For meeting on
1 DECEMBER 2016

Agenda *2016*

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

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A meeting of the East Dunbartonshire Health and Social Care Partnership Integration Joint Board will be held within the **Committee Room, 12 Strathkelvin Place, Kirkintilloch G66 1XT** on **Thursday, 1 December 2016** at **9.30 am** to consider the undernoted business.

(Sgd) Councillor Rhondda Geekie
Chair, East Dunbartonshire Health and Social Care Partnership Integration Joint Board

12 Strathkelvin Place
KIRKINTILLOCH
Glasgow
G66 1XT

Tel: 0141 201 4217
Date: 21 November 2016

AGENDA

Sederunt and apologies

Any other business - Chair decides is urgent

Signature of minute of meeting HSCP Board held on 6 October 2016

STANDING ITEMS			
Item No.	**Contact officer**	**Description**	**Page Nos**
1	Martin Cunningham	Minute of HSCP Board – 6 October 2016. (Copy herewith).	1-8
2	James Hobson	Chief Officers Report to include Delayed Discharge Performance and Audit Scotland Report on Social Work Expenditure	9 - 12
3	Jean Campbell	Finance Report -Month 6 Outturn Report and Forecasting to year end	13 - 24
ITEMS FOR DISCUSSION			
4	Sandra Cairney	Board Diversity and the Public Sector Equality Duty (Copy herewith)	25 - 28
5	Sandra Cairney	Locality Planning - Progress Report (Copy herewith)	29 - 32
6	Paolo Mazzoncini	Chief Social Work Officer Report (Copy herewith)	33 - 58

Item No.	Contact officer	Description	Page Nos
7	Graham Morrison	HSCP GP Clusters Update Report	59 - 62
8	Paolo Mazzoncini	Refugee Crisis and Unaccompanied Asylum Seeking Children	63 - 72
9.	Fiona Borland	Communications Objective: Creating a Brand for the East Dunbartonshire Health & Social Care Partnership	73 - 92
ITEMS FOR NOTING			
9	Linda Tindall	HSCP Board Development Update	93- 96
10	Jean Campbell	Audit Committee Minutes	97-100
11	Graham Morrison	Clinical & Care Governance Group Minutes	101-110
12	Graham Morrison	Professional Advisory Group Minutes	111-116
13	Andy Martin	Alcohol & Drug Partnership Care Inspectorate Validated Self-Assessment Feedback	117-184
		Date of next meeting **Thursday, 26 January 2017** at 09.30am, Council Committee Room, Southbank Marina	

Minute of meeting of the Health & Social Care Partnership Board held within the Committee Room, 12 Strathkelvin Place, Kirkintilloch on **Thursday, 6 October 2016.**

Voting Members Present: EDC Councillors **GEEKIE, MCNAIR & O'DONNELL**

NHSGGC Non-Executive Directors **FRASER & LEGG**

Non Voting Members present:

M. **Brickley**	HSCP Service User Representative
J. **Hobson**	Chief Officer - East Dunbartonshire HSCP
G. **Thomson**	HSCP Voluntary Sector Representative
W. **Hepburn**	HSCP Professional Nurse Adviser
A. **Jamieson**	HSCP Carer Representative – substitute
I. **Twaddle**	HSCP Service User Representative – substitute
L. **Williams**	HSCP Clinical Lead Representative - substitute

Rhondda Geekie (Chair) presiding

Also Present:

F. **Borland**	HSCP Communications
S. **Cairney**	Head of Strategy, Planning & Health Improvement
J. **Campbell**	HSCP Chief Finance and Resources Officer
M. **Cunningham**	EDC Corporate Governance Manager
A. **Martin**	HSCP Head of Adult & Primary Care Services
P. **Mazzoncini**	Chief Social Work Officer
F. **McCulloch**	HSCP Planning & Performance Manager
T. **Quinn**	Head of Human Resources
L. **Tindall**	Organisational Development Lead

APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of I. Ritchie, G. Morrison, A. McCready, J. Robertson, A. Bowman & J. Duffy.

CHAIR'S REMARKS

Councillor Geekie welcomed everyone to the meeting and thereafter everyone, in turn, introduced themselves.

SEMINAR ON CHILDREN'S SERVICES – PAOLO MAZZONCINI, CHIEF SOCIAL WORK OFFICER

The Board heard from Paolo Mazzoncini who provided a brief outline of Children and Families and Criminal Justice Services following their transition to the Health & Social Care Partnership. He provided details on national and local practice and performance matters and summarised the strategic issues and challenges facing the services.

The Board remarked on the Children & Young People (Scotland) Act 2014, the Child Protection Improvement Programme and the work being carried out with HMP Low Moss regarding families support for offenders.

Thereafter the Board thanked the officers for their informative presentation.

1. MINUTE OF MEETING – 6 OCTOBER 2016

There was submitted and noted minute of the meeting of the HSCP Board held on 6 October 2016. The Chair thanked those members who had visited the Lennoxtown Hub and asked that future visits to the Respite services at Bishopbriggs and Twechar should be included in the programme of visits being co-ordinated by Linda Tindall.

2. CHIEF OFFICER'S REPORT

The Interim Chief Officer submitted a Report HSCP 2016/17-02, copies of which had previously been circulated, which summarised the national and local developments in relation to the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 since the last meeting of the Partnership Board. Details from the report included :-

National Update

- significant activity nationally in respect of the Scottish Government and CoSLA requesting information on progress with the implementation of the Living Wage from 1st October 2016.
- Scottish Care and CoSLA have published the results of two surveys undertaken to gather information on the experiences of independent sector providers and HSCP Chief Officers in respect of the National Care Home Contract.
- The Care Inspectorate issued a summary report to each local authority area on the social work activity and spend for the years 2006/7 to 2014/15. These reports were previously provided by the Office of the Chief Social Work Adviser, this is the first time the Care Inspectorate has published this information.
- The Health and Sport Committee issued to all HSCPs a survey requesting information on three key areas in relation to integration authorities:

    - Budget setting
    - Delayed Discharges
    - Social and community care workforce

Local Update

- The Chairman of NHS GGC Board wrote to the HSCP Chair on 11th August to advise of the changes to NHS Non-Executive Director HSCP Board membership with effect from 1st September 2016.
- Paul Cannon, Deputy Head of Administration for NHS GGC wrote to HSCPs on 26th August to confirm the arrangements that have been put in place from 1st September 2016 in relation to NHS Board Non-Executive Director substitute members and proxy voting for HSCP board members.
- Report 2016/17_13, Strategic Acute Service Planning, presented at the August 11th meeting of the HSCP Board advised that an updated report was to be presented at the NHS GGC Board meeting on 16th August. A paper on the proposed next steps, following the NHS Board meeting is attached as an appendix to update HSCP

Board members and advise there needed to be further work undertaken on agreeing the role of HSCPs in the strategic planning for acute services.

- Report 2016/17¬_14 on the board agenda provided an update on progress with implementation of the Phase 2 HSCP management structure, agreed at the last HSCP Board meeting.
- Report 2016/17-06 advised of the appointment of an Interim Chief Officer, by secondment, for ratification by the Board at today's meeting. This secondment was to cover the gap until the substantive vacancy for the Chief Officer was filled, following interviews held on 3rd October 2016. An update on the outcome from the substantive recruitment process will be provided at the meeting.

Following further consideration, the Board agreed as follows:

a) to ratify the appointment of James Hobson as Interim Chief Officer;
b) to note the contents of the report;
c) to return updated and completed register of interest forms to the HSCP Head of Administration as soon as possible;
d) to note that any issues arising from discussion of the Chief Officer's report will be progressed by the Interim Chief Officer.

3. FINANCE REPORT – MONTH 5 OUTTURN & FORECASTING TO YEAR END

Report HSCP 2016/17-03 by the Chief Finance and Resources Officer, copies of which had previously been circulated, update the Board on the projected financial outturn for the Health & Social Care Partnership for 2016/17 and to update on the IJB Budget 2016/17.

The financial performance in relation to the forecast outturn for the Health & Social Care Partnership was based on the period 5 reporting cycle for the period to 31st August 2016 (dates vary between NHS and Council reporting cycles which do not align). This is still early in the financial year and the position could vary significantly based on unknown demand pressures (particularly throughout the winter period) and the volatile nature of Social Work budgets. Members also noted the ability for the HSCP to create surplus and reserves for specific purposes

Following further consideration, the Board:

a) Noted the projected outturn position for the HSCP for 2016/17 and that uncertainty existed in both funding and operational costs of demand sensitive areas;
b) Agreed net revenue budgets of £78.6m to NHS GG&C and £52.1m to East Dunbartonshire Council and that this funding would be spent in line with the strategic plan;
c) Agreed the "set aside" budget for prescribed acute services would be £17.4m.

4. PERFORMANCE REPORT 2016/17 – QUARTER 1

Report HSCP 2016/17-04 by the Interim Chief Officer, copies of which had previously been circulated, a summary of the agreed HSCP targets and measures, relating to the delivery of the strategic priorities, for the period April to June 2016 (Quarter 1).

Positive Performance (on target) improving (19 measures)

Positive Performance (on target) declining (1 measure)

Negative Performance (below target) improving (6 measures)

Negative Performance (below target) declining (7 measures)

Members commented on the report and the general direction of travel in relation to staff performance thereafter the Board noted the report and agreed that should any areas of concern be identified they would be reported to future meetings

5. DELAYED DISCHARGES PERFORMANCE UPDATE

The Head of Adult & Primary Care Services presented Report HSCP 2016/17-04, copies of which had previously been circulated, advising the Board on the progress being made in relation to the Delayed Discharges Action Plan.

The Scottish Government provided an allocation of £510,000 to East Dunbartonshire HSCP to support improvement in reducing Delayed Discharges. A report presented to the HSCP in December 2015 outlined the proposed allocation of this funding, and the Action Plan to support progress.

Thereafter the Board noted the contents of the Report.

6. APPOINTMENT OF INTERIM CHIEF OFFICER

The Head of Human Resources submitted Report HSCP 2016/17-06, copies of which had previously been circulated, advises of the process undertaken to secure, by officer selection, the appointment of an Interim Chief Officer for the HSCP Board. This covered the vacancy created by the retirement of the previous Chief Officer from 1st October for a period of approximately 4 months, or until the vacancy can be filled on a substantive basis.

The Board agreed to ratify the recommendation made by the officer panel to appoint, by secondment, of James Hobson to the post of Interim Chief Officer and that he would take up post on 7th October 2016 until the substantive Chief Officer appointment was completed and the successful candidate could take up post. The Board were also advised that Susan Manion had been appointed as the new Chief Officer of the HSCP.

7. REVIEW OF COMPLEX & CONTINUING HOSPITAL CARE

The Interim Chief Officer submitted Report HSCP 2016/17-07, copies of which had previously been circulated, informing the Board of the on-going review of Complex and Continuing Hospital Care provision across NHS Greater Glasgow & Clyde, highlighting its impact on East Dunbartonshire and outlining actions being undertaken to implement the initial phases of the review and to plan for its later phases.

Having heard various members on the challenging nature of the practicalities facing service users and their families in this regard the Board noted that as more information became available it would be reported and thereafter the Board agreed to note the content of the report and the potential impact on Community Care provision and the costs for East Dunbartonshire as this change was progressed.

8. THE "LIVING WAGE" – IMPLEMENTATION – PROGRESS UPDATE

The Interim Chief Officer presented Report HSCP 2016/17-08, copies of which had previously been circulated, update members on the Living Wage Commitment and to seek approval on the preferred delivery approach as outlined within this report.

National guidance was circulated to help inform local decision making. The guidance entailed four delivery options along with the potential associated risks - all of which have been fully explored. Option 2: *Apply a differing percentage increase per provider, though individual negotiation based on their particular costs* - was considered the best approach for delivering the local commitment. Key determining factors include overall affordability and time constraints.

Following further consideration when members noted that this matter was the subject of national discussions at COSLA, the Board noted the content of the report and approved the approach identified in Option 2 (para 2.3 of the Report) to deliver the living wage commitment in 2016/17.

9. INTERMEDIATE CARE MODEL - UPDATE

Report HSCP 2016/17-09 by the Interim Chief Officer, copies of which had previously been circulated, updated the HSCP Board on the service developments of an intermediate care facility within East Dunbartonshire

The intermediate care project would transition service users from the hospital setting, when medically fit for discharge, to the facility giving the service user time for additional recovery and the opportunity to receive a comprehensive assessment of their longer term health and social care support needs

Following further consideration when members discussed the implications for patient transport, the details of the 1 year pilot, the implications for service users as well as the impact on Social Work and Clinical Services, the Board noted the report

10. WINTER PLAN – 2016 - 17

Report HSCP 2016/17-10 by the Head of Strategy & Health Improvement, copies of which had previously been circulated, which detailed the Winter Plan which addressed the twelve key critical areas set out in the Scottish Government guidance Preparing for Winter 2016/17 and the 6 Essential Actions. The Winter Plan set out the local issues across primary care and community health and social care services for which the HSCP is responsible, to support the NHSGG&C whole system planning.

A rolling action log will be discussed and maintained by the operational managers at the Operational Managers Group meetings throughout the winter period, September 16

– March 17. In addition, situation reports (SITREPs) would be escalated as appropriate. A report analysing the activity, performance and pressures during the winter would be provided for the HSCP Board at the end of the winter period

Following consideration when members discussed the importance of communication of key information and resilience across all the teams involved including the Out of Hours Service, the Board approved the Winter Plan 2016 / 17

11. COMMISSIONING AND CONTRACT MANAGEMNT FRAMEWORK (CMF)

Report HSCP 2016/17-11 by the Interim Chief Officer, copies of which had previously been circulated, summarised the Commissioning and Contract Management Framework (CMF) and asked members to note and agree the underpinning procedures required to support effective delivery of this function.

Members raised various matters including the impact on the local 3rd Sector partners and the possible implications for members of staff. Members also sought clarity on the alignment of this policy with those already existing in both the Health Board and the Council.

Following further consideration, the Board noted and agreed the procedures underpinning the CMF.

12. DRAFT INTERIM INTEGRATED CHILDREN'S SERVICES PLAN 2016-17

Report HSCP 2016/17-12 by the Interim Chief Officer, copies of which had previously been circulated, provided the HSCP Board with an update on the work being done to deliver an Integrated Children's Services Plan for East Dunbartonshire Council.

The Children and Young People (Scotland) Act 2014 places a duty on local authorities and health boards to jointly prepare a Children's Services Plan (CSP) for the area of the local authority covering a 3 year period and to jointly publish an annual report, detailing how the provision of children's services, both universal and targeted and related services in that area have been provided in accordance with the CSP. This is Part 3 of the Act, and CSPs for the period 2017-20 were expected to be in place by April 2017.

Members highlighted the current level of community engagement, the integration of services via the Place Initiative in Hillhead, Auchinairn and Lennoxtown and following further discussion, the Board noted the content of the Report.

13. ED HSCP CLINICAL GOVERNANCE REPORT

Report HSCP 2016/17-13 by the Interim Chief Officer, copies of which had previously been circulated, provided the HSCP Board with the annual clinical governance report that the HSCP requires to submit annually to NHS GGC Clinical Governance Support Unit. This provides assurance to the Health Board, in respect of HSCP health services provided under direction of the Health Board, and operationally managed by the HSCP Chief Officer.

This report covered activities for the calendar year from January 2015 to the end of December 2015 and related, in the main, only to health clinical governance and clinical effectiveness activities.

Following further consideration, the Board agreed:

a) To note the contents of the Clinical Governance Annual Report;
b) To commend the efforts of the members of the Clinical and Care Governance Group to ensure scrutiny and assurance of services has been maintained during a period of significant organisational change;
c) To request an update on the further development of Clinical and Care Governance arrangements to reflect the delegation of additional functions for children's health services, children's social work services and criminal justice social work services in six months' time.

14. PROGRESS ON COMMUNITY JUSTICE WORKSTREAM

Report HSCP 2016/17-14 by the Interim Chief Officer, copies of which had previously been circulated, advised the Board on the progress in respect of the implementation of the Community Justice (Scotland) Act in April 2017. Furthermore the report informed the Board of the response submitted by the Argyll, Bute and Dunbartonshire Criminal Justice Social Work Partnership to the Care Inspectorate for their consultation on the Community Justice Self-Evaluation Guide.

Following further consideration, the Board noted the report.

15. HSCP MANAGEMENT STRUCTURE – PHASE 2 UPDATE

Report HSCP 2016/17-15 by the Interim Chief Officer, copies of which had previously been circulated, provided the HSCP Board with an update on progress in implementing the phase 2 management structure which was agreed at the 11 August HSCP Board Meeting.

Following further consideration, the Board noted progress on implementing the structure and agreed that an update on progress would be provided to the December HSCP Board Meeting.

16. HSCP LOGOS - PRESENTATION

The Board considered the options presented and agreed to continue consideration for further options to be developed and presented to the next Meeting

17. DATE OF NEXT MEETING – 1 DECEMBER 2016

The Board noted that the next meeting would be held on Thursday, 1 December 2016 at 9.30 am and be held within the Committee Room at the Council Headquarters, 12 Strathkelvin Place, Kirkintilloch.

Agenda Item Number: 2

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_02**
Subject Title	**Chief Officer Report**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership** **0141 201 3553** **James.hobson@ggc.scot.nhs.uk**

1.0	**PURPOSE OF REPORT**
1.1	To update HSCP Board members on a number of local and national matters of interest.
2.0	**SUMMARY**
2.1	This report updates HSCP Board Members on a number of matters including: ▪ Appointment of Susan Manion as Chief Officer; ▪ Progress with implementation of Intermediate Care Service; ▪ Update on refurbishment of KHCC; ▪ Accounts Commission report on Social Work in Scotland; and ▪ Audit Scotland report on the NHS in Scotland 2016.
3.0	**RECOMMENDATIONS**
3.1	It is recommended that the HSCP Board: ▪ Notes the content of this report.

4.0 MAIN REPORT

4.1 Appointment of Chief Officer

Following interviews on 3rd October 2016 Susan Manion was appointed as Chief officer of East Dunbartonshire HSCP. Susan was previously Chief Officer with Borders HSCP and will take up her new appointment on Monday 12th December 2016. On 31st October 2016 Susan met with the current Interim Chief Officer and with a number of senior staff from the partnership and went on a brief tour of KHCC. An induction programme will be prepared in advance of her arrival to enable her to meet key contacts and partners during the first few weeks of her appointment and she plans to attend the HSCP Board meeting on 1st December as an observer. Susan will be based at KHCC from 12th December and the other members of the Senior Management Team will be based there permanently from January 2017.

4.2 Intermediate Care Service

East Dunbartonshire's intermediate care beds became operational from 14th November 2016. The beds allow service users to transition from the hospital setting, when medically fit for discharge, to a homely environment, allowing the service user time for additional recovery, rehabilitation and enable a comprehensive assessment of their longer term health and social care support needs.

The intermediate care beds are located within Westerton Care Home, Bearsden within a discrete, self-contained area containing eight single bed rooms. The beds are utilised for the purpose of:-

- Further assessment of service users who are likely to require admission to a residential or nursing care home environment.
- A "step down" function where the service user will receive intensive goal focussed rehabilitation and reablement provided via the care home, care at home service and community rehabilitation with a view to returning to their own home or other appropriate community setting.

This is an initial pilot for 1 year and will be subject to a robust evaluation to inform and influence the future direction of the service.

4.3 Refurbishment of Kirkintilloch Health & Care Centre

The refurbishment work at KHCC is one of the main elements of East Dunbartonshire Council's property strategy and will have a significant beneficial impact for the HSCP by promoting greater integration of staff and moving the senior managers closer to operational staff. The main phase of the development work will be completed between January and March 2017 but in advance of that work an initial phase will create space to enable the HSCP staff currently based at Stobhill to relocate to KHCC by 12th December 2016. This will also benefit the Oral Health Directorate as it will enable OHD staff currently based in Townhead Health Centre to be relocated to the vacated space at Stobhill.

4.4 Accounts Commission Report – Social Work in Scotland

This report published in September comments on the current status of social work services across Scotland and comments on a number of key issues that need to be addressed in future years. The key messages and comments include:

- The current approach to delivering social work services will not be sustainable in the long term as any further cost reductions will reduce the quality of services;

- If services continue to be provided as they are at present additional funding of £510m to £667m would be required by 2020;
- Health and social care integration has made governance arrangements for social work services more complex but councils still retain the statutory responsibility in relation to social work services; and
- The report also highlights a number of issues including difficulties faced in recruiting and retaining social care staff, the impact of reductions in funding and the changing and expanding role of the Chief Social Work Officer.

The full report is available on the Audit Scotland website:

http://www.audit-scotland.gov.uk/report/social-work-in-scotland

4.5 **Audit Scotland Report – NHS in Scotland 2016**

The annual Audit Scotland report on the NHS in Scotland was published in October 2016. The report comments on a number of key strategic and service issues and received extensive media coverage and was discussed at the Scottish Parliament. The report comments on:

- The improvements in service delivery and reductions in waiting times;
- Funding increases are not keeping up with increases in demand for services and NHS Boards have had to make unprecedented levels of savings to achieve financial balance;
- The balance of care is not changing and Boards are finding it difficult to balance current demand for services with increasing investment in community services;
- The National Clinical Strategy is not underpinned by a clear plan for how the required changes will be implemented; and
- Highlights a number of pressures including the increasing costs of drugs, problems with recruitment and retention of staff in certain areas, sickness absence levels, the number of GP vacancies and the rising costs of using temporary staff.

The full report is available on the Audit Scotland website:

http://www.audit-scotland.gov.uk/report/nhs-in-scotland-2016

Agenda Item Number: 3

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_03**
Subject Title	**Month 6 Outturn Report & Forecasting to Year End**
Report By	**Jean Campbell, Chief Finance & Resources Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Jean Campbell, Chief Finance & Resources Officer** **East Dunbartonshire Health & Social Care Partnership** **0141 201 4210** **Jean.campbell@eastdunbarton.gov.uk**

1.0	**PURPOSE OF REPORT**
1.1	The purpose of this report is to update the Board on the financial outturn for the Health & Social Care Partnership for 2016/17 and to update on the IJB Budget 2016/17.
2.0	**SUMMARY**
2.1	The financial performance in relation to the forecast outturn for the Health & Social Care Partnership is based on the period 6 reporting cycle for the period to 30 September 2016 (dates vary between NHS and Council reporting cycles which do not align). This is still early in the financial year and the position can vary significantly based on unknown demand pressures (particularly throughout the winter period) and the volatile nature of Social Work budgets.
2.2	The current position indicates a surplus of £2.6m for the Health & Social Care Partnership as a result of capacity within the Integrated Care Fund and delayed discharge monies as developments are underway which will improve performance and there is also a positive impact from monies allocated to deliver the living wage which will not incur a full year cost in 2016/17. There are also positive variations as a result of vacancies across community health and Children's SW services and a downward trend in care home placements, now managing within budget. This position takes account of the full extent of savings agreed as part of the NHS GG&C Board savings agreed within their financial plan for 2016/17 and transformational savings agreed by the Council as part of the budget savings proposal agreed on the 15th March 2016.
2.3	There are monies available to meet any ongoing demographic pressures and there is partnership reserves of £1.388m carried forward from 2015/16 to provide some additional resilience in 2016/17. However, reserves are non-recurring monies and will therefore require measures in place to manage any budget pressures on an ongoing basis.
2.4	There continue to be risks to the projected outturn position in respect of monies still to be allocated by East Dunbartonshire Council in respect of procurement savings, demand volatility across Social Work budgets, prescribing volatility and conclusion of

living wage negotiations.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

- Notes the projected outturn position for the HSCP for 2016/17 and that uncertainty exists in both funding and operational costs of demand sensitive areas;
- Agrees net revenue budgets of £96.9m (including Acute Set Aside) to NHS GG&C and £52.1m to East Dunbartonshire Council and direct that this funding be spent in line with the strategic plan;
- Agree the application of the transformation savings applied by the Council to the allocation to the IJB detailed in 4.17.
- Note the risk to the projected out turn position detailed in 4.21.

