments on RMP and adjacent policy and procedure update and review, see Element 13. This Element will remain at Amber until the improvement actions have been completed by the partner body responsible for managing the IJB records. Update required on any future change.
11. Audit Trail	**A**	**G**	**A**	The Keeper has previously agreed that the record tracking and identification arrangements in NHS Greater Glasgow and Clyde and in East Dunbartonshire Council. **However, he agreed this element of East Dunbartonshire Council's *Records Management Plan* under 'improvement model' terms (February 2016). This means that he acknowledges that the Council had identified a gap in their records management provision (audit trails were not in a structured, consistent or centralised format). He agreed that the authority had committed to closing that gap. The Keeper's agreement was conditional on him being updated as the project**	No change during interim period since December 2021.	The Assessment Team understands that improvements in this Element currently rely heavily on the ongoing M365 implementation. The full implementation of the new eRDM system will help East Dunbartonshire IJB, alongside East Dunbartonshire Council, in closing this gap.

				progressed. The Council has yet to provide an update, so their plan remains at 'amber'. **As with elements 4 and 10 above, the Keeper can agree this element of the Integration Joint Board's *Records Management Plan* under the same amber 'improvement model' terms as its 'host' authority.**		This Element will remain at Amber until the improvement actions have been completed by the partner body responsible for managing the IJB records.
12. Competency Framework	**G**	**G**	**G**	Update required on any change.	No change during interim period since December 2021.	Update required on any future change.
13. Assessment and Review	**G**	**G**	**G**	Update required on any change.	No change during interim period since December 2021.	As reported under Elements 7 and 10, it is acknowledged that RMP assessment and review has been put on hold until the Council's implementation of Microsoft 365 is complete, as this will necessitate a large-scale review of policies and procedures. East Dunbartonshire IJB should be commended for its participation in the PUR process.
14. Shared Information	**G**	**G**	**G**	Update required on any change.	No change during interim period since December 2021.	Update required on any future change.
15. Records Created or Held by Third Parties	**N/A**	**N/A**	**N/A**	The Keeper agrees that this element is not applicable. Update required on any change.	N/A	Update required on any future change.

7. The Public Records (Scotland) Act Assessment Team's Summary

Version

The progress update submission which has been assessed is the one received by the Assessment Team on 27th March 2023. The progress update was submitted by Vandrew McLean, HSCP Corporate Business Manager.

The progress update submission makes it clear that it is a submission for **East Dunbartonshire Integration Joint Board**.

The Assessment Team has reviewed East Dunbartonshire Integration Joint Board's Progress Update submission and agrees that the proper record management arrangements outlined by the various elements in the authority's plan continue to be properly considered. The Assessment Team commends this authority's efforts to keep its Records Management Plan under review.

General Comments

East Dunbartonshire Integration Joint Board continues to take its records management obligations seriously and is working to bring all elements into full compliance.

Section 5(2) of the Public Records (Scotland) Act 2011 provides the Keeper of the Records of Scotland (the Keeper) with authority to revisit an agreed plan only after five years has elapsed since the date of agreement. Section 5(6) allows authorities to revise their agreed plan at any time and resubmit this for the Keeper's agreement. The Act does not require authorities to provide regular updates against progress. The Keeper, however, encourages such updates.

The Keeper cannot change the status of elements formally agreed under a voluntary submission, but he can use such submissions to indicate how he might now regard this status should the authority choose to resubmit its plan under section (5)(6) of the Act.

8. The Public Records (Scotland) Act Assessment Team's Evaluation

Based on the progress update assessment the Assessment Team considers that East Dunbartonshire Integration Joint Board continue to take their statutory obligations seriously and are working hard to bring all the elements of their records management arrangements into full compliance with the Act and fulfil the Keeper's expectations.

The Assessment Team recommends authorities consider publishing PUR assessment reports on their websites as an example of continued good practice both within individual authorities and across the sector.

This report follows the Public Records (Scotland) Act Assessment Team's review carried out by

Iida Saarinen
Public Records Officer

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair

Agenda Item Number: 9.

East Dunbartonshire HSCP Performance, Audit & Risk (PAR) Committee Agenda Planner

Meetings

January 2023 – June 2024

Updated 20/06/23

Standing items (every meeting)
Minutes of last meeting (JC)
Internal Audit Update (GMcC)
HSCP Annual Delivery Plan Update (JC)
HSCP Corporate Risk Register (JC)
HSCP Performance Management Reports (AW / AC)
Committee Agenda Planner (JC)
Care Inspectorate Reports as available
Relevant Audit Scotland reports as available
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
Internal Audit Plan 2023/24 (GMcC)

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair

Agenda Item Number: 9.

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
Unaudited Annual Accounts 2022/23 (JC)
Performance Management Update Qtr4 22/23 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update
HSCP Board Agenda Items – September 2023
Final Audited Annual Accounts 2022/23 (JC)
Mazars Annual Audit Report (TR)
Care at Home Inspection Update (DP)
HSCP Board Agenda Items – November 2023
Final Audited Annual Accounts 2022/23 (JC)
Mazars Annual Audit Report (TR)
Performance Management Update Qtr 2 23/24 (AC / AW)
HSCP Board Agenda Items – January 2024
Social Work Commissioning Update 2023/24
HSCP Committee Agenda Items – March 2024
Internal Audit Plan 2023/24 (GMcC)
Annual Audit Plan – External Audit (Mazars)

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Caroline Sinclair

Agenda Item Number: 9.

Performance Management Update Qtr3 23/24 (AC / AW)
HSCP Board Agenda Items – June 2024
Annual Internal Audit Report (GMcC)
Final Internal Audit Follow Up Report (GMcC)
Unaudited Annual Accounts 2023/24 (JC)
Performance Management Update Qtr4 23/24 (AC / AW)
HSCP Directions Log Progress Update