4.0 MAIN REPORT

4.1 East Dunbartonshire Health & Social Care Partnership (HSCP) was established on the 3rd September 2015 and 2016/17 represents the first year that budgets will be fully aligned for Adult Services. The incorporation of Children's Social Work and Criminal Justice Services on the 11th August 2016 will further increase the budgets, responsibilities and reporting requirements for the partnership.

4.2 The table below shows the year to date variance and estimated out –turn forecast for the HSCP. Details of the budget movements during the period are included in **Appendix 1.**

Partnership Expenditure	Annual Budget £000	YTD Budget £000	YTD Actual £000	YTD Variance £000	Out-turn Forecast £000
NHS Community Budgets	21,326	7,777	7,814	(38)	700
ED Social Care Fund (£250m)	4,300	2,150	2,150	0	1,400
Oral Health	10,287	4,214	5.091	50	0
FHS & Prescribing	43,652	21,897	21,897	0	0
Adult Social Care	40,545	16,499	15,965	534	284
Children & CJ Services	11.529	5,334	4,696	638	250
Care of Gardens	78	39	39	0	(7)
Adaptations (PSHG)	450	225	225	0	0
Care and	214	107	107	0	0

Repair					
Fleet	452	226	226	0	0
SUB-TOTAL	**132,833**	**59,344**	**58,160**	**1,185**	**2,627**
Acute Set Aside	17,381	7,242	7,242	0	0
TOTAL	**150,214**	**66,586**	**65,402**	**1,185**	**2,627**

HSCP Budget Outturn

4.3 The overall projected out turn for the HSCP is indicating a surplus position for 2016/17 of £2.6m. This is an accumulation of surplus available from monies allocated to deliver on the living wage (£1.4m – non recurring, part year only for 2016/17), surplus on the Integrated Care Fund and delayed Discharge monies (£600k), vacancies across community health services and childcare payroll budgets (£350k) and some surplus on adult social care budgets (£284k). The pressure on Adult Social Care budgets has been alleviated by additional monies allocated through the Council to meet the living wage costs within the care home sector, a downward trend on care home placements and conclusion of the financial assessment process to provide more accurate costs for care home placements. There continue to be pressures on residential school placements within Children's Service's; however these are being managed through surpluses across the partnership budget in respect of positive payroll variances. There are also reserves carried forward at the end of 2015/16 to provide some in year resilience if required.

NHS Budget Outturn

4.4 The table below shows a detailed breakdown of the partnerships NHS budgets for the 6 month period to the 30th September 2016.

NHS Expenditure £000	Annual Budget £000	YTD Budget £000	YTD Actual £000	Variance £000
Addictions – Community	701	351	389	(39)
Adult Community Services	4,342	2,171	2,044	127
Integrated Care Fund	1,200	206	206	0
Child Services – Community	1,367	687	622	65
Learning Disability – Community	690	254	221	33
Mental Health – Adult Community	1,249	620	573	46

Mental Health – Elderly Services	634	313	298	15
Other Services	5,753	424	709	(285)
Planning & Health Improvement	806	461	461	0
Resource Transfer to Local Authority	8,885	4,442	4,442	0
Total Integrated Budgets	**25,626**	**9,927**	**9,964**	**(37))**
Family Health Services – Prescribing	18,809	9,425	9,425	0
Family Health Services – GMS	13,407	6,704	6,704	0
Family Health Services – Other	12,726	6,404	6,404	0
Total Ring-fenced NHS Budgets	**43,652**	**21,897**	**21,897**	**0**
Total Directly Managed NHS Budget	**69,278**	**31,824**	**31,861**	**(37)**
Oral Health – Public Dental Service (Hosted)	10,287	5,091	5,040	51
Acute Set Aside	17,381	7,242	7,242	0
Total IJB Health Budget	**96,946**	**44,157**	**44,143**	**(14)**

4.5 The projected year end out turn for NHS budgets for 2016/17 is that of a surplus of £700k. (an increase of £100k on that previously reported) This relates primarily to capacity within the Integrated Care Fund where monies are yet to be allocated to deliver on strategic priorities, delayed discharges monies where the implementation of the Intermediate Care proposal will only incur a part year spend in 2016/17, delays in filling vacancies and management costs and development monies unallocated. The additional surplus arises from vacancies within District Nursing and Rehabilitation services.

4.6 There are a number of budget pressures in relation to Addictions, a consequence of the effect of the savings allocated in respect of the ADP allocation which will be resolved through adjustment to the level of Resource Transfer to the Council, and Other Services, in relation to accommodation charges for KHCC. However, these are offset by the surpluses in a number of other areas including Adult Community Services relating to vacancies within District Nursing and Rehab and under spend on management costs within Adult and Mental Health services. The latter will form part of the structure considerations as these are further developed.

4.7 GP Prescribing costs are not available until two months after the month in which prescriptions are dispensed which means that only April - July expenditure is

available. This was showing that prescribing expenditure, for East Dunbartonshire, was running ahead of budget at that point to the tune of £87k. Analysis of these variances is being investigated by the partnership's prescribing advisor and measures to mitigate these pressures to be implemented. It is difficult to accurately predict a robust out turn based on four month's data, therefore actual is assumed to be on budget at this stage.

4.8 The overall GP prescribing expenditure position for GG&C is that of an underspend position of £170k which while encouraging is a highly volatile area and increases in certain drug costs remains a concern. There continues to be a risk sharing arrangement in place for 2016/17 across the GG&C board area and this will be managed within the NHSGGC board budgets.

4.9 The Public Dental Service hosted by ED HSCP is projected to achieve a breakeven position. There are a number of savings plans incorporated with the 16/17 budget which are yet to deliver but are expected to be achieved over the course of the current year.

Social Work Budget Outturn

4.10 The table below shows the partnerships Social Work budgets for the 6 month period to the 30th September 2016:-

SW Expenditure	Annual Budget £000	YTD Budget £000	YTD Actual £000	Variance £000
Adult SW Services	40,545	16,499	15,965	534
Children & CJ Services	11.529	5,334	4,696	638
TOTAL SW Budgets	**52,074**	**21,833**	**20,661**	**1,172**

4.11 The projected out turn for Adult Social Work services is now indicating a surplus on budget of £1.9m (£1.7m for Adult Social Care Services, £0.2m for Children's Services). This represents a movement of £1m from that previously reported. A detailed breakdown is provided in **Appendix 2**.

4.12 Adult Social Care Services (£1.684m)

- Living Wage - the bulk of the surplus (£1.4m) is derived from monies allocated from the Scottish Government to deliver the living wage across care home, care at home and housing support services. An allocation of £2.15m was allocated to East Dunbartonshire for this purpose with only a 6 month commitment attached to the delivery of this agenda from the 1st October 2016. In addition, the Council agreed to meet the care home element for 2016/17 from Council reserves which provides an overall surplus of £1.4m. This relates to 2016/17 only and is non- recurring as a full year commitment will be required in 2017/18.

- Agency Budgets – there has been a surplus generated (£284k) across a range of adult social care budgets including supported living and supported accommodation to adults with a learning disability which was previously offsetting pressure in relation to older people care home placements. However a combination of additional monies allocated through the Council to meet the living wage costs within the care home sector (£370k), a downward trend on care home placements (185k)

and conclusion of the financial assessment process to provide more accurate costs for care home placements (£300k) accounts for the movement from that previously reported.

4.13 Children's Services (£250k)

- Payroll – there is a surplus on budget (£420k) as a result of vacancies across the service including the Social Work Teams, Community resources Team and the Children's Residential Unit. A number of these posts are in the process of being filled and this will be an area which will be reviewed as part of structure considerations moving forward.

- Agency & Transfer payments (-200k) - There is currently pressure on residential placements for Looked After Children, which is an area prone to volatility depending on caseload which is being offset to some extent by underspends anticipated within Adoption Allowances, Kinship Payments and transfer payments.

Budget Setting 2016/17

4.14 The NHS GG&C Board approved the 2016/17 Financial Plan on the 28th June 2016. The proposed budget (£96.9m) and detailed breakdown for Health Services is detailed in paragraph 4.4 and includes a savings target of £1.368k for East Dunbartonshire. The full extent of savings has now been identified for 2016/17 and reported previously.

4.15 The Council approved its budget for 2016/17 on the 17 March 2016 and the corresponding contribution to the IJB of £40.5m in line with the integration scheme. A further £11.6m was approved as the contribution to the IJB in respect of Children's SW & CJ Services giving a total of £52.1m.

4.16 The Council's 2016/17 Revenue Budget was balanced by recognising that savings will accrue from a number of Transformation Work streams and these have now been allocated to the HSCP.

4.17 A saving of £372k has been allocated to the partnership represented by a 20% reduction in overtime, agency and mileage budgets. This is detailed as follows:

Overtime	£253,572
Agency	£80,652
Mileage	£37,984
TOTAL	£372,208

4.18 The saving in respect of overtime includes additional basic payments met from basic pay budgets (staffing budgets), as opposed to overtime budgets, and costs attaching to agency staff are met from vacant posts. In order to affect the savings identified, this would mean a reduction in staffing levels across the Social Work establishment predominantly within frontline services such as assessment and homecare services. Therefore, alternative payroll savings have been identified which do not inhibit the partnership's ability to deliver the objectives outlined in the Strategic Plan, as follows:-

Overtime	£133k
Mileage	£150k
Other Pay Costs	£17K
Turnover	£72k
TOTAL	£372k

4.19 These transformational savings have been incorporated into Period 6 budget figures. There remains potential further procurement savings yet to be allocated to the partnership from the Council.

4.20 In addition, there has been an additional budget allocation made to the partnership in respect of the uplift of care home fees to deliver the living wage across the care home sector of £370k. This was agreed as part of the budget setting for 2016/17 to be met from Council reserves.

4.21 The revised budget and contribution to the partnership from the Council is £52.08m.

Financial Risks

4.22 The most significant risks that will require to be managed during 2016/17 are;

- **Prescribing Expenditure** – Prescribing cost volatility represents the most significant risk within the NHS element of the partnership's budget. At this stage of the year it is now possible to make an informed assessment of the in year position against budgets and to estimate the likely out-turn for 2016/17, however based on previous year experience this will require close ongoing monitoring.
- **Achievement of Savings Targets** –There are elements of savings targets for procurement, within the Council, which have yet to be allocated out which may present in year pressure.
- **Demographic Pressures** – Increasing numbers of older people is placing significant additional demand on a range of services including Home Care. In addition achieving the required reductions in delayed discharges is creating increased demand for care home places and resulting in increased levels of self-directed support payments. These factors increase the risk that overspends will arise and that the partnership Board will not achieve a balanced year end position.
- **Children's Services** – managing risk and vulnerability within Children's Services is placing significant demand pressures on residential placements which will increase the risk of overspend which may impact on achieving a balanced year end position.
- **Living Wage** – the costs associated with implementing the living wage are subject to on-going negotiation with a small number of service providers and are underpinned by a contribution from providers which may not be sustainable on a recurring basis. There remain uncertainties on the future funding allocation for this area in terms of uplifts, sleepovers and affordability for a full year.

5.0 IMPLICATIONS

5.1 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. The implications for the Council are as undernoted.

5.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

Budget Movement 2016/17
East Dunbartonshire HSCP

APPENDIX 1

Service	Approved budget 2016/17 £000	Supplementary Budget £000	Budget Savings £000	Virement £000	Revised budget 2016/17 £000	Comment
Social Work						
Children's SW & CJ Services	11,630		(101)		11,529	Transformational Savings allocation
Adult SW Services	40,500	370	(271)		40,599	Council Allocation to Living Wage within Care Homes, transformational savings allocation.
	52,130					
Health						
Child Services	702			(1)	701	Property Maintenance Transfer
Adult Community	4,298	44			4,342	District Nursing Resource Allocation
ICF	1,200				1,200	
Child Services	1,367				1,367	
LD - Community	307	383			690	Learning Disability Resource Allocation
MH - Adult Community	1,249				1,249	
Mh - Elderly	637			(3)	634	Property Maintenance Transfer
Other Services	5,773			(19)	5,754	Property Maintenance Transfer
Planning & HI	806				806	
RT	8,885				8,885	
	25,221	427	0	(23)	25,626	
Oral Health	10,301			(14)	10,287	
FHS & Prescribing	43,037	615			43,652	Additonal monies from the SG to fund prescribing
Acute Set Aside	17,381				17,381	
	95,940	1,042	0	(37)	96,946	

Health and Social Care Partnership
Projected Outturn at Period 6

Health and Social Care Partnership	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Projected Outturn	Projected Outturn Variance	Prior Year Outturn
Non-Teaching Employee Costs	8,012,626	7,854,411	158,215	18,746,727	18,502,741	243,986	18,309,210
Property Costs	181,873	111,318	70,555	266,091	228,329	37,762	183,290
Supplies & Services	493,828	429,728	64,100	1,091,734	1,091,342	392	1,042,033
Agencies & Other Bodies	20,808,788	19,632,263	1,176,525	46,337,107	46,168,079	169,028	41,552,394
Transport & Plant	206,499	183,081	23,418	494,790	509,752	-14,962	419,230
Transfer Payments	79,586	-62,440	142,026	163,580	82,278	81,303	3,192,823
Administrative Costs	87,731	30,787	56,944	183,798	178,252	5,546	231,927
Financing Costs	0	0	0	0	0	0	90,000
Income from Government Grants	-47,200	-36,281	-10,919	-69,044	-69,044	0	0
Sales	-4,169	-3,642	-527	-8,571	-8,571	0	-9,050
Fees & Charges	-538,475	-481,265	-57,210	-791,123	-813,790	22,667	-837,562
Recharges to Other Departments	0	-20,260	20,260	-81,037	-81,037	0	-99,958
Income from Rents	0	-59,920	59,920	0	0	0	0
Other Income	-7,448,740	-6,915,891	-532,849	-14,259,778	-14,247,804	-11,974	-13,103,193
OVERALL TOTAL	**21,832,347**	**20,661,889**	**1,170,458**	**52,074,274**	**51,540,526**	**533,748**	**50,971,144**

Adults and Older People	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Projected Outturn	Projected Outturn Variance	Prior Year Outturn
Non-Teaching Employee Costs	5,681,021	5,705,974	-24,953	13,290,075	13,467,673	-177,598	13,323,797
Property Costs	50,905	40,651	10,254	103,824	102,269	1,555	123,202
Supplies & Services	434,280	387,340	46,940	972,648	971,984	664	938,990
Agencies & Other Bodies	17,609,570	17,059,266	550,304	39,773,921	39,355,780	418,141	36,822,433
Transport & Plant	172,004	144,784	27,220	411,993	418,311	-6,318	345,862
Transfer Payments	34,276	-76,287	110,563	70,446	33,384	37,062	2,689,825
Administrative Costs	65,096	-43,139	108,235	133,498	132,032	1,466	200,080
Financing Costs	0	0	0	0	0	0	90,000
Income from Government Grants	-47,200	-36,281	-10,919	-69,044	-69,044	0	0
Sales	-4,169	-3,642	-527	-8,571	-8,571	0	-9,050
Fees & Charges	-538,475	-480,303	-58,172	-791,123	-811,866	20,743	-837,197
Recharges to Other Departments	0	-20,260	20,260	-81,037	-81,037	0	-99,958
Income from Rents	0	-59,920	59,920	0	0	0	0
Other Income	-6,958,717	-6,652,599	-306,118	-13,261,390	-13,249,416	-11,974	-12,098,257
Adults and Older People - Total	**16,498,591**	**15,965,584**	**533,007**	**40,545,240**	**40,261,498**	**283,742**	**41,489,727**

Children and Families	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Projected Outturn	Projected Outturn Variance	Prior Year Outturn
Non-Teaching Employee Costs	2,331,605	2,148,437	183,168	5,456,652	5,035,069	421,584	4,985,413
Property Costs	130,968	70,667	60,301	162,267	126,060	36,207	60,088
Supplies & Services	59,548	42,388	17,160	119,086	119,358	-272	103,043
Agencies & Other Bodies	3,199,218	2,572,997	626,221	6,563,186	6,812,299	-249,113	4,729,961
Transport & Plant	34,495	38,297	-3,802	82,797	91,441	-8,644	73,368
Transfer Payments	45,310	13,847	31,463	93,134	48,894	44,241	502,998
Administrative Costs	22,635	73,926	-51,291	50,300	46,220	4,080	31,847
Financing Costs	0	0	0	0	0	0	0
Income from Government Grants	0	0	0	0	0	0	0
Sales	0	0	0	0	0	0	0
Fees & Charges	0	-962	962	0	-1,924	1,924	-365
Recharges to Other Departments	0	0	0	0	0	0	0
Income from Rents	0	0	0	0	0	0	0
Other Income	-490,023	-263,292	-226,731	-998,388	-998,388	0	-1,004,936
Children and Families - Total	**5,333,756**	**4,696,305**	**637,451**	**11,529,034**	**11,279,028**	**250,006**	**9,481,417**

Comments	Prior Year (2015/16) YTD figure at P6
Actual payroll costs at September 2016 are broadly comparable to the same period in September 2015. Transformational savings in relation to agency, overtime and mileage have now been applied and this is causing pressure in some areas. As with previous years, the cost of Homecare staff overtime is displaying significant pressure but it is anticipated that this some of this will be managed down as vacancies are filled. There is also a projected overspend in the Rehabilitation service due to spend on agency staff. These overspends are partially offset with vacancies and efficiencies in other services.	5,928,693
Minor variances across services - No significant variations expected at this time.	34,112
Spend on equipment and adaptations is tightly controlled within budget limits with critical and substantial criteria continuing to be applied in this area. This is being monitored through the Equipu contract and other activity under the service level will ensure a break even position. There are some year to date variances across the other budget lines which require to be fully investigated to determine if there are any further procurement savings that can be made. These variances have yet been reflected in the year end position. The year to date position also reflects a large credit note that has not yet been applied.	354,939
This is volatile area for the partnership as any changes in caseload can have a significant impact on commitments. At this stage, overall, a projected underspend is anticipated. Older people, particularly residential and day care, is a pressure area but this is in part offset by a lower than anticipated cost of Supported Living and Supported Accommodation. £370k has been applied to residential budgets to cover the cost the introduction of the Scottish Government's Living Wage of £8.25/hr from 1st October 2016. The cost for non-residential services will be met from the additional resources provided through the £250m Health & Social Care investment which will be applied by the IJB.	15,788,415
Minor variances across services - Small overspend expected in the hire of private vehicles.	123,945
There is a projected underspend in relation to the independent living fund which has been superseded by direct payments. There is therefore no new demand on this budget and as individual services cease for existing cohort, any new services move onto direct payments pathway.	1,144,985
Minor variances across services - No significant variations expected at this time.	48,797
N/A	0
No significant variations expected at this time.	0
No significant variations expected at this time.	-4,645
Additional income expected in relation to Sheltered Housing, offset by reduced income in other Community Care services.	-549,110
No significant variations expected at this time.	0
No significant variations expected at this time.	0
The finalisation of the Resource Transfer Allocation is now complete. The final position is slightly lower than originally anticipated but is offset by minor underspends in other areas.	-6,619,809
	16,250,322

Comments	Prior Year (2015/16) YTD figure at P6
Actual payroll costs at September 2016 are at a comparable level to the same period in September 2015 and as such it is expected that savings will accrue by the end of the financial year. Transformational savings in relation to agency, overtime and mileage have now been applied but these are more than offset by the savings due to vacancies, etc.	2,156,139
Based on the current spending profile, a year-end underspend is anticipated in relation to the furniture and fittings budget and other property costs. This will be monitored throughout the year.	5,898
There are some year to date variances across the budget lines which require to be fully investigated to determine if there are any further procurement savings that can be made. These variances have yet been reflected in the year end position.	50,628
There is currently pressure on residential placements for Looked After Children, which is an area prone to volatility depending on caseload. Based on current levels of spend, an underspend is anticipated within Adoption Allowances and Kinship Payments. Criminal Justice across the partnership has been overspent in the past few years and, whilst measures are ongoing to reduce the level of spend, an overspend is anticipated for 2016/17.	1,960,667
Based on current level of spend a small overspend anticipated in relation to private hire of vehicles.	33,615
The Pathways budget for young people leaving care is running at a lower level than anticipated. There is currently work being done on the payment process around this type of support and the funds being held in the Client Budgetary Account.	209,947
Minor variances across services - No significant variations expected at this time. YTD significantly overspent due to a miscode.	20,071
No significant variations expected at this time.	0
No significant variations expected at this time.	-16,830
No significant variations expected at this time.	0
No significant variations expected at this time.	0
No significant variations expected at this time.	0
No significant variations expected at this time.	0
No significant variations expected at this time.	-256,163
	4,163,972

Health and Social Care Partnership
Projected Outturn at Period 6

Adults and Older People	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Projected Outturn	Projected Outturn Variance	Prior Year Outturn
Integrated Health & Social Care S	82,390	-18,774	101,164	194,847	199,209	-4,362	439,399
Community Care - Services To Adults SA	72,971	35,654	37,317	169,082	97,521	71,561	246,551
Adults SAA	6,075,817	5,905,194	170,623	14,503,947	13,806,493	697,454	14,846,622
Addictions SAAA	-23,465	437,768	-461,233	564,381	658,312	-93,930	582,879
Change Fund Summary SCF	0	155,349	-155,349	0	155,349	-155,349	-138,392
Rehabilitation Services SRO	2,555,376	2,227,513	327,863	5,504,851	5,658,216	-153,364	6,036,787
Resource Services SAR	304,432	325,867	-21,435	717,782	775,469	-57,688	722,000
Resource Services - Day SARD	885,135	800,946	84,189	2,118,408	1,823,588	294,820	1,916,702
Resource Service - Sheltered Housing SARHS	47,180	-7,061	54,241	51,739	-89,118	140,857	-17,244
Homecare Summary SHC	2,428,635	2,544,621	-115,986	6,056,491	6,383,909	-327,417	5,825,916
Supporting People	37,560	28,811	8,749	75,114	75,114	0	75,115
Community Care Services SDA	9,577,849	9,854,070	-276,221	21,635,831	21,742,057	-106,226	20,371,213
Social Work Resources	78,482	0	78,482	156,964	156,964	0	156,964
Social Work Finance	-6,146,710	-6,544,737	398,027	-12,293,366	-12,282,753	-10,613	-10,614,939
Planning & Commissioning SRP	522,940	220,363	302,577	1,089,168	1,101,169	-12,001	1,040,154
Services to Adults - Total	**16,498,591**	**15,965,584**	**533,007**	**40,545,240**	**40,261,498**	**283,742**	**41,489,727**

Children and Families	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Projected Outturn	Projected Outturn Variance	Prior Year Outturn
Children & Families SC	142,408	58,295	84,113	305,353	297,496	7,857	243,165
Children & Young People SDC	1,619,019	1,450,400	168,619	3,437,744	3,432,030	5,714	2,819,137
Criminal Justice SDK	-96,652	91,177	-187,829	-81,617	-59,424	-22,193	-56,609
Childcare Resources SDR	3,668,980	3,096,433	572,547	7,867,554	7,608,926	258,628	6,475,724
Children and Families - Total	**5,333,756**	**4,696,305**	**637,451**	**11,529,034**	**11,279,028**	**250,006**	**9,481,417**

Overall Total	**21,832,347**	**20,661,889**	**1,170,458**	**52,074,274**	**51,540,526**	**533,748**	**50,971,144**

Agenda Item Number: 4

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_04**
Subject Title	**Board Diversity and the Public Sector Equality Duty**
Report By	**Sandra Cairney, Head of Strategy, Planning and Health Improvement** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Kelly Gainty, Adults and Community Care Support Worker** **East Dunbartonshire Health & Social Care Partnership** **0141 777 3311** **Kelly.gainty@eastdunbarton.gov.uk**

1.0	**PURPOSE OF REPORT**
1.1	The purpose of this report is to inform the members of East Dunbartonshire Health and Social Care Partnership Board of their, as members of the Board, and the Partnership's legal duties, to comply with Section 149 of the Equality Act 2010 (The Public Sector Equality Duty) and the Equality Act 2010 (Specific Duties)(Scotland) Regulations 2012.
2.0	**SUMMARY**
2.1	Public authorities are subject to the general duties set out in the Equality Act 2010 (The Public Sector Equality Duty).
2.2	Public authorities in Scotland are subject to specific duties under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 one of which relates to the use of member information (referred to in the Equality Guide as 'board member information' or 'information on board diversity'.
2.3	A guide has been published 'Board Diversity and the Public Sector Equality Duty' which is specifically aimed at those responsible for implementing the Public Sector Equality Duty, particularly of interest to board members and those in charge of holding and using board member information.
2.4	Public authority board members will be required to complete a confidential online data gathering system pertaining to equalities and protected characteristic information.
2.5	The Scottish Government has made a commitment to ensure that those appointed to public boards better reflect the diversity of the Scottish population.
3.0	**RECOMMENDATIONS**
3.1	It is recommended that the HSCP Board: ▪ when invited by Scottish Ministers, complete the online system designed to gather equalities information. ▪ analyse the anonymised information to ensure that it meets the general duties

contained within the Equalities legislation.

- include reference to the protected characteristic of the gender of its board members within its Equalities mainstreaming report.
- report on intended actions and progress within the Equalities mainstreaming report relating to Board diversity.

4.0 MAIN REPORT

4.1 Public authorities are subject to general duties under the Equality Act 2010 (The Public Sector Equality Duty). However, in Scotland, public authorities are further legally obligated to fulfil specific duties as legislated in the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

4.2 The general duties requires the Partnership to have due regard to the need to: eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct; advance equality of opportunity between people who share a relevant protected characteristic and those who do not; and; foster good relations between people who share a relevant protected characteristic and those who do not. The protected characteristics are: Age, Disability, Ethnicity, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Religion or Belief, Sex and Sexual Orientation. The specific duties are:

- Report on the mainstreaming equality duty
- Publish equality outcomes and report progress
- Assess and review policies and practices
- Gather and use employee information
- Use information on members or board members gathered by the Scottish Ministers
- Publish gender pay gap information
- Public statements on equal pay
- Consider award criteria and conditions in relation to public procurement
- Publish in a manner that is accessible.

4.3 The Scottish Government, under this new requirement, will be collecting information on the diversity of public board members. Public authorities will be expected to use this information to increase the diversity of board membership during recruitment and succession planning programmes. As at the end of December 2015 Scotland's board members are reflected as (in comparison to the Scottish population 2011 Census): Female 42% (51.5%); Disabled 11.8% (19.6%); Ethnic Minority 3.5% (4.0%); Aged 49 and under 17.6% (54.3%) and Lesbian, Gay and Bisexual 3.0% (6.0%).Public authorities board member categories of Female, Disabled and Ethnic Minority has, in the main, increased over the last 10 years, however the number of board members categorised as 'disabled' has reduced since 2014/15.

4.4 The new requirement to gather and report on board member information will improve transparency; help to further develop Scotland's board diversity; and create an opportunity to share good practice. Scottish Ministers will decide on the timing of the information gathering however it will take place at regular intervals. Public authorities will be required to use the information better to meet its general equality duties. Public authorities will ensure that information relating to their board members' gender characteristic will form part of their mainstreaming report and will also report on future intended actions to improve diversity.

4.5 A timetable has been agreed as follows:

- Scottish Ministers will invite board members to complete information on their relevant protected characteristics (November 2016);
- Board members will provide their own details using the secure online system

(November 2016);

- Scottish Ministers will make the information on the current diversity of their board members available to public authorities (December 2016);
- Scottish Ministers will publish anonymised national and sectoral level information on the relevant protected characteristics of public authority board members (April 2017).

4.6 An online system will be established and board members will be invited to complete information on relevant protected characteristics (using the online system). Chief Officers/Chief Executives of public authorities will only be able to see a summary of the progress of this information; they will not be able to see protected characteristics of individual board members. The aggregated and anonymised information on the relevant protected characteristics of board members will be made available to each public authority. The data will be held confidentially and only information related to the gender of public board members will be published.

4.7 Public bodies will ensure that, due to the small numbers of board members, no information on protected characteristics will be published in the equalities mainstream report except for information relating to the gender of board members.

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 5

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_05**
Subject Title	**Locality Planning Group Progress Report**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Gillian Notman, Change & Redesign Manager** **East Dunbartonshire Health & Social Care Partnership** **0141 355 2394** **Gillian.notman@ggc.scot.nhs.uk**

1.0	**PURPOSE OF REPORT**
1.1	To inform the Board with an update report on the Locality Planning Groups in East Dunbartonshire.
2.0	**SUMMARY**
2.1	The East and West Locality Planning Groups have met three times. The West Locality Planning group have focused on the following priorities:- ▪ Supporting people with dementia and mild cognitive impairment in their community ▪ Developing positive dialogue with acute on shared experiences of intermediate and continuing care. The East Locality Planning group's priorities are:- ▪ Prevention and early screening for cancer. ▪ Supporting people who are housebound in the community ▪ Outcomes of discussions and actions report into the Strategic Planning Group.
3.0	**RECOMMENDATIONS**
	It is recommended that the Health and Social Care Partnership Board ▪ Note the content of this report.

4.0 MAIN REPORT

4.1 East Dunbartonshire has two locality groups which have been established in geographical areas.

4.2 West Locality is defined as including the towns and villages of:-

- Bearsden
- Milngavie
- Bardowie
- Baldernock

4.3 The East Locality is defined as including the towns and villages of:-

- Kirkintilloch
- Bishopbriggs
- Torrance
- Lenzie
- Lennoxtown
- Milton of Campsie
- Twechar
- Balmore

4.4 These two locality groups have now met three times. They have representation from general practice, primary care, secondary care, housing, social work, third sector, voluntary originations, service users and carers.

4.5 In an initial workshop, an assessment of need was carried out which explored service and community strengths and potential gaps in service delivery. This information formed the baseline for discussions with each locality to help them prioritise what areas they wanted to begin to work on to help make a difference within their community.

West Locality Group

4.6 The group focused on dementia. Data suggests that the number of older population is rising and that the trend for diagnosing dementia is increasing year on year. Dialogue between the memory consultant and GPs suggested routes where there could be better referral pathways as well as more support with GPs on initial screenings. Dealing with a cohort of people who have mild cognitive impairment (MCI) but not a diagnoses of dementia, was an area which the group felt they wanted to proactively support community capacity by forging better connections between the partners. The emphases on linking in with current services, particularly those who have strong self management approach have been highlighted as a useful model to help support clients and their carers.

4.7 Concerns about the model and access to day care services were an area which the group wanted to improve. Through dialogue with service leads, the backlog of referrals to these centres has been addressed. Moving away from the traditional model towards one which focuses on matching individual into services including community capacity is a key theme for these discussions. There are positive developments around emulating the memory joggers groups which have been working within Glenkirk, into a community setting.

4.8 Tentative links with housing are underway. The group would be keen to have active

dialogue with planners, particularly around local developments of care homes. Influencing their local development plan would be welcomed.

4.9 Developing positive dialogue with acute consultants has begun with our shared experiences of intermediate and continuing care.

East Locality Group

4.10 Inequalities was the main focus initially, however this was then honed down into exploring issues and developments on cancer screening. Whilst these discussions at still at a high level, the group are keen to explore more data at a practice level to ascertain how they can collectively engage with those people whose uptake of screenings is poor. Care after cancer treatment has been a theme with emphases on using social prescribing as a means of supporting wider rehabilitation. There are plans to make links with Practice Nurses and the Walking Programme Coordinator to facilitate better pathways between the hospital and the community. Establishing links with the local cancer prevention group are underway.

4.11 Engaging with housebound clients has raised some inequalities and is an ongoing theme. Examples on how some voluntary services are dealing with isolation and loneliness will be discussed at the later date.

4.12 At our next meeting the locality groups will aim to reflect where we have got to in relation to the strategic plan, what we would like to influence and make a difference and propose future areas for consideration in the next year.

Agenda Item Number: 6

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_06**
Subject Title	**Chief Social Work Officer Report 2015/2016**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Paolo Mazzoncini, Chief Social Work Officer** **East Dunbartonshire Health & Social Care Partnership** **Paolo.mazzoncini@eastdunbarton.gov.uk** **0141 201 3553**

1.0	**PURPOSE OF REPORT**
1.1	The purpose of this report is to present the Chief Social Work Officer's (CSWO) Annual Report to East Dunbartonshire's Health and Social Care Partnership.
2.0	**SUMMARY**
2.1	Each year, the CSWO is required to produce a summary report advising the Council of performance in relation to the discharge of statutory duties and responsibilities, as well as the functions of the CSWO. With the commencement of the Public Bodies (Joint Working) (Scotland) Act 2014, this reporting arrangement was extended to include Integration Joint Boards (IJBs).
2.2	The Chief Social Work Advisor to the Scottish Government developed a standardised framework for reporting in order to ensure consistency across Scotland. This report utilises that framework and provides the annual report for the period 1st April 2015 to 31st March 2016. (**Appendix 1** provides the summary Annual Report).
2.3	The information contained within the report reflects the key matters affecting Social Work Services over the reporting period.
2.4	This report was considered by East Dunbartonshire Council at the full Council meeting on 10th November 2016.
3.0	**RECOMMENDATIONS**
3.1	It is recommended that the Health and Social Care Partnership Board: ▪ Notes the content of the report.

4.0 MAIN REPORT

4.1 Local authorities are legally required to appoint a professionally qualified Chief Social Work Officer under section 3 of the *Social Work (Scotland) Act 1968*. The overall objective of the CSWO is to ensure the provision of effective professional advice to local authorities in relation to the delivery of social work services as outlined in legislation. The statutory guidance states that the CSWO should assist local authorities and their partners in understanding the complexities and cross-cutting nature of social work service delivery, as well as its contribution to local and national outcomes.

4.2 Key matters such as child protection, adult protection, corporate parenting and the management of high risk offenders are covered in this report. The report also provides information relating to the following:

- Summary Reflections - Key Challenges and Developments;
- Partnership Structures/Governance Arrangements;
- Social Services Delivery Landscape;
- Finance;
- Service Quality and Performance;
- Delivery of Statutory Functions;
- User and Carer Empowerment;
- Workforce Planning and Development; and
- Improvement Approaches.

Appendix 1

Annual Chief Social Work Officer Report

October 2016

CONTENTS PAGE

1. Summary Reflections – Key Challenges and Developments

This report focuses on the period 1 April 2015 to 31 March 2016 and covers the range of activities undertaken by social work services in East Dunbartonshire Council.

This last year has been a challenging one. We have faced increasing demand for children and adult social work services at a time when public finances have been significantly constrained. The complexity of service users' personal situations has also changed. In many cases, service users who engaged with social work services presented with numerous needs often linked to poor mental health, addiction, poverty and deprivation. It is evident that these pressures and their combined effects will continue to pose serious challenges in the coming years. Audit Scotland in its report, *Social Work in Scotland* (2016) echoed these points, noting:

> '*Councils' social work departments are facing significant challenges because of a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies. If councils and IJBs continue to provide services in the same way, we have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase).*'
> (see http://www.audit-scotland.gov.uk/report/social-work-in-scotland)

Legislative changes have brought new challenges too. Developing our services to meet the requirements of the *Children and Young People (Scotland) Act 2014*, for example, has meant a re-imagining of what our services need to do differently and better. We have worked closely with our partners, notably in education, health, Police Scotland and the Scottish Children's Reporter's Administration, to ensure that we are in a good position to implement the requirements of the Act. Importantly, we have agreed key processes for sharing information, developing the Child's Plan, expanding our Corporate Parenting practice but we recognise that we have further work to do. Reshaping our services to meet the policy imperatives around Continuing Care, Aftercare and Children's Rights will be key areas of development in 2016/17.

The *Public Bodies (Joint Working) (Scotland) Act 2014* focused our attention on health and social care integration. It was passed by the Scottish Parliament in February 2014 and came into force on 1 April 2016. In East Dunbartonshire this led to the development of an Integration Joint Board, to which the Council and NHS Greater Glasgow and Clyde delegated key functions and responsibilities. Adult care services are now delivered in partnership under the auspices of East Dunbartonshire's Health and Social Care Partnership. Much of our work in 2015/16 was taken up with transition planning and putting in place the supporting structures and processes to make this a successful endeavour. Whilst these arrangements are now working effectively, we recognise that further work will be required over the coming years around workforce planning, service redesign and delivering better outcomes for service users.

We have also seen similar changes in the governance and planning of criminal justice services with the introduction of the *Community Justice (Scotland) Act 2016*. This Act transfers responsibility from Scotland's eight Community Justice Authorities (CJAs) to thirty-two Community Planning Partnerships (CPPs) on 1st April 2017. Criminal Justice Services within East Dunbartonshire Council area continue to be delivered as part of a wider Criminal Justice Partnership (CJP) between East and West Dunbartonshire and Argyll & Bute Councils. A significant degree of planning and action with partner agencies was undertaken in 2015/16 to ensure that new and robust arrangements would be in place. As required by the legislation, a transitional plan was collated, approved by the CPP and forwarded to the Scottish Government who indicated that they were content with the plan. There are challenges for criminal justice services too in the coming years. The changes to legislation enabling the automatic early release of long term prisoners and the expansion of the Multi Agency Public Protection Arrangements to include '*certain high risk offenders who are assessed by the responsible authorities as posing a risk of serious harm by reason of their conviction*' (see http://www.gov.scot/Publications/2016/03/6905/0) will require a review of our processes and practice.

Social work services in East Dunbartonshire have met these challenges head-on. There has been progress on a number of practice fronts. Notably we have:

1. continued to provide a range of resources to support vulnerable children, young people and adults in a time of austerity;
2. developed our Kinship Care Policy and Procedures to ensure that carers are fully embraced and supported in East Dunbartonshire;
3. established the Functional Family Therapy service to support social work staff undertaking complex holistic assessments and interventions with troubled young people and families;
4. maintained high standards across our registered services; achieving an "*Excellent*" grading for the quality of our Home Care Service and '*Very Good*' grades for our Residential, Fostering and Adoption, and Community Support services;
5. pooled the funding from the Scottish Government to the Criminal Justice Partnership - in association with three Community Planning Partnerships - to employ a Transitional Planning Officer to help deliver on the key requirements of the new Act. The funding was also used to support a number of related activities such as awareness-raising events and development days.
6. increased the use of self-directed support (SDS) across East Dunbartonshire. We have seen an increase in the number of customers, older people in particular, who are choosing to utilise SDS option 2 as their preferred choice for implementing their support plan;
7. contributed to the development of a Recovery Orientated System of Care (ROSC) with the Alcohol and Drug Partnership;
8. reviewed our practice to promote easier access to services, as part of the East Dunbartonshire Alcohol and Drug Service, and strengthened our work together in relation to children affected by parental substance misuse;
9. significantly reduced the number of bed days lost (delayed discharge) by focusing our Hospital Assessment Team on the early identification of need and the appropriate targeting of available resources;
10. revised our information systems to better record Adult Support and Protection concerns;
11. continued to ensure staff are suitably trained to meet the practice challenges present.

2. Partnership Structures/Governance Arrangements

There has been significant change in our partnership and governance arrangements. On 5 March 2015, East Dunbartonshire Council approved an Integration Scheme to facilitate the establishment of the East Dunbartonshire Health & Social Care Integration Joint Board (IJB) by Parliamentary Order. The report to Council set out an indicative timeline for the empowerment and delegation of powers to the full Integration Joint Board. After Council approval of the Integration Scheme, it was then submitted for approval to the Scottish Government on 6 March 2015. This approval was given and on the 3 September 2015 the Integration Joint Board began its work proper.

It should also be noted that during the period covered by this report (April 2015-March 2016), Children and Families and Criminal Justice Social Work Services were part of East Dunbartonshire's Education and Children's Services Directorate, whilst adult social work services were part of East Dunbartonshire's Health and Social Care Partnership (HSCP). However in May 2016, the decision was taken by the Council and NHS Greater Glasgow and Clyde to transfer Children and Families and Criminal Justice services and NHS Children's Services to the HSCP. This was subsequently approved by the Cabinet Secretary for Health and Sport on 5 July 2016 and given effect by the HSCP Board on 11 August 2016.

This report therefore reflects a period of time when adult social work services were partly managed through the Council's organisational structure and then subsequently through the Health and Social Care Partnership structures. This report also focuses on the contribution made by Children and Families and Criminal Justice Social Work Services whilst still located in the Council's Education and Children's Services Directorate. The next Chief Social Work Officer's report in 2017 will cover in more detail the organisational changes affecting Children and Families and Criminal Justice Services that occurred late this year.

The requirement for every local authority to appoint a professionally qualified Chief Social Work Officer (CSWO) is contained in section 3of the *Social Work (Scotland) Act 1968.* The overall objective of the CSWO

is to ensure the provision of effective professional advice to local authorities in relation to the delivery of social work services. The *Public Bodies (Joint Working) (Scotland) Act 2014* provides for the delegation of certain social work functions by a local authority to an integration authority. The CSWO's responsibilities in relation to local authority social work functions continue to apply to functions which are being delivered by other bodies under integration arrangements. However, the responsibility for appointing a CSWO cannot be delegated and must be exercised directly by the local authority itself.

In East Dunbartonshire Council the duties of the Chief Social Work Officer (CSWO) are discharged by the Head of Children and Families and Criminal Justice. Within the Council there are clear structures and processes that enable the CSWO to fulfil the role and function. The CSWO has been able to help shape the broader planning agenda for social work within the Council, the Health and Social Care Partnership and the Community Planning Partnership. The CSWO has also had the opportunity to influence budgetary decisions to ensure the needs of vulnerable adults and children are met and resources are deployed effectively.

The CSWO attends a range of key partnership meetings including the Child Protection Committee, the Adult Protection Committee, the Delivering for Children and Young People Partnership (DCYPP), the Health and Social Care Partnership Board and the Multi Agency Public Protection Arrangements Strategic Oversight Group (MAPPA SOG). In 2015, a key area of development was the establishment of a Public Protection Group. This CSWO-led group focuses on common areas in policy, procedures and practice across child protection, adult support and protection, and the management of high risk offenders (via MAPPA). Particular attention had been given to risk assessment and risk management practices. The group began work on multi-agency protection-based audit and developing training for managers and workers. However, changes in the CSWO position meant that this area of work was not progressed significantly during 2016. That said, there is a strong commitment to doing so in this coming year.

The CSWO is a non-voting member of the HSCP Board. The post holder is also a core member of the Professional Advisory Group (PAG). Its purpose is to provide a source of expert professional health and social care advice to the HSCP Board, linking the Board to professionals within health and social work, including the General Practitioner (GP) Forum. The PAG provides professional expertise to inform planning, the identification of priorities and the redesign of service provision. It also ensures that all staff are registered on the appropriate professional Register, undertake training and development and are fit to practice. The PAG supports the delivery of the national outcomes and relevant health and social care quality and safety standards, and assures the HSCP Board that professional assurance frameworks are implemented. Professional leads bring areas of concerns and ideas about development, quality improvement and safety to the Group. The PAG has direct responsibility for the Clinical and Care Governance Group and the Training and Practice Development Group. The Clinical and Care Governance Group addresses health and social care aspects of governance to ensure that service delivery to the population of East Dunbartonshire is safe, effective and person-centred. The CSWO is also a member of this Group.

There are also a number of sub groups where the CSWO is represented. Each of the sub groups consider a range of performance information (qualitative and quantitative) and collectively provides an overview of the way statutory duties are discharged.

The CSWO reports to the Strategic Service Committees and Council meetings on key matters affecting social work services. Topics covered have included proposed changes to legislation, policy and procedure, inspection activity as well as performance reporting. Elected members are kept appraised of important developments in social work. The Social Work Committee meets on an eight-weekly basis and this provides an important forum for detailed discussion on a range of social work matters.

Recent Stakeholder Engagement (Your Services, Your Choices) activity has focused on working with local community groups and the wider East Dunbartonshire public through a large-scale survey and focus groups to identify local budgetary priorities and options for future public service delivery.

3. Social Services Delivery Landscape

East Dunbartonshire lies to the north of Glasgow and has a population of 106,960. The Council covers a geographical area of 77 square miles and is in the mid-range of Scottish local authorities. East Dunbartonshire

is recognised as an excellent place to live based on health, life expectancy and school performance. Major inequalities exist across the authority with pockets of significant deprivation. Recent analysis of local data confirms a continuing gap in equalities between our most and least deprived communities.

In terms of population in East Dunbartonshire, the mid-2015 population estimates show 61% are of working age, 17% under 16 years of age and 22% of pensionable age. Recent projections suggest that the population of East Dunbartonshire Council will decline by 6.8% over the next 25 years. Significantly, the number of children (aged 0-15 years) is projected to decrease by 13.4 % during this period, whilst the population of pensionable age is expected to rise by 25.4%. The working age population is predicted to decrease by 17.2%. The highest population increase will be seen in those aged 75 and over with a predicted increase of 93%.

The Council has a diverse community, with 4.2% of the population regarding themselves as being from a Black/Minority Ethnic Community (BME) according to figures from the 2011 Census. The Indian community is the largest group within the BME community.

East Dunbartonshire is, in the main, a prosperous area where employment rates are high and levels of crime fall significantly below the Scottish average. That said, there are pockets of deprivation where major inequalities exist and the quality of life falls below the national average. Within the authority, seven data zones fall into the top 25% most deprived in Scotland. These data zones are located in Hillhead, Lennoxtown, Auchinairn and Kirkintilloch West. The Scottish Index of Multiple Deprivation (SIMD) ranks in the Hillhead area have improved with two datazones moving out of the 5% most deprived in Scotland and the majority of datazones showing less deprivation than in SIMD 2012. However, Hillhead remains the most deprived area in East Dunbartonshire, with one datazone in the top 10% most deprived in Scotland; the same datazone also appears in the top 5% most deprived in the Health domain. This picture presents a significant challenge for the service.

East Dunbartonshire's social work services have operated within a landscape that has been significantly affected by austerity, changing demographics, increasing demand for services, new legislative and policy imperatives and the increasing complexity of risk/need. The economic downturn has resulted in financial constraint for East Dunbartonshire Council, as it has done for many other Scottish local authorities and public bodies. In adult services, there have been – and continue to be – particular concerns relating to increasing demand on services for older people, for those individuals with a learning disability and for those people with substance misuse and mental health difficulties. In children services, we have seen a rise in the numbers of vulnerable children coming to the attention of social work services. This is demonstrated by increased numbers of children on the child protection register, a growth in the numbers of children who require to be looked after and an upsurge in the numbers of vulnerable children in need of social work interventions. Similarly in the field of criminal justice, the introduction of Community Payback Orders has resulted in initial increases to the number of disposals from Court.

In terms of the market place itself, in 2015/16, East Dunbartonshire Council and the Health and Social Care Partnership provided 32% of the services available with 68% commissioned from the private sector and voluntary sector. The HSCP undertook a strategic commissioning approach in 2015 and involved local third sector, private and not-for-profit bodies in that process. Service users, carers groups and other stakeholders were engaged throughout that process too. Whilst there has been progress on this front, there is more to be done to ensure that all partners are fully involved in future developments and that co-production is embedded in service re-design/development.

4. Finance

Managing public sector austerity and reducing financial resources, within a climate of increasing demand for services is a key risk area for the Council. Like other local authorities, East Dunbartonshire Council has faced increasingly difficult financial challenges over recent years, and the reduction in public sector budgets will continue over the next financial planning period (3-5 years). The most significant uncertainties to the delivery of service objectives are:

- *The demographics associated with an ageing population* – care budgets face on-going pressure. This still remains a significant challenge to be addressed.

- *Complexity of care required* – There are numerous areas where complex care packages are required and these are costly to deliver. There are examples in child protection; in working with children/young adults with significant mental health problems and a history of self-harm; and with offenders who pose significant risk of serious harm to the public.
- *Inflation* – limited provision is available to address price movements. Containing spend pressures will be difficult in areas like care fees, recycling costs, utility costs etc.
- *Scottish Government funding* – Council specific information on the levels of revenue grant funding is not available beyond 2016/17. This uncertainty is having an impact on forward planning.
- *Welfare reform* – provision has been made for services and income sources related to Welfare Reform. Discretionary Housing Payment and Universal Credit are key factors. The reforms are still being rolled out nationally, and the impact in future years is uncertain.

The approved 2015/16 Revenue Budget for East Dunbartonshire Council had to incorporate a range of outcomes, which the Scottish Government wanted to achieve, that included:

- Continuation of the freeze to Council Tax at levels set in 2007;
- Maintenance of teacher numbers in line with pupil numbers and probationer places;

If a Council did not agree to the package of commitments, its Grant funding would be significantly reduced. Even with these additional resources, the gap between the Cost of the Current Level of Service (CCLS) and 2015/16 available funding was £2.712m. Measures to address this gap are contained in East Dunbartonshire Council's "Strategic Planning and Performance Framework 2015/16 – 2017/18: Transformational Change and Budget Reduction Strategy" which considers alternative models of service delivery and workforce planning.

The Council continued to work with Greater Glasgow and Clyde NHS Board (NHSGGC) during 2015/16 and, as noted earlier, the East Dunbartonshire Health and Social Care Partnership (HSCP) commenced for Adult Services on 3 September 2015. During 2015/16, a due diligence exercise was carried out to consider the sufficiency of the budget provided for the partnership by the Health Board and the Council. This identified significant financial pressure in relation to adult social care packages which have been the subject of regular reports to the IJB. This culminated in an agreement from the Council that in the first year, there would be an underwriting of reported pressures from Council reserves. The Council is committed to working in partnership to ensure the success of the HSCP in the delivery of integrated services to the people of East Dunbartonshire.

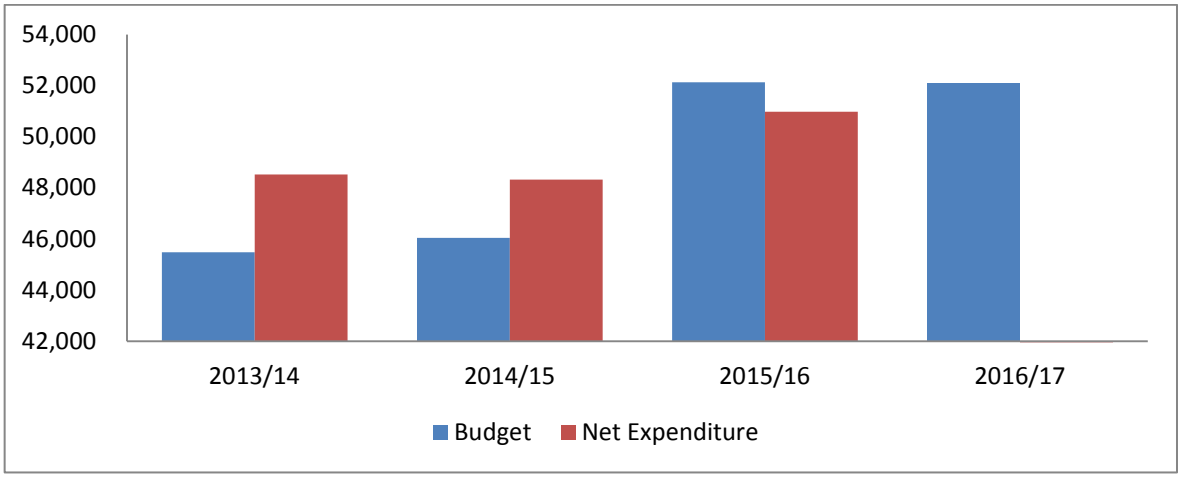
Financial governance arrangements have been developed to support the IJB in the discharge of its business including financial scoping, budget preparation, standing orders, financial regulations and the establishment of an Audit Committee to ensure the adequacy of the arrangements for risk management, governance and the control of the delegated resources.

Financial Trends

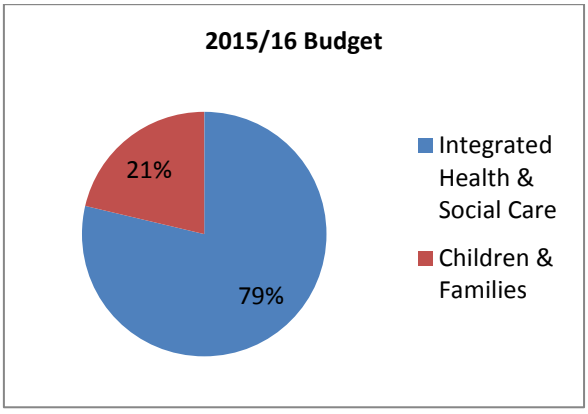
The elderly demographic within East Dunbartonshire continues to present the greatest risk on care budgets supporting older people to remain within their own home or in residential care.

The table and graph below highlight the impact these demographic pressures and the national delayed discharge policies are having on Social Work expenditure. The pressures are recognised by the Council and additional resources are being incorporated into the budget allocation each year. However the rate of acceleration of demand risks is outstripping available resources for older people services. Additional monies allocated to the 2015/16 budget provided some alleviation of pressures for Children and Families budgets (1,5m underspend in 2015/16 as a result of vacancies across the service and reduced demand in respect of residential placements), however adult and older people budgets continue to experience pressure (£0.4m overspend in 2015/16 primarily relating to care home placements for older people).

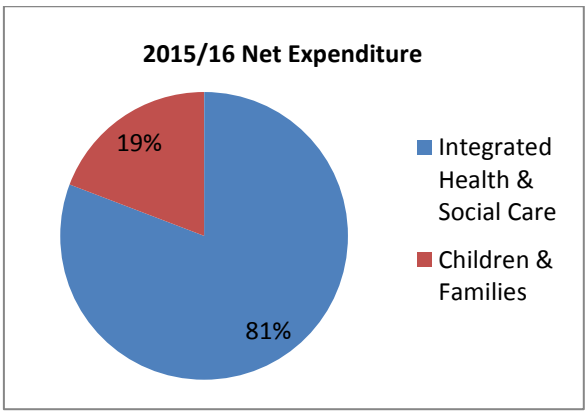
	£000	£000	£000
Social Work	2013/14	2014/15	2015/16
Budget	45,478	46,043	52,133
Net Expenditure	48,524	48,324	50,972
Variance	(3,046)	(2,281)	1,161



The largest budget increases from 2013/14 to 2016/17 relate to residential accommodation for older people, direct payments as a Self-Directed Support (SDS) option, homecare and supported accommodation for adults with a learning disability.



Despite these budget increases, for 2015/16 the reported overspend for adult services can be attributed to the same adult service areas. Children and families budget performance for 2015/16 was more favourable overall, with reported underspends in employee costs and agencies and other bodies. The successful introduction of new models of care have supported a positive shift in the balance of care and assisted in supporting more children and young people within the community.



The adult social work service has analysed financial pressures and trends and has undertaken service re-design in the provision of Homecare by focusing on complex care and re-ablement. There have been measures to contain costs by reviewing eligibility criteria and introducing charging for some services.

The table below provides more detail on the areas of service provision experiencing the greatest pressure.

2015/16	Budget £000	Spend £000	Variance £000	Category
Homecare Private Providers	4,523	4,493	30	Mainly Older People
Residential Accommodation	13,861	15,154	(1,293)	Mainly Older People
Supported Accommodation	7,211	6,997	215	Mainly Learning Disability
Direct Payments	3,378	3,048	330	Mainly Older People
Day Care	3,039	3,138	(99)	Mainly Learning Disability
Supported Living	4,789	5,027	(238)	Mainly Learning Disability
			(1,056)	
Other Variances			2,217	Payroll Surplus across SW and reduced demand on residential schools
Reported Underspend			1,161	

The Council has progressed early intervention in many ways including the "Place Agenda", focusing resources on areas of deprivation. During 2014, a new-build community facility opened in Hillhead, an area of multiple deprivation, and has developed over the period. A range of early intervention approaches have led to significant reductions in the number of children referred to the Children's Hearing System, a speedier response to families affected by domestic abuse and a more coordinated response to vulnerable pregnant women. Work with community groups and families are planned and on-going. Also in 2015 we developed a new service to deliver Residential Respite and Short Break Services for children and young people with disabilities.

The Council carried out a Budget Stakeholder Consultation to understand community priorities to be considered during the process of updating its long term financial strategy. Feedback clearly demonstrates the priority associated with Social Work Services. Accordingly, officers are developing options for securing appropriate service provision to vulnerable clients, mindful of the challenges of on-going financial constraint. Options will be developed and taken forward in partnership with other statutory agencies.

The East Dunbartonshire Council website contains a wide range of committee reports, which are available to the public. Reports of interest in providing an overview of the financial plans and performance include:

CE/02/15/GC Strategic Planning & Performance Framework 2015/16-2017/18: General Fund Revenue Budget 2015/16

CST/027/16/AD	Strategic Planning & Performance Framework 2016/17-2017/18: Transformational Change and Budget Reduction
EPB/113/16/MD	East Dunbartonshire Council Audited Annual Accounts 2015/16

5. Service Quality and Performance

East Dunbartonshire Council and the Health and Social Care Partnership have robust performance monitoring, management and quality assurance systems in place. Social work services report on a monthly, quarterly, six monthly and annual bases. At a community planning partnership level, there are also effective arrangements in place to report on performance and measure the quality. Performance reports are presented quarterly to the Community Planning Executive Group (Chief Officer's Group: COG) and thereafter to the Community Planning Partnership Board. Responsibility for performance is located with the Delivering for Children and Young People's Partnership (DCYPP), the Child Protection Committee (CPC), the Adult Protection Committee (APC) and the MAPPA Strategic Oversight Group (SOG). Each group is required to provide accountability reports alongside associated improvements plans. This approach takes account of commissioned services which are also subject to regular review.

Performance management systems utilise a range of data that informs the deployment of resources and the development of services. This includes:

- statistical data highlighting patterns and trends
- outcomes from quality assurance activity
- the outcome of casefile audits – both thematic and case specific
- consultation activity involving service users and carers
- benchmarking activity
- the outcome of external inspection by the Care Inspectorate

A culture of self-evaluation and continuous improvement has been embedded across all services**.** A coordinated approach has seen the implementation of outcome-focused assessment and care planning. A programme of systematic case file audits has been one of a number of tools which have secured improved standards. Supervision and training remains a key priority to ensure our staff are supported to maintain the knowledge and understanding required to deliver on our statutory functions.

Social work services continue to make a substantial contribution towards achieving local and national outcomes. East Dunbartonshire social work services collaborate with partners in planning, delivering and evaluating these outcomes. It should be noted that a number of these services are delivered in joint teams, i.e. with staff from health and social work services. Joint planning is strongly established and formal joint action plans are in place within Older People Services, Drug & Alcohol services, Learning Disability and Mental Health services, and for Carers. Common themes which inform these plans include a focus upon outcomes, a commitment to improving the balance of care, a systematic approach to risk, and a vision of the service user and carer at the centre of all activity, with maximum opportunities for self-direction, self-management and co-production.

Within adult services, a standing Community Care Improvement Group (CCIG) oversees a programme of continuous self-evaluation and focused improvement across all adult services. Central to its operation is an annual Case File Audit, now in its fourth year of operation. Improvements have been demonstrated in key areas such as chronologies and the quality of assessments. Main areas of current focus for the group are: outcome focused protection plans; the development of local procedures to reflect recent Mental Welfare Commission guidance on proxy powers; the revision of Risk Assessment and Management (RAMP) procedures and an associated training programme.

Over 2015-16 we have observed an on-going rise in the number of individuals utilising the Self Directed Support Option 2 - where the individual exercises choice over the type of support they want and how it will be delivered but asks the local authority to arrange it - as their preferred choice. We started the year in April 2015 with 10 customers and finished the year in March 2016 with 65 customers. This proved attractive to individuals as it gave them choice but no requirement to financially administer their individual budget. We

also continue to see a slow, steady increase in the types of support of a more creative/innovative nature being sourced by social work practitioners in partnership with customers, carers, families and third sector organisations. We have been working closely with our third sector organisations building capacity and providing training for Personal Assistants who are directly employed by direct payment recipients. Through the 'Get Onside' project our local advocacy service has developed a creative way of capacity building. They have delivered courses to adults with physical and/or learning disabilities and more recently older children from one of the local special needs schools in East Dunbartonshire. We have also worked closely with our independent SDS support service in delivering training courses for Personal Assistants. This training included First Aid, Moving and Assistance as well as sessions about SDS and equality awareness.

East Dunbartonshire's Joint Learning Disability Team worked with approx. 400 people with a diagnosed learning disability in 2015/16. There is a range of local services available to individuals including supported accommodation properties, residential services, respite services, day care, and a framework containing a number of nationally recognised care providers delivering varying levels of support to our service users. The team is supported by a number of professionals from other health disciplines such as Psychiatry, Psychology, Physiotherapy, Dietetics and Speech and Language who although not permanently situated in the team are available for support and assistance. The learning disability services and resources available to local citizens have been to a high standard. Services such as supported accommodation, respite, daycare and residential services have on the whole provided a continuum of support to service users and carers ranging from signposting of simple information to 24-hour care encompassing all aspects of physiological, emotional, intellectual and social support.

East Dunbartonshire's Alcohol and Drug Partnership (ADP) has been instrumental in developing the Recovery-Orientated Systems of Care (ROSC). Work has included the development of a 'Relapse' protocol to provide a safe and supported route back into treatment services so individuals can continue on their road to recovery. Recovery Communities are emerging which form part of the ROSC.

Alongside this, the East Dunbartonshire Alcohol and Drug Service (EDADS) has focused its work on three main areas around improving access to services, strengthening the protocols around services for *Children Affected by Parental Substance Misuse* (CAPSM) and *Special Needs in Pregnancy* (SNIPS) and promoting the alcohol clinic for people with alcohol related difficulties. During 2015/16, EDADS re-organised access to duty services to promote walk in services putting the emphasis on building motivation, reducing harm, access to peer recovery services in the community and promoting family inclusive practice. Service users with more complex health needs were referred by GPs to be screened by nurses in the team. Completion rates of assessment improved dramatically for walk in referrals. EDADS and Children and Families Social Work services worked closely together. EDADS also linked to SNIPS through the Senior Practitioner in the team. This service adopts and early intervention model for vulnerable pregnant women. The Senior Practitioner acts as the link with the whole health and social work/care team to share information and co-ordinate actions.

Major work has been undertaken to modernise our care at home services. The Home Care Review aligned to the Council's vision, principles and values and promotes service development and improvement. The central aim was to deliver a more effective, efficient, flexible and cost effective service. Home Care Re-ablement is now provided in all geographical areas of the Council; promoting person centred care and realising potential. The Home Care team achieved an Excellent grading for the Quality Theme Care and Support at the most recent Care Inspection in 2016.

The Hospital Assessment Team's performance against hospital discharge targets has continued to improve. In 2014/15 a total 4,916 bed days were lost to delayed discharge; this figure improved to 3,636 in 2015/16. The team received more than thirty referrals on average each month. Consistently, for more than 60% of people referred, discharge was achieved before a person's discharge appeared on EDISON delayed discharge recording. Whilst delayed discharge continues to be subject to both seasonal and non-seasonal fluctuation, our EDISON delayed discharge performance has improved further this year as a consequence of our sustained focus upon earlier identification and targeting of available resources.

The Council's Adult Intake Service continues to provide a high quality service as a first point of contact for all new adult social work referrals. The team receives and screens all initial Adult Support and Protection / Concern referrals. The team consistently received more than 200 new referrals each month in the period. The

care pathway for service users moving from the adult intake to receiving adult social work teams has improved and restructuring of some team roles should consolidate improved performance and reduced waiting times across the second part of the coming financial year.

The tables below provide a brief overview of the success we have had in meeting the National Health and Wellbeing Outcomes.

People are able to look after and improve their own health and wellbeing and live in good health for longer

National Core Indicator	2013/14	2015/16
Percentage of adults able to look after their health very well or quite well	97%	95.1%

HSCP Performance Measure	2015/16Target	Actual (Mar 2016)
Number of alcohol brief interventions delivered	487	625
Rate of drug related deaths (per 100,000 pop per year) (2014)	1.9	3.7
Rate of alcohol related deaths (per 100,000 pop per year) (2014)	25	15.6
Percentage of clients will wait no longer than 3 weeks from referral to alcohol and drug treatment (Oct - Dec 15)	91.5%	70.5%

People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

National Core Indicator	2013/14	2015/16
Percentage of adults supported at home who agree that they are supported to live as independently as possible	82%	88.3%
Percentage of adults supported at home who agree that they had a say in how their held, care or support was provided	76%	86%

HSCP Performance Measure	2015/16 Target	Actual (Mar 2016)
Rate of unplanned acute bed days 75+ (per 1,000 pop) (Rate at quarter end)	392	372
Number of emergency admissions 75+ rate (per 1,000 pop) (Rate at quarter end)	29	33
Number of acute bed days lost to delayed discharge	3684	3636
Number of acute bed days lost to delayed discharges for Adults with Incapacity (aged 65+)	1596	569
People with a diagnosis of dementia on the QOF register (as at Feb 16)	950	767
Number of newly diagnosed people with Dementia in receipt of one year's post diagnostic support	100%	100%
Number of people 65+ with anticipatory care plans in place (GP & District Nursing)	75	216
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	90%	98.4%

Rate of alcohol related admissions (per 1,000 pop – rolling year)	4.8	4.4
Number of people aged 65+ in permanent care home placement	640	674
Number of people 75+ with a telecare package (Feb'14)	188	176
Percentage of people 65 or over with intensive needs receiving care at home (Percentage at quarter end)	32%	38.1%
Percentage of EDC homecare customers 65+ receiving a service during evenings or overnight	50%	50.9%
Percentage of EDC homecare customers 65+ receiving service at weekends	84%	90.2%

People who use health and social care services have positive experiences of those services, and have their dignity respected

National Core Indicator	2013/14	2015/16
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	75%	74.7%
Percentage of adults receiving any care or support who rate it as excellent or good	82%	84.2%
Percentage of people with positive experience of care at their GP Practice	91%	91.1%

HSCP Performance Measure	2015/16 Target	Actual Mar 2016
Percentage of Adults with a direct payment in the month who use this to fund personal care	80%	78.6%

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

National Core Indicator	2013/14	2015/16
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	83%	86.3%
HSCP Performance Measure	**2015/16 Target**	**Actual Mar 2016**
Percentage of people 65+ indicating satisfaction with their social interaction opportunities	93%	100%
Percentage of service users satisfied with their involvement in the design of their care packages	95%	100%
Percentage of service users satisfied with the quality of social care provided	99%	100%

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

National Core Indicator	2013/14	2015/16
Percentage of carers who feel supported to continue in their caring role	39%	44.7%

HSCP Performance Measure	2015/16 Target	Actual Mar 2016
Number of carers who feel supported and capable of continuing in a caring role	94%	100%

People who use health and social care services are safe from harm

National Core Indicator	2013/14	2015/16
Percentage of adults supported at home who agreed they felt safe	83%	86.5%

In 2015/16, the Education and Children's Services Directorate delivered crucial services to children, families, carers, vulnerable people and the wider community of East Dunbartonshire. The Business Improvement Plan was focused on:

- *Local Outcome 3- Our children are safe, healthy and ready to learn.*

Children and Families Social Work Services and Criminal Justice made good progress in delivering a high quality social work service to the most vulnerable in our community. We also maintained robust systems to deal with those adults known to pose significant risk to our community. In this regard, we demonstrated continuous improvement at both operational and strategic levels.

The most recent Care Inspectorate inspection of the Fostering and Adoption Services was very positive and the service was awarded grades of good and very good across all areas inspected. Other inspections have taken place within East Dunbartonshire's residential unit for children and young people, Ferndale, and the Family Support Team. Both of these services were issued with a letter of congratulation by the Convener of the Social Work Committee as recognition of the sustained high quality of service delivery to and for young people across EDC.

Ferndale Children's Residential Unit continued to offer a high quality service to some of our most vulnerable children and young people. Staff remain child centred and successfully created a warm and nurturing environment within the unit. As noted in the most recent inspection, children's views are listened to and respected. The delivery of the Ferndale Outreach Service continued to contribute to the positive shift in the balance of care. This service supports children and young people in their transition from the Unit to home or to independent living. Additionally support is provided to children and young people who are at risk of homelessness, in order to allow them to remain at home safely. The service provides flexible and responsive care to our most vulnerable families assisting many parents to develop the skills necessary to safely provide care and support for their children.

In 2015/16, the Family Support Team provided a range of supports for our most vulnerable families through a flexible and responsive service. The support they provided included emotional and practical support for families; individual work with children; supervised contact; monitoring/check visits; supporting education; undertaking safety audits, and providing community-based supports.

At a strategic level, we continued to make good progress in relation to the delivery of early intervention arrangements for children affected by domestic violence (NORM: Non Offence Referral Management), for children at risk of offending (EEI: Early and Effective Intervention) and in respect of women who experience vulnerability in pregnancy (SNIPS: Special Needs In Pregnancy Service). These multi-agency arrangements have been successful in identifying and responding to concerns at a much earlier stage. New procedures have been implemented which support staff with the management of sexually harmful behaviours in young people.

In terms of improving our practice we have rolled out a comprehensive training programme to fully implement the National Risk Framework. While this is a multi-agency approach, Children and Families Social Work Services have adopted a lead role. Our risk assessment and risk management planning practices have improved incrementally and the enhanced training has contributed to our success in this regard. We have

adopted a new model of risk management in the community for high risk / high vulnerability young people: Care and Risk Management (CARM). Having piloted this, we are now keen to develop the model further and a small group is working to take this forward. The model has been approved by the DCYPP and will be included in the forthcoming Integrated Children's Services Plan. We are also engaging the support of the Centre for Youth and Criminal Justice at the University of Strathclyde to help us take this forward.

Buttercups residential respite facility for children and young people with disabilities continued to deliver high quality responsive services at a local level. This service has been well received by parents and provides a positive experience for children who require to spend time away from home. The unit is very well supported and runs to capacity most of the time.

Over the last two years, Children and Families Social Work services have led on the implementation of a Whole System Approach (WSA) across a multi-agency range of services. This reflects the Getting it Right for Every Child (GIRFEC) agenda and ensures that children and young people at risk of offending are identified and responded to at the earliest opportunity. The funding for this, which was provided by the Scottish Government, has now come to an end and the systems developed over the last 24 months have been embedded and continue to be further developed as practice moves on. The Scottish Government has indicated that they were very happy with the way the funding was utilised and noted that the contribution of the WSA Service Manager was instrumental in bringing agencies together to work on this development.

Multi-agency collaboration in respect of the GIRFEC agenda continued to be an area of activity for partner agencies across East Dunbartonshire. The Centre for Excellence for Looked After Children in Scotland (CELCIS) worked with key stakeholders to ensure policies, procedures and training were in place prior to the full enactment of the *Children and Young People (Scotland) Act 2014*. A significant volume of inter-agency work has been undertaken to progress the GIRFEC agenda in East Dunbartonshire.

Listed below are a number of the key performance areas we progressed during the period.

		Annual Status	Annual	
Code	PI Title	2015/16 Status	2015/16 Value	Annual Target 2015/16
ECS-01-BIP-3	% of child care Integrated Comprehensive Assessments (ICA) for Scottish Children's Reporter Administration (SCRA) completed within target timescales (20 days), as per national target		88%	75%
ECS-02-BIP-3	% of first Child Protection review case conferences taking place within 3 months of registration		84%	95%
ECS-04-BIP-3	% of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated		100%	100%
ECS-07-BIP-6	% of CJSW Reports submitted to court by due date		99%	95%
ECS-08-BIP-6	The % of individuals beginning a work placement within 7 working days of receiving a Community Payback Order		83%	80%

		Annual Status	Annual	
Code	PI Title	2015/16 Status	2015/16 Value	Annual Target 2015/16
ECS-BIP14-53-03	Attendance levels of Looked After children attending all EDC schools	✓	90.1%	90%
ECS-BIP14-61-03	Percentage of parents completing the Triple P programme who state that their parenting skills have improved	✓	100%	100%
ECS-BIP14-62-03	Number of parents participating in the Triple P programme	✓	194	135

East Dunbartonshire Council has made significant progress over the last year in meeting the public sector reform agenda and priorities. Much of this work has been predicated on a strong tradition of partnership working locally, which has been informed by the Christie Commission's findings and the Scottish Government's response outlining how best to renew public services in Scotland (see http://www.gov.scot/Publications/2011/09/21104740/9). As noted earlier, East Dunbartonshire Council's adult social work services were delegated to the newly formed Health and Social Care Partnership on 3 September 2015. The HSCP's vision is to *work with people to build strong communities, promote wellbeing and provide access to care and support*. The key outcomes for the Partnership are linked to providing high quality person-centred care, which is delivered through seamless, integrated services that use resources efficiently and effectively (see http://library.chps.org.uk/mediaAssets/CHP%20East%20Dunbartonshire/Strategic%20Plan%202015-2018%20Final.pdf).

6. Statutory Functions

The overall function of the Chief Social Work Officer (CSWO) is to ensure the provision of effective, professional advice to local authorities, both elected members and officers, in the authority's provision of social work services. The role assists the authority in understanding the complexities of social work service delivery, including particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders and also the key part social work plays in contributing to the achievement of national and local outcomes. The CSWO also has an important role in the overall performance improvement agenda, workforce and organisational development, and the identification and management of corporate risk insofar as they relate to social work services. There is clarity about the purpose and contribution of the CSWO in the new arrangements that exist with the development of the Integrated Joint Board and the establishment of the East Dunbartonshire Health and Social Care Partnership.

There are also a number of duties and decisions that relate primarily to the curtailment of individual freedom, the protection of both individuals and the public, and the welfare of vulnerable children and adults which must be made either by the Chief Social Work Officer or by a professionally qualified social worker to whom the responsibility has been delegated by the Chief Social Work Officer and for which the latter remains accountable. These areas include:

- deciding whether to implement a secure accommodation authorisation in relation to a child (with the consent of a head of the secure accommodation), reviewing such placements and removing a child from secure accommodation if appropriate;
- the transfer of a child subject to a Supervision Order in cases of urgent necessity;

- acting as guardian to an adult with incapacity where the guardianship functions relate to the personal welfare of the adult and no other suitable individual has consented to be appointed;
- decisions associated with the management of drug treatment and testing orders;
- carrying out functions as the appropriate authority in relation to a breach of a supervised release order, or to appoint someone to carry out these functions.

Interventions by social workers often take place within difficult and complex circumstances. The CSWO has a responsibility to ensure that staff are able to access relevant training and are supported to undertake their role and discharge their duties in an appropriate and professional manner. Within East Dunbartonshire a range of governance structures have been established to ensure statutory duties and responsibilities are discharged effectively. These arrangements include the Adult Protection Committee, the DCYPP and the MAPPA SOG. The CSWO has access to wide-ranging information from the various groups that are in place.

Child Protection Services

The protection of children remains a crucial priority for the Council. The information in the tables below highlights the activity which took place in this regard in 2015/16. There is also comparison data with the preceding four years.

Over the last five years we have seen some changes to the pattern of referrals relating to child protection; physical abuse, neglect, poor parental mental health and drug/alcohol misuse have been key areas of concern. There have been some fluctuations in the numbers of child protection investigations taking place over the period, with on average 163 taking place annually. With the exception of 2012/13, there has been an overall increase the number of child protection case conferences convened annually alongside a rise in the overall number of children who are subject to registration.

	2011/12	2012/13	2013/14	2014/15	2015/16
CP Investigations	174	142	171	154	172
CP Conferences	256	212	265	301	313
CP Registrations	71	42	80	69	83
CP De-registrations	62	56	68	73	73
Total on CP Register at Year End	**46**	**32**	**44**	**40**	**50**

The number of children and young people discussed at a child protection case conference in 2015/16 is noted below alongside information relating to de-registrations and re-registrations over the last five years. Our quality assurance arrangements identify that children are placed on the Child Protection Register for an appropriate length of time with very few requiring early re-registration.

Type of Case Conference	Number of Young People
Pre-birth	7
Initial	100
Review	204
Transfer in	2
TOTAL	**313**

No. of De-registrations by length of Registration	2011/12	2012/13	2013/14	2014/15	2015/16
Less than 6 months	34	36	39	41	38
6 months to under 1 year	24	14	21	23	28
1 year to under 18 months	3	6	5	9	6
18 months to under 2 years	1	0	3	0	1
TOTAL	**62**	**56**	**68**	**73**	**73**

Re-registrations by length of time since last de-registered	2011/12	2012/13	2013/14	2014/15	2015/16
Less than 6 months	5	3	1	4	0
6 months to under 1 year	2	4	0	0	0
1 year to under 18 months	2	0	0	0	0
18 months to under 2 years	4	0	0	0	3
2 years or more	5	0	6	10	11
TOTAL	**18**	**7**	**7**	**14**	**14**

Looked After Children (LAC): Balance of Care

Social work services play an important role in supporting vulnerable families to remain together where it is safe and appropriate to do so. East Dunbartonshire Council provides practical and emotional support services to enable parents to change and improve the quality of care provided to their children. However, there are times when maintaining the family together is not possible and alternative care arrangements are assessed as necessary. The needs of the child are always considered paramount. For some children the provision of alternative care will only be required for short periods whilst for others this will be much longer. A variety of placements are available to meet the needs of the child, including foster placements, formal kinship care and adoptive placements, residential care, residential schools and secure care.

East Dunbartonshire Council introduced a Formal Kinship Care Policy in 2014/15. This has improved our systems and practices in assessing, supporting and approving carers. The change in the policy has enabled some children to remain within their own communities and be cared for by extended family or friends.

The following chart summarises the placement details of looked after children in East Dunbartonshire in 2015/16 and over the preceding four years. In terms of the balance of care figures, the chart illustrates that a significant majority of children (86%) in 2015/16 were being looked after at home and in their community.

Placement Type	31 Mar 2012	31 Mar 2013	31 Mar 2014	31 Mar 2015	31 Mar 2016
At Home with Parents	44	64	44	65	51
Semi-Independent Living / Supported Accommodation	0	0	0	4	1
With Friends/Relatives	55	48	52	47	54
With Foster Carers	30	28	29	41	40
With Prospective Adopters	4	2	1	0	1
Total Community	**133**	**142**	**126**	**157**	**147**
Hospital	0	0	0	1	1
LA Children's Home	7	6	7	9	10
Residential School	7	6	6	2	3
Secure Accommodation	1	2	2	0	0
Voluntary Children's Home	5	5	7	4	8
Close Support Unit	1	0	1	0	0
In Custody	0	0	0	0	1
Total Residential	**21**	**19**	**23**	**16**	**23**
% COMMUNITY PLACEMENTS	**86%**	**88%**	**85%**	**91%**	**86%**

Criminal Justice Services

As noted earlier, criminal justice services within East Dunbartonshire Council area are delivered as part of a wider Criminal Justice Partnership (CJP) between East and West Dunbartonshire and Argyll & Bute Councils. Services in this area, and across the partnership, are delivered on a statutory basis and respond to the needs of those in the community who are involved in offending.

Community Payback is designed to ensure that offenders *payback* to society, and to particular communities, in two ways. In the first instance a Community Payback Order requires an offender to make reparation, often in

the form of unpaid work. And in the second, the Order can require them to address and change their offending behaviours, thereby improving the safety of local communities and providing opportunities for the individual's reintegration as law abiding citizen. The CPO aims to create a robust and consistently delivered community penalty which enjoys public and judicial confidence and thereby provide a viable alternative to custody in appropriate cases.

The following chart outlines the volume of work undertaken by Criminal Justice Services in relation to Community Payback Orders (CPOs) over the last few years of available data.

Community Payback Orders	Unpaid Work Requirement Only	Supervision Requirement only	Both Unpaid Work and Supervision Requirements	TOTAL ORDERS
2012/13	130	73	49	**154**
2013/14	150	90	69	**171**
2014/15	124	81	47	**158**
2015/16	146	89	59	**176**

Immediacy of contact between the individual and their supervising officer is an important feature of the CPO. It ensures that the individual is informed of their responsibilities and the potential consequences of failing to adhere to these. It also ensures that individuals begin their placement quickly and start making reparations to the community for their offending. In East Dunbartonshire in 2015/16, 83% of individuals began a work placement within 7 working days of receiving a Community Payback Order. This was 3% above our annual target.

East Dunbartonshire's criminal justice services also provide reports to the Court, the Parole Board and to the Scottish Prison Service. It is important that these reports are submitted on time in order that other key justice processes are not adversely affected. East Dunbartonshire Council has a good history of meeting its responsibilities in that regard. For example, in 2015/16, 99% of reports to the Court were submitted on time, which was 4% above our annual target.

Adult Support & Protection

The Council is designated as lead agency for Adult Support and Protection (ASP) by the 2007 Act, with statutory duties to set up and support East Dunbartonshire's Adult Protection Committee; to make inquiries where an adult is suspected to be at risk of harm; and to apply for protection orders where these are required to safeguard the adult. The Council's duties were delegated to the Health and Social Care Partnership with the establishment of East Dunbartonshire Integration Joint Board on 3 September 2015. The Social Work Adult Protection procedures were revised and implemented in advance of this.

The Adult Protection Committee is independently chaired and has representation from all key agencies. A new convenor was appointed in August 2015. The convenor and Committee are supported and resourced by the Council's Adult Protection Coordinator. A report on the Committee's activity is submitted to the Scottish Government on a biennial basis. The Committee has established an annual multi-agency casefile audit, and an annual stakeholder conference which incorporates a consultation element. In 2015/16, the audit provided valuable information about the impact of organisational changes and new policies on inter-agency ASP service delivery.

The performance of the Social Work service in respect of ASP activity is reported regularly via internal and Community Planning structures, providing a reliable indicator of the efficiency of our systems and processes. From 2015, the Scottish Government has also asked the local authority to provide an annual return on local statutory ASP activity, which allows us to benchmark local demand and outcomes against the national picture.

The Adult Protection Committee has also established a Quality and Development Partnership (QDP) sub-group which monitors and supports the development of good ASP practice by care providers. ASP referral data from 2014-15 highlighted that providers had overtaken Police Scotland as the main source of referrals in the East Dunbartonshire area. This trend has continued in 2015-16 and thought to be the result of efforts to

increase provider awareness of their duty to share information about adults at risk of harm, rather than an increased incidence of harm in care delivery settings.

Further analysis revealed significant variation in reporting rates between care home providers, as well as of the appropriateness of the referrals which were being made. The two main principles underpinning the 2007 Act are that any intervention should benefit the adult, and be the least restrictive option. Making inappropriate and hence unnecessary referrals is clearly not in accordance with the principles. To support a more standardised approach to practice, the QDP group in consultation with providers' forum developed an ASP thresholds guidance framework. The framework also highlighted the need to respond to emerging patterns of concern indicated by repeat referrals. The framework was piloted between October 2015 and March 2016 and has been evaluated positively by both care home managers and Social Work staff. Analysis of referrals made during the period suggest there has been a significant increase in the proportion of adults referred who were assessed as being adults at risk of harm, indicating that the framework has been successful in its aim to improve the consistency of decision-making about ASP across the care home provider community.

The principles equally apply to the other end of the intervention pathway, where consideration may be given to applying to the Courts for a protection order. In 2015-16, as in the previous year, East Dunbartonshire applied for a protection order in respect of one adult. This contrasts with the situation in the early years after the Act was implemented, when up to six adults were being protected by means of a court order at any one time. The table below outlines the provision of Adult Support and Protection Services in 2015-16:

Nature of Activity	**Number**
Duty to Inquire	403
Planning meetings (including those convened under the Repeat Referrals Protocol)	32
Investigations	25
Case conferences	17
Review case conferences	29
Protection plans initiated in 2015-16	13
Temporary Banning Orders	1
Banning Orders	1

Mental Health Services

The Mental Health service features significantly in all aspects of social work protection activity. Whilst activity under the *Mental Health (Care and Treatment) (Scotland) Act 2003* remained fairly stable this year, there has been an increase in the last four years for assessments for Adults With Incapacity (AWI) and applications for Guardianship orders. A trend towards increased use of AWI measures is forecast for East Dunbartonshire in the longer term, since people are living longer, healthier lives, and more people may seek financial/welfare powers to safeguard a parent who is affected by dementia, or an adult child who lacks capacity and unable to manage welfare of finances.

There has been an increase nationally in the use of both Emergency Detention and Short Term Detention Certificates. In East Dunbartonshire, we have seen an increase of statutory interventions which has led to patients receiving inpatient and community based services.

Research undertaken by the Scottish Social Services Council (SSSC) workforce Team and the Mental Welfare Commission in Scotland has identified a need to find a means of better recruitment and training for Mental Health Officers. They noted that the Mental Health Officer workforce is ageing and plans are required to maintain a satisfactory staffing level across Scotland. East Dunbartonshire has an excellent record of selection and training for Mental Health Officers with a 100% pass rating. The Council is committed to considering how best to support and retain Mental Health Officers locally.

7. User and Carer Empowerment

Social Work Services have a rolling programme of consultations involving adults, carers, children, young people and their families in experience, satisfaction and impact surveys which contribute to a partnership understanding across services. Each survey generates a report that analyses the responses and identifies learning outcomes. Since April 2013, a common approach has been adopted to ensure that purpose, results and consequences of consultation are clearly specified to better support the contribution to improvement planning.

We pro-actively engage with adults, children and families to gather and record their views during the process of inspection. Case audits and feedback from external inspection confirm a positive picture in this regard. We actively promote and support outcomes based approaches by using appropriate frameworks which are outcome focused. There are robust arrangements in place to elicit and record the views of children and young people supported by our Fieldwork Services, Children's Residential Service, Community Resources and Community Support Service. There are similar systems in place for the collation of service user feedback in the area of Criminal Justice.

Children and Families social work staff have also worked with Looked After Children to help them plan for a secure financial future using the national *Junior Individual Saving Accounts* (ISAs) scheme. The UK Government Scheme, which was set up in January 2011, targets children who have been Looked After for 12 consecutive months and who do not have a Child Trust Fund. The Government contributes an initial £200 payment when an account is opened. The Share Foundation – a registered charity – has been authorised by the Government to set up and manage the Junior ISAs for all looked after children. The Share Foundation will also be raising funds which it will contribute to the Junior ISAs that it manages. The money in a Junior ISA belongs to the young person, but they cannot take the money out until they are 18. Children can take control of their own account if they are over 16 years when they cease to be Looked After but will not be able to access any funds until they are 18. This money offers the eligible young people some much needed support for their transition to independence and adulthood.

Information on Looked After Children in East Dunbartonshire is returned to The Share Foundation on a quarterly basis. Eighty-eight children have been eligible for the Junior ISA Scheme since its introduction and the total amount generated for these young people is in the region of £18,500. Sixty-five Junior ISAs remain in place for children currently Looked After by East Dunbartonshire Council.

The Self-Directed Support Reference Group continues, when required, to assist the Council when developing new information materials or when we are reviewing the Council's Self-Directed Support Strategy. ***Take Ctrl East Dunbartonshire*** also support an established Stakeholders Group with input from the Council's Self-Directed Support Lead Officer. Take Ctrl, in partnership with the Council, has various activities planned over the 2015-2018 period which include: further development of Personal Assistant and Employer training, establishing a SDS Champions Groups; a SDS Story Book told from the perspective of the service user; and the development of an interactive SDS computer game for children and young people.

The Adult Protection Committee has an established Service User and Carer consultation sub-group. During 2015-16, the group participated along with Social Work staff in a project to improve ASP service user feedback mechanisms. It also participated in public awareness activity, including the production of a newsletter article, and co-hosting an information stand at a major community event, Kirkintilloch Canal Festival

The joint Carers Working Group oversees the delivery of a joint Carers strategy and is chaired by a carer. Scottish Families Affected by Alcohol & Drugs (SFAAD) Family development worker – working with Families and Carers – has developed a number of support groups across the authority. The organisation also offers a bereavement service for those who have experienced loss due to drugs/alcohol, which in the past had been a significant gap. During the past three years the Scottish Drugs Forum has been commissioned to progress Service User Satisfaction Surveys and focus groups facilitated by peer supporters who have skills and credibility in engaging with service users. This has given a valuable service user perspective on the quality of services and potential gaps.

8. Workforce Planning and Development

Workforce planning and development remains a key priority for social work services. In 2015/16, workforce planning centred on adult social work services and their planned move into the Health and Social Care Partnership. The primary concern was around ensuring that the staffing levels were sufficient to meet the priorities set in the HSCP strategic plan. Recruitment and retention of staff has generally been at an acceptable level, despite the financial climate. That said, there have been specific issues with mental health officer levels in East Dunbartonshire – a problem experienced across many Scottish local authorities – that will be taken forward in 2016/17.

With respect to the CSWO post, this became vacant in late 2015 and was advertised and subsequently filled on a permanent basis in May 2016. During the intervening period, temporary arrangements were in place. East Dunbartonshire presently employs a Chief and a depute to fulfil the role.

In January 2015, a mapping exercise (Phase one) was carried out to establish a management structure to undertake the management of staff within the delegated functions of the Health and Social Care Partnership. This involved establishing posts that would report directly to the Chief Officer and those required by legislation. Three posts – Head of Strategy, Planning and Health Improvement, Head of Adult and Primary Care and Chief Finance and Resources Officer – were established and subsequently filled. Work is continuing to complete key aspects of the revised structures before moving onto Phase 2 that will focus on the reporting arrangements to Heads of Service.

9. Improvement Approaches

There are a number of areas where we consider improvements need to be made in the coming years. These are listed in brief below. We will continue to work with colleagues and partners to ensure that we make the required progress. We are committed to delivering high quality social work services that meet the needs of service users and their carers and the expectations of our communities.

Self-Directed Support - We need to build capacity and increase the uptake of SDS options amongst particular service user groups, including children and families; adults with mental health difficulties; and adults recovering from addiction problems. We also need to promote a greater understanding of the full capabilities of SDS Option 2 (in providing choice, control and flexibility) amongst our stakeholders. We plan to:

- Introducing a one year brokerage pilot project for adults with a mental health illness. Feedback from this service user group has told us that the traditional type of support does not fully meet their needs. The brokerage pilot will explore creative, innovative packages of support utilising both paid support and community assets;
- Continue the preliminary discussions to replicate a 'Get Onside' course for people in recovery from addictions. Previous courses have been extremely successful in not only building capacity about SDS but have introduced service users to other forms of support within their local communities;
- Host a number of workshops for staff and providers exploring how our systems can change in order that we can support service users to fully utilise Option 2.

Learning Disability - East Dunbartonshire Council and East Dunbartonshire Health and Social Care Partnership have committed to fundamentally reviewing the shape of services and the design of learning disability resources within the authority. In recent years it has become increasingly apparent that services within the local area need to adapt and change to meet the challenges of best value, the increasing expectations of service users and the priorities set out in national guidance, particularly the *Keys to Life*.

Addiction Services – We consider that the established care pathways could be improved. Whilst there is good partnership working, there is potential to further minimise the duplication of effort and simplify access to appropriate support and resources. We also consider there is work to be done to improve the multi-agency approach to dealing with complex cases, for example where significant poor mental health, addiction and offending issues are prevalent.

The *Carers (Scotland) Act 2016* – This is due to be commenced in April 2018 and work on this has started and will need to continue as we move forward. The Act:

- changes the definition of a carer so that it covers more people;
- places a duty on local authorities to prepare an adult care and support plan or young carer statement for anyone it identifies as a carer, or for any carer who requests one;
- introduces a duty for local authorities to provide support to carers who are entitled under local criteria;
- requires local authorities and NHS boards to involve carers in carers' services;
- introduces a duty for local authorities to prepare a carers strategy; and
- requires local authorities to establish and maintain advice and information services for carers.

Older People's Services – This is a continuing workstream. We consider there are improvements to be made towards co-production and community resourcing to ensure that we can best support people within their communities for longer. We also acknowledge that we need to make the best use of the integrated resources available. The strategic vision is being defined with partners and initiatives taken forward as part of our review of day care services to older people.

Children and Families – As noted earlier, we recognise that there are improvements that we can make to our practice in respect of Continuing Care, Aftercare and Children's Rights. We also consider that we could improve the balance of care (in respect of looked after children) in East Dunbartonshire. We will work on these areas in the coming year. Alongside this, there are wider workstreams that we know will have a bearing on the future shape of children and families social work services. For example, the Scottish Government's Child Protection Improvement Programme is likely to impact on a number of areas, including the work of Child Protection Committees; the practice surrounding initial and serious case reviews; inspection activity; and the registration of children on the Child Protection Register.

Criminal Justice - The current Service Level Agreements between the Scottish Prison Service (SPS) and a number of local authorities providing prison-based social work services have expired. At a national level, the SPS and Social Work Scotland are in discussions about future arrangements; presently these services are being provided under a letter of agreement which expires in March 2017. There is an urgent need to develop an alternative, and more effective, methodology to determine the relationship between prison-based social work and the SPS. Our joint approach needs to be service-user focused whilst retaining the clear mandate for public protection. Given that East Dunbartonshire Council hosts a prison in its area and that prison-based social work services are provided there, this will be a key area of work going forward. Additionally, with the implementation of the MAPPA extension, we will continue to work with our partners to ensure that there is a clear focus on the effective management of high risk offenders in the community.

Agenda Item Number: 7

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_07**
Subject Title	**General Practice Cluster Group Development**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Graham Morrison, Clinical Director** **East Dunbartonshire Health & Social Care Partnership** **0141 201 3553** **Graham.morrison@nhs.net**

1.0	**PURPOSE OF REPORT**
1.1	To provide the HSCP Board with an update on development of general practice cluster groups.
2.0	**SUMMARY**
2.1	The Cabinet Secretary for Health Wellbeing and Sport announced on Thursday 1 October 2015 that: "*I have instructed my officials to work with the BMA to dismantle the Quality and Outcomes Framework in preparation for the new contract in 2017 by developing a transitional arrangement for quality in 2016/17 in Scotland. QOF has delivered many innovations, but its time is past. Scotland's GPs need a new and different future, starting in 2016. I want to move towards a system of values driven governance that reflects and is sensitive to the different needs of the different communities that you serve. Allowing the best use of expertise to be shared across clusters of practices…the new Scottish GP will be at the heart of quality and improvement."*
2.2	In light of this, in April 2016, the Quality and Outcome Framework (QOF), which awarded GP practices points for achieving national and local targets (resulting in payment) was dismantled and replaced by Transitional Quality Arrangements for a 12 month period.
2.3	This change is designed to remove a significant administrative burden on Practices, however Practices are expected to continue to provide high quality clinical care relying on the professionalism of GPs and their staff to provide all of the relevant elements of the care that they (the GPs and their staff) consider to be clinically appropriate to their patients i.e. removing the link between achievement and payment by dismantling QOF does not remove or reduce the obligation on general practitioners to treat patients in a clinically appropriate way.
2.4	While QOF has been dismantled, a new element introduced in the transitional contract was the concept of Cluster groups for GP practices.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

- Note the progress made to date on development of the GP Cluster groups

4.0 MAIN REPORT

4.1 Each GP practice has been asked to appoint a Practice Quality Lead (PQL) who will engage in a local cluster group, with a nominated GP from that cluster having a leadership role as a Cluster Quality Lead (CQL).

4.2 It is anticipated that each and every GP will have a role in Continuous Quality Improvement within the practice, with each PQL engaging with the CQL. This will provide CQLs with a mandate to improve quality in the wider health and social care system, including the use of secondary care, partly based on the input from each practice in the cluster.

4.3 The minimum work stream requirements for transitional year include:-

- undertake coding as agreed and provide appropriate* lifestyle advice (*definition of "appropriate" and exact timing to be determined by the GP practice);
- the activity associated with current flu vaccination as outlined in the Directed Enhanced Service is continued, particularly so for the following disease areas: CHD,Stroke and TIA, Diabetes and COPD;
- review their last two annual Practice Access Activity Reports for evidence of any recurrent themes and take appropriate actions using an agreed national template;
- review a random sample of their Anticipatory Care Plans using an agreed national template;
- continue to work with the NHS Board prescribing advisors and prescribing support pharmacists, where available, to agree appropriate actions related to prescribing and seek to evidence change.

4.4 GP practices and clusters will have oversight and direct involvement in improving the quality of all health and social care services provided to patients registered within their locality, including the current chronic disease management programme and use of secondary care services.

4.5 The Scottish Government is to supply data to support the peer review GP Cluster Continuous Quality Improvement process over this period and has now laid out what information will be available to clusters.

Time Commitment and Funding

4.6 Each PQL and GP practice is expected to find 2 hours monthly from the time freed up by the ending of QOF.

4.7 The Scottish Government is now also funding Each GP practice to release the PQL for an additional session per month to be involved in this quality work.

4.8 Funding for the CQL is to be funded from outwith the GMS funding envelope. The HSCP is funding CQLs for 2 sessions per month to move this work forward.

Cluster Formation

4.9 Within East Dunbartonshire we have taken a view that the process of cluster formation should be driven from the ground up. We have had extensive discussions with representatives from all GP practices through our GP forum to determine the make up of cluster groups.

4.10 We have asked the formed cluster groups of GPs to nominate a member from within the group to take on the role of CQL.

4.11 Training in Quality improvement activity for CQLs is scheduled to take place at the end of November via the Health Board's Primary Care support Unit.

4.12 The Government has laid out a 4 stage timetable for the transitional year:-

Stage 1 – first quarter of 2016/17 (1.4.16 to 30.6.16)

Practices agree who will fulfil the Practice Quality Lead role and that person will work with the local partnership liaison person and LMC representatives to agree the cluster arrangements i.e. which practices are in which cluster.

Achieved

All PQLs are in place and a structure of 3 Clusters has been agreed as follows:-

- Bishopbriggs and Auchinairn
- Kirkintilloch and outlying villages
- Milngavie and Bearsden
- Stage 2 – second quarter (1.7.16 to 30.9.16)

Stage 2 – second quarter (1.7.16 to 30.9.16)

Practice Quality Leads* and the partnership/board and LMC, identify, appoint and empower a Cluster Quality lead and agree the time commitment to which this role will need to be resourced and how it will operate locally. The CQL role will be resourced by the partnership/board.

Achieved

- Each Cluster has appointed a CQL.

Stage 3 – third quarter (1.10.16 to 31.12.16)

The PQLs* and CQLs begin to build relationships locally via the clusters, between and across practices, primary and secondary care, health and social care and between the public and third/voluntary sectors.

Practices and the local system start to consider the issues arising from the activities outlined earlier in this report and any the other issues that might be local priorities, and agree by the end of this quarter which to take action on in quarter 4.

In progress

- Cluster groups are now meeting together, forming relationships and considering what areas are local priorities.
- The HSCP has embedded a prescribing support pharmacist and a change manager into each group to support the group and supply information as required.

Stage 4 – fourth quarter (1.1.17 to 31.3.17)

Practices and the local system take action on the priorities agreed at the end of quarter 3 and agree evaluation/outcome measures that will demonstrate quality improvement.

In progress

- The Clinical Director is meeting regularly with the CQLS to monitor progress and discuss how these groups move forward and begin to link in with other structures both within a HSCP and health context.
- A new GP contract to move on from this transitional year is currently under negotiation.

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 8

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016_08**
Subject Title	**Refugee Crisis and Unaccompanied Asylum Seeking Children**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Paolo Mazzoncini, Chief Social Work Officer** **East Dunbartonshire Health & Social Care Partnership** **0141 201 3553** **Paolo.mazzoncini@eastdunbarton.gov.uk**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to:-

- Update the HSCP Board on East Dunbartonshire Council's decision to support refugees through the Asylum Seeker Dispersal Scheme.
- Inform the HSCP Board of the work that has begun with respect to the resettlement arrangements for Syrian refugees and unaccompanied asylum seeking children (UASC).
- Request that the HSCP Board consider the role it can play in supporting the Council's response to the refugee crisis.

2.0 SUMMARY

2.1 East Dunbartonshire Council considered a report on the Syrian Vulnerable People Relocation Scheme and Unaccompanied Asylum Seeking Children at its meeting on 10th November 2016. There had been a previous discussion on this at the Policy and Resources Committee of 8th September 2016, where the Committee considered Report No. PNCA/024/16/GM Asylum Seekers Dispersal Scheme.

2.2 On the 10th November 2016, the Council noted the report and:

a) Directed officials to conduct an assessment of the scale of the Council's capacity, the resources required and the arrangements that need to be put in place to support the request from the Home Office;

b) Notwithstanding recommendation a) above, instructed officers to progress arrangements meantime for the Council to receive i) up to four families under the Syrian Vulnerable People Relocation Scheme through the provision of accommodation by the Council and Registered Social Landlords (RSLs) as available, and ii) up to four Unaccompanied Asylum Seeking Children under that Scheme, subject to compliance with appropriate statutory and other requirements regarding looked after children, including identification of appropriate

accommodation and/or foster placements and wrap around care packages;

c) Directed officials to report back to the next Council meeting with a progress report in respect of recommendations b) and c) above and with further information to enable detailed consideration of a sustainable medium to long term response to the humanitarian crisis in Syria; and

d) Remitted the report to the Community Planning Partnership Board and Integrated Health & Social Care Partnership Board for consideration by both bodies of the role that partners could play in supporting the Council's response to refugee crisis.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

a) Notes the contents of the report.

b) Considers the role the HSCP can play in supporting East Dunbartonshire Council's response to the refugee crisis.

4.0 MAIN REPORT

4.1 The attached report (**Appendix 1**), which was considered at the East Dunbartonshire Council meeting on 10th November 2016, provides contextual facts and specific information on the various schemes operating across the UK in relation to refugees and unaccompanied asylum seeking children.

4.2 The report also sets out the Council's intention to accommodate up to 4 families under the Syrian Vulnerable Persons Resettlement Programme and 4 unaccompanied asylum seeking children (dependent on certain conditions).

APPENDIX 1

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AGENDA ITEM NO: 9

EAST DUNBARTONSHIRE COUNCIL	**10 NOVEMBER 2016**
CE/10/16/CE	**GERRY CORNES, CHIEF EXECUTIVE**
CONTACT OFFICER:	**PAOLO MAZZONCINI, CHIEF SOCIAL WORK OFFICER (TEL: 0141 578 8039) AND THOMAS GLEN, DEPUTE DIRECTOR, PLACE, NEIGHBOURHOOD AND CORPORATE ASSETS (TEL: 0141 578 8525)**
SUBJECT TITLE:	**REFUGEE CRISIS AND UNACCOMPANIED ASYLUM SEEKING CHILDREN**

1.0 PURPOSE

1.1 The purpose of this report is to:

a) Provide Council with an update following the meeting of the Policy and Resources Committee held on 8th September on work to support refugees through the Asylum Seeker Dispersal Scheme;

b) Update Council in respect of the resettlement arrangements for Syrian refugees and unaccompanied asylum seeking children (UASC).

c) Seek a decision from Council to increase the current levels of support offered to asylum seekers impacted by conflict

2.0 SUMMARY

2.1 At the Policy and Resources Committee of 8th September 2016, the Committee considered Report No **PNCA/024/16/GM** Asylum Seekers Dispersal Scheme.

2.2 This Report provides an update on work to date to progress the matters agreed at that Committee and seeks to provide further information on the range of schemes in place to support refugees and asylum seekers.

2.3 Given the on-going crisis and the further requests for support received from the Home Office, this Report sets out a recommendation for the Council to consider additional support in relation to unaccompanied children and families affected by the on-going humanitarian crisis.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Council:

a) Notes the contents of the Report;

b) Directs officials to conduct an assessment of the scale of the Council's capacity, the resources required and the arrangements that need to be put in place to support the request from the Home Office;

c) Notwithstanding recommendation b) above, instructs officers to progress arrangements meantime for the Council to receive (i) up to four families under the Syrian Vulnerable People Relocation Scheme through the provision of accommodation by the Council and RSLs as available, and (ii) up to four Unaccompanied Asylum Seeking Children under that Scheme, subject to compliance with appropriate statutory and other requirements regarding looked after children, including identification of appropriate accommodation and/or foster placements and wrap around care packages;

d) Directs officials to report back to the next Council meeting with a progress report in respect of recommendations b) and c) above and with further information to enable detailed consideration of a sustainable medium to long term response to the humanitarian crisis in Syria; and

e) Remits this report to the Community Planning Partnership Board and Integrated Health and Social Care Partnership Board for consideration by both bodies of the role that partners can play in supporting the Council's response to refugee crisis.

GERRY CORNES
CHIEF EXECUTIVE

APPENDIX 1

4.0 BACKGROUND

4.1 Members will be aware of the on-going humanitarian crisis that has been created as a result of conflicts in Syria, Iraq and Afghanistan over recent years and the resultant number of refugee and asylum seekers now displaced across Europe.

4.2 The civil war in Syria, which began in 2011, has caused the mass movement of people, both within Syria and to neighbouring countries. Syrians now make up the largest refugee population in the world. It is reported that almost five million people have fled to neighbouring countries to escape the conflict. The United Nations estimates that one in ten Syrian refugees in the Middle East and North Africa region needs to be resettled elsewhere.

4.3 In January 2014, the UK government announced that it would establish a Syrian Vulnerable Persons Resettlement (SVPR) programme to allow certain refugees to resettle in the UK. The Home Office is responsible for the programme. Individuals requiring urgent medical treatment, survivors of violence and torture, and women and children at risk were initially prioritised. The programme was small in scale, resettling 239 refugees up to the end of September 2015. Shortly thereafter, it was announced that the programme would be expanded to resettle 20,000 of the most vulnerable Syrian refugees in the UK by May 2020. The government later added a milestone to resettle 1,000 Syrian refugees before Christmas 2015, which was achieved.

4.4 As well as children who have the right to be resettled with family members already in the UK via the *Dublin III* regulations, on 4 May 2016 the Government announced that it would be resettling unaccompanied children from other European countries into the UK. This commitment is set out in the Immigration Act 2016 (commonly known as 'the Dubs amendment'). Under the Amendment, children arriving would have to be under 18 years of age; in Europe before 20 March 2016 and the transfer to the UK determined to be in the best interests of the child and thus priority would be given to cases with a UK family link. New arrivals therefore will be a mixture of family reunion cases and unaccompanied children.

4.5 On 1 July 2016, the Home Office and Department for Education launched a new voluntary transfer arrangement between local authorities for the care of unaccompanied children who arrive in the UK and claim asylum. The *National Transfer Scheme* encourages all local authorities to volunteer to support unaccompanied asylum-seeking children (UASC) so there is a more even distribution of caring responsibilities across the country. Under the scheme, a child arriving in one local authority area already under strain caring for unaccompanied asylum seeking children may be transferred to another council with capacity.

4.6 The Scottish Government and a number of Scottish local authorities have given a commitment to accept children and young people and vulnerable adults under these schemes. That said, they have noted the challenges that exist in so doing.

4.7 An unaccompanied asylum-seeking child (under 18yrs of age) has the same legal status as a young person '*looked after*' by the local authority. Service responses therefore need to comply with relevant legislation – such as the *Children (Scotland) Act 1995* and the *Children and Young People (Scotland) Act 2014*. Any regulated placement and/or service provided would be subject to inspection by the Care Inspectorate. Importantly, that would include a requirement to provide support until the individual had reached the age of 26, or until a decision is taken regarding their immigration status.

4.8 At the Policy and Resources Committee of 8th September 2016, the Committee considered report No **PNCA/024/16/GM** Asylum Seekers Dispersal Scheme.

APPENDIX 1

4.9 The report provided Members with an update on the Asylum Seeker Dispersal Scheme and recommended that Council enter into further discussions with the Home Office over an initial agreement to participate in the scheme. Following consideration Council agreed the following recommendations:

a) that Serco undertake an initial scoping exercise and feedback to Council for a further decision, should this be necessary;

b) that officers liaise with local Registered Social Landlords to explore whether there was available accommodation in the area and ensure that it was suitable to house refugees within the Syrian VPR scheme and should this be the case to then indicate to CoSLA of our intention to participate; and

c) that a report be brought back at the earliest opportunity.

It should be noted that there are different schemes in relation to the relocation and resettlement of asylum seekers and refugees.

4.10 The longest running of these is the Asylum Seeker Dispersal Scheme which has been in operation since 1999. At that time the UK government set out its proposals to move people seeking asylum away from London and the south east. Glasgow City Council was the first Scottish Local Authority to sign up to the Dispersal Scheme around 2001 however no other Scottish Local Authorities have since signed up to this specific scheme. Serco has held the contract to manage the Asylum Seeker Dispersal Scheme in Scotland since 2011. Serco retain all financial support from the Home Office to administer the Scheme, with no funds being allocated to Local Authorities for participation in this Scheme. Since September, Officers have been in contact with Serco to discuss an initial scoping exercise in relation to the Asylum Seeker Dispersal Scheme, with work ongoing to be reported back to Council once further information is available. Asking Serco to have a look at the market in East Dunbartonshire would not commit the Council to anything at this stage.

4.11 Officers have contacted the main and specialist housing Registered Social Landlords across the area to assess their ability to provide suitable accommodation for any scheme. The contacts have included:

Larger Registered Social Landlords with mainstream properties (8)

Antonine HA *
Cube HA
Clyde Valley HA
Link HA*
Sanctuary HA - min properties
Trust HA
Castlerock HA*
Hillhead HA*

* Housing Associations with more than 100 properties

Specialist Providers for Older People, Disabled etc (6)

Bield HA - Sheltered
Cairn HA - one block only
Hanover HA - Sheltered

APPENDIX 1

Key HA - social work
Loretto HA - social work
Blackwood HA - social work

4.12 Feedback to date has been limited and officers continue to seek confirmation of support however initial discussions with Hillhead Housing Association have been positive. A commitment has been given to house one family and work is on-going to assess whether they are able to identify further accommodation. In addition, officers have had positive discussions with Antonine Housing Association and this issue will be considered at AHA's next Board Meeting. In part, the ability to provide accommodation is dependent on the availability of a package of wraparound support from the Council, Health and Social Care Partnership, RSLs, and other Community Planning Partners and support organisations.

4.13 Based on the initial responses and the need to develop a co-ordinated package of care for any families offered accommodation officers are recommending that as an early action the Council makes the offer of accommodation for up to four families. It is not possible to provide definitive costings for accommodating four families as this will depend on the individual circumstances and needs of each family and the extend of the care and support required. However given our limited resources for accommodating adults and family units through any Refugee or Asylum Seeker scheme, prioritisation should be given to resettling families specifically under the Syrian VPR Programme and not the Asylum Seeker Dispersal Scheme, due to the higher level of Home Office support provided to assist local authorities. This will go some way to ensuring the Council can provide more sustainable levels of support to these vulnerable families. The number of families accommodated will be subject to the demand from the Home Office and the availability of support from partners as well as the identification of suitable housing within locations across East Dunbartonshire.

4.14 Since the September report the Council has monitored and seen the growing crisis experienced by refugees and asylum seekers through conflicts in Syria and elsewhere and the effect this has had on the numbers and issues facing refugees across Europe. Most recently this has been highlighted by the closure of the former refugee and asylum seekers camp known as 'The Jungle' in Calais in northern France and programme of dispersals to other locations in France and more widely across Europe.

4.15 The issue of support to refugees and asylum seekers is one that has been a matter of on-going discussions between Councils at CoSLA and the Scottish and UK Governments to assess the level of demand and the ability of all arms of Government and other public services to respond to this crisis.

4.16 In addition to the Asylum Seeker Dispersal Scheme and the Syrian Vulnerable Persons Resettlement (SVPR) programme, referenced in the September Report and both discussed above, there are presently a number of other schemes in place across the UK aimed at resettling unaccompanied children and families with children with disabilities and health.

4.17 As well as updating on the September report, this report seeks support for East Dunbartonshire Council participation in three schemes, namely:

- the Syrian Vulnerable Persons Resettlement (SVPR) programme also known as the Syrian Resettlement Programme,
- the Vulnerable Children Scheme, and

- the Unaccompanied Asylum Seeking Children (UASC) arrangements.

4.18 The Minister of State for Immigration wrote to Scottish local authorities in September 2016 asking them to respond to three formal requests:

- The first was for those local authorities that had not already done so to register with the National Transfer Scheme (NTS)

- The second was for each local authority to confirm the total number of unaccompanied children that could be placed in its care, under the Unaccompanied Asylum Seeking Children (UASC) arrangements, for the remainder of the financial year, noting the 0.07% of the child population threshold operating under the NTS. This would help understand the current capacity for local authorities to help care for unaccompanied children brought into the UK from mainland Europe under the provisions of the Immigration Act 2016.

- The third was for local authorities to consider taking children with disabilities and their families under the Vulnerable Children's Scheme.

4.19 The Council is required to respond to these requests. There are a number of issues to be considered, including:

- the potential resource implications (e.g. identifying appropriate accommodation, staffing, and funding. The Home Office provides funding for each individual supported but concern has been expressed by some local authorities that this may not fully meet the costs incurred.);

- legislative aspects (e.g. UASC are considered '*looked after children*' and therefore the Council would be required to promote, support and safeguard their wellbeing, and fulfil the associated legal requirements);

- child specific matters (e.g. ensuring the arrangements for each child meets their needs and helps them grow and develop); and

- community engagement (e.g. preparing local communities in supporting newly arrived children and vulnerable adults).

4.20 The Scottish Government and CoSLA's Strategic Migration Partnership have been in discussions with the Home Office to progress this matter. As a response to the increasing humanitarian crisis, it is proposed that officers immediately commence arrangements for the Council to receive up to four families and up to four unaccompanied children. However it is recognised that the Council has yet to define its longer term approach. It will be necessary for officers to carry out a full assessment in order to assist elected members with future decisions.

4.21 Officers are continuing to work with partners across the Health and Social Care Partnership and other Community Planning Partners to assess the availability of support through education, children's and other services.

4.22 It is estimated that the annual cost of accommodating a young person would be a minimum of £70k per child, based on a foster care package, an allocated social worker and the cost of additional support for wellbeing and raising attainment within education. This does not take account of other support needs including basic needs, translation, transport or other services.

APPENDIX 1

4.23 Support would be available to the Council through the Home Office under the Unaccompanied Asylum Seeking Children (UASC) programme which would offset around half of these costs based on daily rates. These reimbursement rates would however reduce as and when any child reached the age of 18.

4.24 Colleagues in Children's Services are assessing the availability of accommodation within residential and/or foster placements and advise that there is the potential to offer support for a number of children through the identification of appropriate placements.

4.25 Given the on-going crisis officers are recommending that an initial offer of accommodation be made to look after and accommodate up to four unaccompanied young people, subject to the identification of a suitable placement and the development of an integrated package of care from across partners and the provision of support from the Home Office.

4.26 Given the complexity of the needs of those children and adults fleeing conflict zones, the level and specialist nature of support is an important consideration in assessing the ability of the Council and its partners to provide accommodation and the necessary practical and emotional support services. This will continue to be monitored over the coming weeks and months as potential children and families are identified and placements offered. A Report will be brought back to Council in December 2016 to provide a further update to members.

4.27 Where any placement is offered, officers will also be required to monitor and assess the impact on the local community to ensure that there is minimal reaction from local residents towards those provided with accommodation through the programme.

4.28 Officers will continue to work with colleagues in CoSLA and with the Scottish and UK Government to ensure that resources are allocated from Government to support local authorities in supporting these important schemes whilst reflecting the on-going challenges on local authority resources.

5.0 IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as an emerging policy. This Report sets out an immediate response to an evolving situation and directs officers to report back with proposals for a wider policy-based approach. As such detailed analysis and consideration of the policy implications will be addressed in the subsequent Report once further information and analysis is available.

5.2. Place, Neighbourhood & Corporate Assets Implications

Officers from Housing Services will be required to liaise with RSLs and identify Council accommodation which is suitable for housing refugee families and assist in on-going support around settlement and any arising issues.

Officers from Community Planning & Partnerships will be required to work with the Council's partners and with the relevant communities in order to assist with the settlement of refugee families and unaccompanied children, including supporting the provision of education and wrap around care, and supporting communities in advance of any settlement.

5.3. Education, People and Business Implications

APPENDIX 1

Officers from Education Services will be required to make appropriate arrangements to ensure the education of any refugee children received by the Council.

Officers from Corporate Communications will be required to manage the press and communications associated with the arrival of refugee families and unaccompanied children to East Dunbartonshire.

Financial implications are as yet unclear however further information will be included within the Report to the next meeting of the Council which will set out detailed proposals going forward.

Officers from Legal Services will be required to provide legal support and assistance in relation to on-going consideration of the relevant regulations and their interpretation within a Scots Law context

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 9

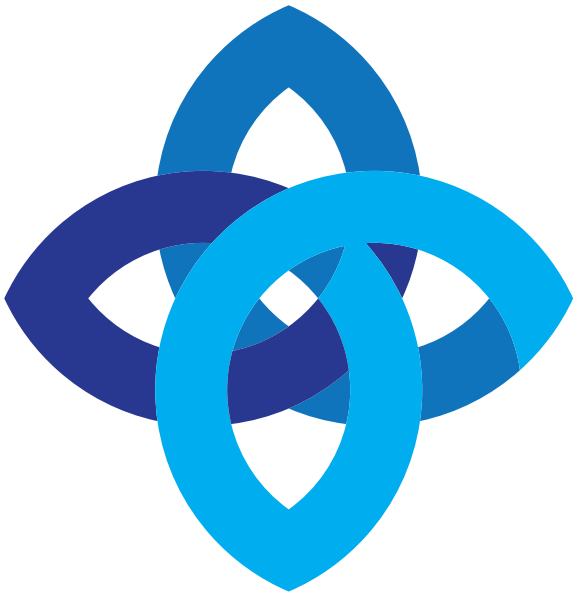
EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_09**
Subject Title	**Communications Objective: Creating a Brand for the East Dunbartonshire Health & Social Care Partnership**
Report By	**Sandra Cairney, Head of Strategy Planning & Health Improvement** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Fiona Borland, Communications Adviser** **East Dunbartonshire Health & Social Care Partnership** **0141 574 5530** **Fiona.borland@eastdunbarton.gov.uk**

1.0	**PURPOSE OF REPORT**
1.1	To seek approval for the branding that will be used to identify the East Dunbartonshire Health and Social Care Partnership (HSCP).
2.0	**SUMMARY**
2.1	A brand is important because it helps to give an organisation a clear, strong identity and also helps staff/employees to identify with the HSCP.
2.2	Creating a brand for the HSCP is a key part of its developing communication plan and a main priority for its Communication Adviser.
2.3	This branding will be used on all future correspondence, including letterheads, emails, newsletters, staff news, website presence and press releases.
2.4	Members of the Board considered a number of options at the last Board meeting, and subsequently asked for several more options to be presented.
2.5	The following report outlines several draft logos which have been created by designers from both NHS Greater Glasgow and Clyde, and East Dunbartonshire Council.
3.0	**RECOMMENDATIONS**
3.1	It is recommended that the HSCP Board: a) Decides which of the options should become the HSCP's logo, or; b) Requests that further option are created for consideration.

East Dunbartonshire Health and Social Care proposed logo design version 1 - spec sheet 1

East Dunbartonshire
Health and Social Care
Partnership



Specification:
Process blue three Colours:
1. C=85 M=50 Y=0 K=0
2. CMYK Cyan
3. C=100 M=95 Y=5 K=0
4. Black.

Interlinking band indicating continuity and partnership. Signifying a combination of the various partners and groups for the partnership as a whole.

Grayscale:
1.55%
2. 30%
3. 86.6%
4. Black

East Dunbartonshire
Health and Social Care
Partnership

logo design version 1 - spec sheet 1 continued

East Dunbartonshire
Health and Social Care
Partnership

Blue, Black version

East Dunbartonshire
Health and Social Care
Partnership

Greyscale and black version on white

East Dunbartonshire
Health and Social Care
Partnership

White and grey-scale version on black

East Dunbartonshire
Health and Social Care
Partnership

East Dunbartonshire
Health and Social Care
Partnership

Scaled versions

East Dunbartonshire
Health and Social Care
Partnership

East Dunbartonshire Health and Social Care Partnersip

Letter example

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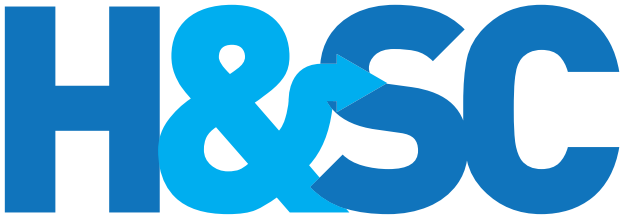
examples of possible page layout using logos

East Dunbartonshire Health and Social Care proposed logo design version 2 - spec sheet 2

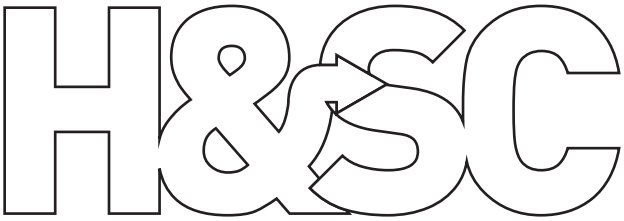


Capital letters representing Health and Social Care connected with one another signifying unity.
Use of the ampersand as a bridging device with the added 'arrow head' as an indicator of the forward direction the Partnership is undertaking.

Specification:
Three Colours:
Dark blue
Process C=85 M=50 Y=0 K=0
Lighter blue
Cyan
Black

Gray-scale:
On white with black 50%
On black with white 25%

logo design version 2 - spec sheet 2 continued



Outlined version

Grey-scale version

Scaled logos with possible web button

East Dunbartonshire
Health and Social Care
Partnership

East Dunbartonshire Health and Social Care Partnersip

Letter example

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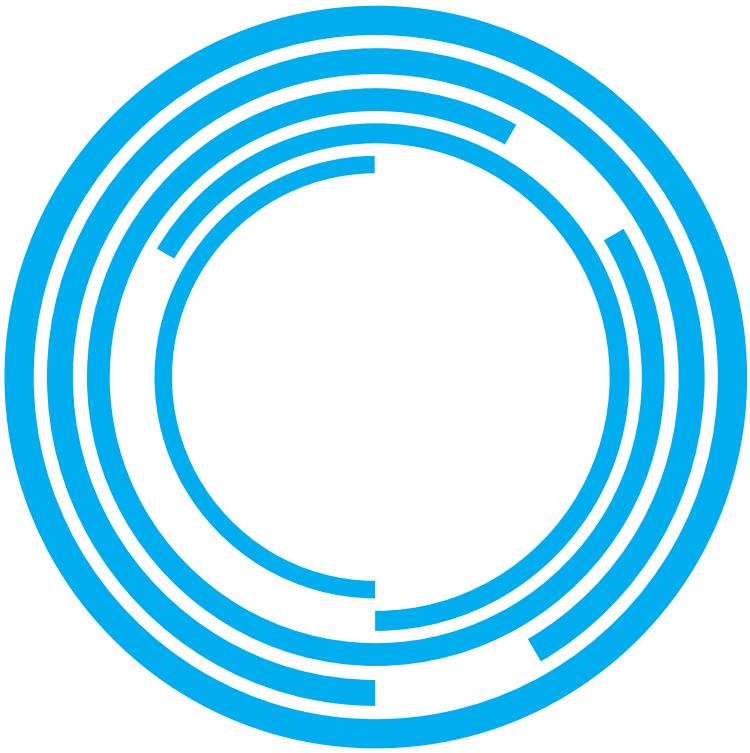
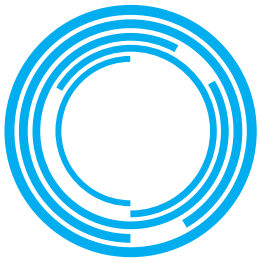
examples of possible page layout using logos

East Dunbartonshire Health and Social Care proposed logo design version 3 - spec sheet 3



Series of concentric shapes encompassed with one surrounding ellipse to signify the coming together of the partnership.



East Dunbartonshire
Health and Social Care Partnership

Specification:
Two Colours:
Cyan, black.

Gray-scale:
On white with black 50%
On black with white 25%

logo design version 2 - spec sheet 2 continued

East Dunbartonshire
Health and Social Care
Partnership

Blue, black version

East Dunbartonshire
Health and Social Care
Partnership

Blue, white and
grey-scale version

East Dunbartonshire
Health and Social Care
Partnership

White and
grey-scale version

East Dunbartonshire
Health and Social Care
Partnership

Black and
grey-scale version

East Dunbartonshire
Health and Social Care
Partnership

East Dunbartonshire
Health and Social Care
Partnership

Scaled logos

East Dunbartonshire
Health and Social Care
Partnership

East Dunbartonshire Health and Social Care Partnersip

Letter example

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examples of possible page layout using logos

East Dunbartonshire Health and Social Care proposed logo design version 4

East Dunbartonshire
Health & Social Care

East Dunbartonshire Health and Social Care Partnersip

Letter example

Ihiciunt faccabore illacepta doluptassita non eum ipsamus plaboria volupta temquam lam, voloratia dem quodici atecatae corporum faccatet haritia turibus dendebis cullore il int volorerendes utati omnimodi di delese et provitas sequuntur aut laboreium ipsus num doloreium re voluptat modis que consequunte perferro velisti co-nem dolore, soluptate doluptust est dolo quiamus ipiscia sperum qui sitis des aciis ad qui doluptas minus sum nis aut es aut autesecate comnihi caboribusci corrovit am, velectorem delesequi res dolorit ibusdandis ellest, tenihic ipsaperest dus, que exerspisim fuga. Ihit, corro modi consecu llupta doluptatate sit optat deleste stiore desseca ectiore ctoreius rerovitibus invelle nihitas sum et quam, venima vel magnatur se nemolorecte enim quatur, omnistiae con persperio tem ipsanda escident.

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East Dunbartonshire Health and Social Care proposed logo design version 5

East Dunbartonshire
Health & Social Care

East Dunbartonshire
Health & Social Care

East Dunbartonshire
Health & Social Care

East Dunbartonshire Health & Social Care

East Dunbartonshire Health and Social Care Partnersip

Letter example

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East Dunbartonshire Health and Social Care proposed logo design version 6a & 6b


EAST
DUNBARTONSHIRE
Health & Social Care Partnership


EAST
DUNBARTONSHIRE
Health & Social Care Partnership


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NHS Greater Glasgow and Clyde

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EAST DUNBARTONSHIRE HSCP

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 10

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_10**
Subject Title	**Update on the HSCP Board Development Programme 2016/17**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Linda Tindall, Senior Organisational Development Adviser** **East Dunbartonshire Health & Social Care Partnership** **0141 201 3553** **Linda.tindall@ggc.scot.nhs.uk**

1.0	**PURPOSE OF REPORT**
1.1	This report and **Appendix 1** provide an update in respect of the Development Programme for the HSCP Board for 2016/17 and notes suggested activities for 2017/18.
2.0	**SUMMARY**
2.1	In December the Scottish Government published a guide supporting the formation of Integration for Joint Boards. A number of the identified development exercises in this document took place in 2015.
2.2	A proposed programme of development opportunities were outlined in a report for discussion by the HSCP Board on 11 February 2016. A draft programme of development activities was approved by the Board on 31 March 2016 and a confirmed timetable approved by members on 26 May 2016.
2.3	HSCP Board members have attended/participated in a variety of development activities with some refinement required to the original agreed programme.
2.1	**Appendix 1** reports on the activities that have already taken place, what is still to take place and makes suggestions for development opportunities for 2017/18.
3.0	**RECOMMENDATIONS**
3.1	It is recommended that the HSCP Board: ▪ Notes progress made against the amended programme 2016/17, and ▪ Approves further suggested development activities for 2017/18

Appendix 1

HSCP BOARD DEVELOPMENT PROGRAMME 2106/17 AND SUGGESTED ACTIVITIES FOR 2017/18

Development Activities already taken place	
Service Visits	▪ KHCC – Health & Social Work staff working in the health centre ▪ Woodlands Centre – Elderly Community Mental Health Team & Silverbirch – work experience and skills development for people with learning disabilities ▪ Milngavie Clinic – Community NHS district nursing, health visiting teams and podiatry and physiotherapy services ▪ Lennoxtown Community Hub
Topic Specific Seminars	▪ Joint Health Improvement Plan functions and key deliverables ▪ Understanding the additional HSCP in scope services for Children and Families and Criminal Justice Social Work
Half Day Seminar	▪ Develop a good working knowledge of how performance management systems and performance data is used in the HSCP
Development Activities – 2016/17	
Service visits	▪ 7 December 2016 – visit to Milan Centre – ethnic day care centre in Kirkintilloch ▪ 9 February 2017 - Low Moss Prison – Work of the prison and links to East Dunbartonshire HSCP
Topic Specific Seminars	▪ 26 January 2017 – The role of the HSCP Board in the strategic planning of unscheduled care
Half Day Seminar	▪ 16 March 2017 – Working to support localities and understanding the GP contract
Suggested Activities for 2017/18	
Service Visits	▪ Homecare Team – KHCC ▪ Service User & Carer Representatives support meeting ▪ Respite provision in Bishopbriggs and Twechar ▪ Smart technology demonstration suite ▪ Carers link – Supporting Young Carers in East Dunbartonshire ▪ Visit to the Children's Unit at Ferndale
Topic Specific Seminars	▪ Introduction to Adults with incapacity and the role of the Mental Health Officer ▪ Care Homes – Relationship between the HSCP and the wider service provision ▪ Introduction to the Carers Act 2017
Half Day Seminar	▪ HSCP governance arrangements including clinical governance

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 11

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_11**
Subject Title	**East Dunbartonshire Health & Social Care Partnership Audit Committee Minutes of 29th September 2016**
Report By	**Jean Campbell, Chief Finance and Resources Officer East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Jean Campbell, Chief Finance and Resources Officer East Dunbartonshire Health & Social Care Partnership 0141 201 4210 Jean.campbell@eastdunbarton.gov.uk**

1.0	**PURPOSE OF REPORT**
1.1	To provide the HSCP Board with the minute of the Audit Committee Meeting held on 29th September 2016, attached as **Appendix 1**.
2.0	**RECOMMENDATIONS**
2.1	It is recommended that the HSCP Board: ▪ Note the content of the minute attached at **Appendix 1**.

East Dunbartonshire
Health and Social Care Partnership

Interim Chief Officer: Mr James Hobson

Minutes of
East Dunbartonshire Health & Social Care Partnership Audit Committee Meeting
held at 1:00pm on Thursday 29th September 2016
in the Corporate Meeting Room, HSCP HQ, Stobhill Hospital

Present:	**Ian Fraser (Chair)**	**(IF)**	**Jean Campbell**	**(JC)**
	Rhondda Geekie	**(RG)**	**Louisa Yule**	**(LY)**
	Peter Lindsay	**(PL)**	**Anne McNair**	**(AM)**
	David O'Connell	**(DO)**		
	Jamie Robertson	**(JR)**		
In attendance:	**Kirsty Gilliland (Minutes)**	**(KG)**		

No.	Topic	Action by
1.	**Welcome and Apologies**	
	Mr Ian Fraser welcomed those present. No apologies were noted.	
2.	**Minutes of previous meeting – 20th June 2016**	
	The minute of the meeting held on 20th June 2016 was approved as an accurate record.	
3.	**Audit Scotland – 2015/16 Draft Annual Audit**	
	Mr McConnell gave an overview of the Draft Annual Audit for 2015/16 and advised that there are no matters other than those set out in the report that need to be brought to the attention of the Committee. Cllr McNair referred to paragraph 77 of the report and asked Mr Lindsay to be more specific. Mr Lindsay explained that the revenue budget monitoring reports provided only actual expenditure variances against budget expenditure for the whole financial year and not for the period in which the Partnership was operational during 2015/16. This will resolve itself in 2016/17. Cllr McNair referred to paragraph 81 of the report and asked for further information. Mr Robertson advised that this was linked into paragraph 80. This is in reference to East Dunbartonshire Council, PricewaterhouseCoopers (PwC) and NHS Greater Glasgow & Clyde. There was no formal mechanism in place for the internal audit service provider for NHS Greater Glasgow & Clyde, PwC, to consult with the Audit Committee regarding the audit work they planned to carry out in relation to the Partnership, nor was there a protocol for PwC reports to be presented to the Audit Committee. The process needs formalised through further discussion. Cllr Geekie asked if this would be discussed further at the Committee and Mr Fraser confirmed this. Cllr McNair highlighted that the budget timescales are different. Ms Campbell explained that financial reporting is different, therefore, timescales are different. She advised that the Health Board will not formally set the budget until June 2017, however, we will have an	

	indicative budget in advance. National work is underway to dovetail health board and council budget setting processes to give earlier indications of the finalised budgets for partnerships. There will be no definitive decision until December. Cllr McNair asked that there is more transparency with regards to papers being available to the public. Ms Campbell advised that this information will be more readily available as the website is developed as part of the communication strategy. The Committee noted the report and Mr Fraser thanked Mr McConnell for the update.	
4.	**Final Audited Accounts 2015/16**	
	Ms Campbell presented the audited final accounts for 2015/16 and advised that this had been updated to remedy any consistency and presentational issues. The report detailed a surplus of £1.388m which will be allocated to reserves and carried forward to 2016/17. An element of the carry forward is required to meet on-going commitments; however, there will be a surplus to meet the priorities set out in the Strategic Plan, and to provide some resilience for on-going pressure and slippage in savings plans. The Committee approved the accounts and Mr Fraser thanked Ms Campbell for the update.	
5.	**NHS GG&C Internal Audit 6 Monthly Update**	
	Ms Campbell presented the NHS GG&C Internal Audit 6 Monthly update to the Committee. The report is a reflection of audit work carried out within NHS GG&C over a 6 month period which has an impact upon the delivery of the strategic plan. Ms Campbell advised that East Dunbartonshire HSCP is looking locally at their own risk management issues / arrangements. Any areas identified as high risk will be discussed at the Clinical and Care Governance Group. Ms Campbell advised the Committee that this was a high level summary. Further information could be requested. Mr Fraser thanked Ms Campbell for the update.	**JC**
6.	**EDC – Internal Audit Report Update**	
	Mr Robertson gave an overview of the internal audit reports issued in the period since the last meeting that are of relevance to the activities of the Health & Social Care Partnership. He highlighted several areas, including the Fostering Services Report; Shared Services and the risks identified in relation to direct payments and authorisation of Carefirst payments. Mr Robertson advised that an action plan had been formulated in order to rectify these issues. Mr Fraser thanked Mr Robertson for the update.	
7.	**Date of Next Meeting**	
	To be arranged.	

Agenda Item Number: 12

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_12**
Subject Title	**Clinical & Care Governance Group Minutes of 5th October 2016**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Dr Graham Morrison, Clinical Director** **East Dunbartonshire Health & Social Care Partnership** **0141 201 3553** **Graham.morrison@nhs.net**

1.0 PURPOSE OF REPORT

1.1 To provide the HSCP Board with the minute of the Clinical & Care Governance Group Meeting of 5th October 2016, attached as **Appendix 1**.

2.0 RECOMMENDATIONS

2.1 It is recommended that the HSCP Board:

- Note the content of the minute attached as **Appendix 1**

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Clinical & Care Governance Sub Group
5th October 2016, 2.30pm
Room G13, Kirkintilloch Health & Care Centre

Members Present

Name	Designation
Lisa Williams	Associate Clinical Director
Andy Martin	Head of Adult & Primary Care Services
Claire Carthy	Fieldwork Manager
Philip O'Hare	Clinical Risk Co-Coordinator
Carolyn Fitzpatrick	Prescribing Lead
Fiona Munro	Manager, Rehab & Older Peoples Services
Andrew Millar	Clinical Effectiveness Co-Coordinator
Lorraine Currie	Nurse Team Leader, PCMHT / CMHT
Wilma Hepburn	Professional Nurse Advisor
David Formstone	Fieldwork Manager - Adults

In Attendance

Name	Designation
Lorna Barr	Nurse Team Leader, Children & Families
Dianne Rice	Minutes

Apologies

Paolo Mazzoncinni	Chief Social Work Officer
Lorna Hood	Senior Nurse, children & Families
Graham Morrison	Clinical Director

No.	Topic	Action
1.	**Apologies and attendance**	
	Apologies and attendance are detailed on page 1	
2.	**Minutes of previous meeting – 27th July 2016**	
	The minutes of the meeting on 27th July 2016 were agreed as an accurate record.	
3.	**Matters arising**	
	Death Verification in Care Homes Wilma Hepburn advised the group that the Verification of Expected Deaths Policy has been reviewed, updated and will be available soon for use within the community, by DN teams. The main change is that community staff will be able to verify expected deaths during normal working hours as well as out of hours, providing that a VOED form is on place. Wilma explained that there has been confusion around this topic and that Out of Hours are looking for Care Homes to verify **all** deaths, that occur within care homes. Once the Verification of Expected Deaths Policy has been agreed, Care Homes will also have the opportunity to use this if they wish.	**WH**
	Clinical & Care Governance Workplan Lisa Williams advised that she is awaiting comments on the document. Lisa advised that she will re-circulate the document to the working group and plan a further meeting to progress this piece of work. It was agreed that input will be sought from appropriate individuals as needed.	**LW**
	Outcomes from audits / pdsa completion Lisa Williams highlighted that all teams completing audits or a pdsa should make sure that all actions highlighted should be completed.	**All**
	Insulin Incidents It was noted that there had been 3 incidents in relation to Insulin administration in the community highlighted in the past few incident reports. Discussion had taken place at previous meetings in relation to the categorisation of these incidents. These incidents are not a minor incident and should be categorised as "3 or 4" because of the potential for harm. Wilma Hepburn advised that action plans have been devised in relation to these incidents and the relevant staff work through these and share outcomes. Philip O'Hare advised that if incidents are found to have a common theme then a combined SCI could be completed with the support of the Clinical Risk Department. Dianne Rice noted that the incidents, although finally approved, still are categorised as minor and asked if these could be changed after final approval.	

	Philip advised that information on incidents can be changed at any point to reflect the accuracy of the incident.	

5	**(a) Core Audit Report**	
	The group reviewed the audits from each service. No issues were highlighted. Lisa and Dianne will meet to discuss when the core audits should be included within the agenda.	**DR/LW**
	(b) Safety Cross Report	
	The group reviewed the safety cross report. No issues were highlighted.	
	(c) LD Governance	
	Andy Martin highlighted that since integration there seemed to be gaps within responsibility structures. LD and Mental Health Governance have their own separate reporting structures, and he expressed concern as to where ultimate HSCP responsibility lies in terms of over-arching responsibility for governance within LD and Mental Health. It was highlighted that the reporting structure may be incorporated in the Clinical Governance and HSCP Reporting structure which was submitted to the Board with the move to integration. Lisa Williams agreed to review this, and seek clarity from the CGSU/ other HSCPs as to how they are managing their governance arrangements, and feedback to the group. The group agreed that the agenda should state LD Governance Update, Mental Health Update and EDADS Update.	**LW**
	(d) CG Partnership Minutes – 21st July 2016	
	These minutes were circulated previously with the agenda for information. Lisa Williams advised that there had been a recent meeting, however, had not compiled notes of this. Lisa will circulate her notes to the group once complete.	**LW**
	(e) Board Clinical Governance Forum – 16/08/16	
	These papers were circulated previously with the agenda for information.	
6.	**(a) Care Homes Update**	
	Andy Martin informed the group that he had met with Graham Morrison, Clinical Director in relation to issues arising from GP interfacing with Care Homes. Andy advised that there is an existing group which they are looking to strengthen - the group to include representatives from both GP and Care Home sector. Andy advised that Gillian Notman, Change & Redesign Manager is currently looking at the Terms of Reference for the group. Andy expressed that there is a need to future proof plans for the upcoming development of further care homes within the area. East Dunbartonshire HSCP will be introducing 8 Intermediate Care beds which will be based within a Bearsden Care Home. This will provide an opportunity to discharge people out of hospital and provide them with Rehabilitation / Physiotherapy service etc whilst determining the most appropriate final placement for them. These are essentially 'Step-Down' beds, and will be filled	

	by the Hospital Assessment teams. Use of the beds will be closely monitored. Lisa Williams made reference to the Care Home grading system and asked if there was anything to highlight in relation to issues. Andy advised that there is a quarterly report submitted and this has shown no recent issues.	

	(b) Clinical Risk Update	
	Philip O'Hare attending the meeting and provided 2 incident reports covering the periods April – June 2016 & July – September 2016. These reports were circulated prior to the meeting for information. Philip expressed that he had no concerns in relation to East Dunbartonshire HSCPs incidents. Discussion took place around 2 SCI's which are currently outstanding and Philip asked that these are investigated and closed by the Commissioner of the incident. SCI incident should be completed within 3months. DR and LW will look into this to ensure this happens.	
	(c) Incident Report – 15/07/16 – 15/09/16	
	The incident report for the above period was discussed. An incident was highlighted which resulted because of a staff shortage. Andy Martin advised that this issue was being dealt with. There was some discussion as to the appropriateness of this having been recorded as a Datix incident, as this was not a clinical issue and no incident actually happened. AM advised this had been discussed.	
	(d) Datix Meeting – 5th August 2016	
	The minutes were circulated previously with the agenda for information. Philip O'Hare updated the group that at this meeting they discussed the new one click dashboard, LearnPro modules and overdue incidents.	
7.	**Public Health Report**	
	There were no reports to note. Carolyn Fitzpatrick, Prescribing Lead highlighted that they are currently dealing with an issue in relation to Lloyds Pharmacies changing their Standing Operating Procedures which has resulted in them withdrawing from the medication protocol. The prescribing team are currently contacting affected patients to identify another pharmacy to retrieve their medications.	
8.	**Quality Improvement Work Plan**	
	Andrew Millar attending the group and updated on new projects taking place. These included Process for Pressure Ulcer Care. Andrew also advised that feedback received from End of Life Care and the LD Weight Management Attendance was positive.	
9.	**(a) Scottish Patient Safety Programme**	
	This paper was circulated previously with the agenda for information. Lisa Williams asked that this paper be circulated to the group once received at the HSCP for review and action as needed. Not all the group are currently receiving this document.	
	(b) Clinical Governance Related Guidance Newsletter – July 2016	

	This paper was circulated previously with the agenda for information.	
	(c) SPSO Update – August 2016	
	This paper was circulated previously with the agenda for information.	
	(d) Patient Feedback Options Paper – Draft	
	This paper was circulated previously with the agenda for information. Dianne Rice updated the group that there have been 2 meetings so far and this paper was the result of these meetings. At present the group have identified methods of collecting overall feedback and are in the process of scoping costs and processes.	
10.	**(a) Complaints Report – 15/07/16 – 15/09/16**	
	The group reviewed the complaints report and subsequent paperwork and agreed all was relevant and appropriate.	
	(b) GP Complaints Report	
	This paper was currently unavailable for the meeting. Lisa Williams will summarise recent report and will be discussed at the next meeting.	
	(c) Pharmacy Complaints Report	
	This paper was currently unavailable for the meeting. LW advised that independent pharmcists overall engage posiytively with Complaints information and provide data to the board as requested. Complaints are very minimal.	
	(d) Optometry Complaints Report	
	This paper was currently unavailable for the meeting. LW advised that independent optometrists have minimal complaints and provide data to the health board as requested.	
11.	**(a) Child Protection Case Conference Attendance Report – 01/04/16 – 30/06/16**	
	The report was circulated previously with the agenda for information.	
	(b) Child Protection Operational (Partnership) Group Minutes – 7th July 2016	
	The minutes were currently unavailable for the meeting.	
	(c) Child Protection – Clinical Governance Update report	
	No update was available for the meeting.	
	(d) NHSGG&C Board wide Child Protection Action Plan 2016-19 Draft	
	This paper was circulated previously with the agenda for information. Andy Martin advised that the Child & Adult Protection Performance Group monitor and update this action plan on behalf of East Dunbartonshire Health & Social Care	

	Partnership.	
	(e) Adult Protection	
	Andy Martin informed the group that the bi-ennial report was now available.	
	(f) Investigation by the Mental Welfare Commission for review and identification of local learning	
	Lisa Williams asked that the group review the recommendations from this report and identify any local actions / learning. Andy Martin advised that this will be discussed at the next Child & Adult Protection Performance Group and will feedback at the next meeting. Lisa Williams will also highlight the recommendations at the next GP Forum.	**AM/DR/ LW**
12.	**Infection Control Minutes**	
	These minutes were currently unavailable for the meeting.	
13.	**Service User Representation**	
	Dianne Rice to contact David Radford in relation to a representative.	**DR**
14.	**Public Feedback on sharing learning from adverse events**	
	This report was circulated previously with the agenda for information.	
15.	**Any other business**	
	There was no other competent business to note.	
16.	**Date and time of next meeting**	
	23rd November 2016, 2pm, Room F33b, KHCC	

Agenda Item Number: 13

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_13**
Subject Title	**Professional Advisory Group Minutes of Meeting of 26th October 2016**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Dr Graham Morrison, Clinical Director** **East Dunbartonshire Health & Social Care Partnership** **0141 201 3553** **Graham.morrison@nhs.net**

1.0	**PURPOSE OF REPORT**
1.1	To provide the HSCP Board with the minute of the Professional Advisory Group (PAG) Meeting held on Wednesday 26th October 2016, attached as **Appendix 1**.
2.0	**RECOMMENDATIONS**
2.1	It is recommended that the HSCP Board: ▪ Note the content of the minute attached as **Appendix 1**.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mr James Hobson

HSCP PROFESSIONAL ADVISORY GROUP MEETING
WEDNESDAY 26th OCTOBER 2016, CORPORATE MEETING ROOM

Present:	Graham Morrison	**(GM)**	Clinical Director
	Carolyn Fitzpatrick	**(CF)**	Lead Prescriber
	Adam Bowman	**(AB)**	Consultant Physician
	Wilma Hepburn	**(WH)**	Professional Nurse Advisor
	Aminah Haq	**(AH)**	Community Pharmacy Lead
	Morven McElroy	**(MM)**	Lead Optometrist
	Fiona Munro	**(FM)**	Community Rehabilitation
	Ashley Fergie	**(AF)**	Consultant Old Age Psychiatrist
In attendance:	Linda Tindall	**(LT)**	Senior Organisational Development Officer
	Lorraine Arnott	**(LA)**	Minutes

No	Topic/Subject	ACTION
1.	**Welcome & Apologies**	
	GM welcomed Morven McElroy to the PAG membership, and advised that she was welcome at all meetings or if and when she felt the need to provide updates and address any issues when appropriate. Introductions were then given from all members. Apologies were then noted on behalf of Lisa Williams, Andy Martin, Paolo Mazzoncini and Michael Mcgrady (Oral Health Directorate).	
2.	**Previous Minutes**	
	Accepted as a true and accurate record. Matters arising from previous minutes; • GM asked WH for brief update on nursing revalidation. WH advised that everything was fine, provided with a list every 3 months of staff due for revalidation. • With regard to Safe Disposal of Needles issues GM informed that this had been included as an agenda item for the forthcoming GP Forum meeting for discussion. • WH informed that she had fed back to the Clinical and Care Governance Group with regard to the ongoing problems surrounding the issue of insulin. It would appear to be a wider GG&C issue. • GM informed that discussion had taken place with regard to the issues with Care Homes and advised that a ToR had been prepared. GM will ensure that the group is kept up date on this issue.	

	• Step Down (Intermediate Care Beds), GM informed that there was not much more to report on with this matter at present, other than to advise that plans are still moving forward. Will be in a position to provide a more detailed update at the next meeting in January. It needs to be emphasised that this is a pilot programme and that any issues or impacts needs to be reported and addressed.	
3.	**Developing the HSCP's Vision and Values –** Linda Tindall, Senior Organisational Development Officer	
	Linda Tindall, Senior Organisational Development Officer attended the meeting to provide a short presentation on Developing the HSCPs Vision & Values. Exercises were carried out to determine members top three personal values. The vision for East Dunbartonshire HSCP is stated as "*working with people to build strong communities, promote wellbeing and provide access to care and support*". On this basis, members were asked to provide their three most important values. Also, two short video clips shown to highlight the differing experience from a service user and a member of staff with their own personal experience of patient care. A short exercise was then carried out to determine how we engage with members of public and patients in day to day activities and the most important values as a HSCP. GM thanked LT for her helpful presentation and session.	
4.	**Medication Protocol**	
	CF provided update in relation to current medication protocol. She advised that the protocol was in place to allow East Dunbartonshire Home Care staff to administer medicine to patients using MAR sheets. Health Care staff requested that if beneficial if more that 4 doses of medication be supplied in blister packs. She informed that this protocol had been in place for 10 years, however recently Lloyds Pharmacy have raised concerns that this process did not align within their Standard Operating Procedure. Meeting held with Area Managers, where they stated that they would no longer be prepared to issue MAR sheets to Home Care staff, resulting in patients being moved to different pharmacies. CF clarified that all current patients had been resolved and transferred to other pharmacies however it would appear that this is a board wide issue. GM suggested that both he and CF meet with Andy Martin, Head of Adult and Primary Care Services to discuss this issue.	**GM & CF**
5.	**Whole System Planning Session**	
	GM highlighted to members the reason for the above session, and the information gathered from this. Paper previously circulated with agenda. He identified several pertinent points from this paper and discussed with members, particularly in relation to HSCP Commissioning Plans, changes to address service pressure, and financial outlook. He also highlighted Strategic Service planning and reducing demand for Acute Care.	

	GM recommended that all members take the time to read over the document in its entirety and makes themselves aware of the work ongoing surrounding these issues. This session was held for the benefit of all Chief Officers.	
6.	**Clinical Care Governance**	
	Insulin Issues/Care Homes Both issues discussed at earlier agenda item.	
7.	**HSCP Board Issues**	
	GM informed that there were currently no issues to report.	
8.	**GP Cluster Group Update**	
	GM provided oversight of the framework around the GP cluster groups as a brief reminder for all members. • 2 CQL Leads confirmed and in place • Bishopbriggs cluster still requires a CQL. GM will meet with this cluster in early November to try and facilitate selection. • Enthusiasm and positivity still being shown by all clusters to date. • Each cluster has attached pharmacist in an advisory role. There may be a requirement in the future for Optometrist in an advisory role capacity.	
9.	**Any Other Business**	
	GM informed the membership that as of the beginning of January he would be standing down from his role as Clinical Director for East Dunbartonshire HSCP. He stated that it had been a privilege to carry out the role for a numbers of years and thanked the membership of the PAG for the continued support. No other business was discussed.	
10.	**Date of next meeting:**	
	• 11th January 2017, Corporate Meeting Room, Stobhill Hospital	

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 13

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**1st December 2016**
Report Number	**2016/17_14**
Subject Title	**Alcohol & Drug Partnership: Care Inspectorate Validated Self Assessment Feedback**
Report By	**James Hobson, Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Andy Martin, Head of Adult & Primary Care Services** **East Dunbartonshire Health & Social Care Partnership** **0141 201 4209** **Andy.martin@eastdunbarton.gov.uk**

1.0	**PURPOSE OF REPORT**
1.1	The purpose of the report is to inform the Board of the feedback recently received from the Care Inspectorate following on from the self-evaluation exercise carried out earlier this year into East Dunbartonshire Alcohol & Drug Partnership's implementation of *The Quality Principles: Standard Expectations of Care and Support in Drug & Alcohol Services*.
2.0	**SUMMARY**
2.1	At the beginning of 2016, the Scottish Government commissioned the Care Inspectorate to undertake a programme of validated self-evaluation across Alcohol and Drug Partnerships (ADPs) in Scotland.
2.2	The aim of the project was to provide an evidence informed assessment of local implementation, measurement and quality assurance of ADP and service compliance with *The Quality Principles: Standard Expectations of Care and Support in Drug & Alcohol Services.*
2.3	The self-evaluation was coordinated by the ADP Coordinator and the Team Manager of East Dunbartonshire Alcohol & Drug Service (EDADS) and submitted to the Care Inspectorate in late January 2016. Surveying of staff, service users and carers took place in February 2016 with active fieldwork in East Dunbartonshire taking place in April. The Summary of the Care Inspectorate's findings is set out in **Appendix 1**.
3.0	**RECOMMENDATIONS**
3.1	It is recommended that the HSCP Board: ▪ Notes the feedback from the Care Inspectorate

4.0	MAIN REPORT
4.1	The Care Inspectorate gathered the views of staff across services providing treatment, care and support and from individuals accessing drug and alcohol services. They carried out two online surveys in January and February 2016, aimed at gathering both the views of staff and users of services in relation to each of the Quality Principles. The staff survey was completed by 11 staff members and the service user survey was completed by 33 individuals. The results of these surveys are set out in **Appendix 2.**
4.2	They read the files of 10 individuals who received treatment and support from health, statutory and third sector services delivering drug and alcohol services. They met with 10 individuals receiving services to listen to their views about their experiences of services. They also spoke to 10 staff in these services who work directly with individuals and to members of the Alcohol and Drugs Partnership responsible for strategic planning. The analysis of this file-reading is attached as **Appendix 3**.
4.3	The Care Inspectorate validation team was made up of a Strategic Inspector working with an Associate Assessor with knowledge and practice experience in alcohol and drugs services and support from staff the Scottish Drugs Forum, National Quality Development team.
4.4	In the course of the validated self-evaluation process, they identified a number of strengths which were making a positive difference to individuals and families, as well as areas for improvement. These are identified within this feedback summary.
4.5	*The Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Services* have been developed to ensure anyone looking to address their problem drug and/or alcohol use received high quality treatment and support that assists long term, sustained recovery and keeps them safe from harm.
4.6	The Principles are intended to ensure that those who are providing treatment, care, rehabilitation, wider services and support for people recovering from problematic drug and/or alcohol use, know what is expected of them and how to continually improve the quality of the service they provide. They are also intended to ensure that commissioners of services make certain that the quality of drug and alcohol treatment and support services they commission are appropriate to meet the needs and aspirations of the people they serve.

The Quality Principles: Alcohol & Drug Partnership (ADP) Validated Self-Assessment and Improvement
East Dunbartonshire

Introduction

To support effective implementation of the Quality Principles, the Scottish Government commissioned the Care Inspectorate to undertake a programme of validated self-evaluation across Alcohol and Drug Partnerships (ADPs) in Scotland. The aim of the project was to provide an evidence-informed assessment of local implementation, measurement and quality assurance of ADP and service compliance with *The Quality Principles: Standard Expectations of Care and Support in Drug & Alcohol Services*.

To find this out we gathered the views of staff across services providing treatment, care and support and from individuals accessing drug and alcohol services. We carried out two online surveys in January and February 2016, aimed at gathering both the views of staff and users of services in relation to each of the Quality Principles. The staff survey was completed by 11 staff members and the service user survey was completed by 33 individuals.

We read the files of 10 individuals who received treatment and support from health, statutory and third sector services delivering drug and alcohol services. We met with 10 individuals receiving services to listen to their views about their experiences of services. We also spoke to 10 staff in these services who work directly with individuals and to members of the Alcohol and Drugs Partnership responsible for strategic planning. We are very grateful to everyone who talked to us as part of this validated self-evaluation process.

The Care Inspectorate validation team was made up of a Strategic Inspector working with an Associate Assessor with knowledge and practice experience in alcohol and drugs services and support from staff from the Scottish Drugs Forum, National Quality Development team.

In the course of the validated self-evaluation process, we identified a number of strengths which were making a positive difference to individuals and families, as well as areas for improvement. These are identified within this feedback summary.

1. Key performance outcomes

Quality Principle 1.
You should be able to quickly access the right kind of drug and alcohol service that keeps you safe and supports you throughout your recovery.

Strengths

- The majority of individuals experienced timely access to drug and alcohol services that were meeting their needs. Reporting arrangements were in place enabling monitoring of waiting times and reporting of the HEAT standard, ensuring appropriate performance across services was maintained.

Areas for Improvement

- The ADP recognised that there could be benefit in adopting the use of the national Recovery Outcome Web (ROW) tool. Training was being delivered with the intention of ROW being implemented when DAISy is launched.

2. Getting help at the right time

Quality Principle 2.
You should be offered high quality, evidence-informed treatment, care and support interventions which keep you safe and empower you in your recovery.

Strengths

- Most individuals who accessed services benefited from a range of treatments and supports that met their needs and facilitated their recovery.
- Most individuals benefited from a range of harm reduction interventions and initiatives that were matched to an individual's needs and offered throughout recovery.

Areas for improvement

- Individuals we met described a fragmented approach to some pathways hindering access to services and supports. Some individuals felt strongly that NHS treatment services took too long to screen, assess and treat them. They also indicated that more could be done to support their wider social and housing needs. East Dunbartonshire ADP had recognised that there could be benefit in strengthening referral pathways to ensure smoother transition between services. The ADP's Pathways Planning Subgroup was implementing this work to further support Recovery Orientated System of Care (ROSC) development.

3. Impact on staff

Quality Principle 3.
You should be supported by workers that have the right attitudes, values training and supervision throughout your recovery journey.

Strengths

- The majority of individuals completing the service user survey indicated that workers were welcoming, worked in a person-centred way and believed in their ability to change and recover. Case file analysis indicated that all individuals had regular meaningful contact with workers.

Areas for improvement

- The majority of staff agreed that they had effective support and challenge from their line managers. However, this was evident in less than half of the case files read. There was no evidence of managerial or quality assurance oversight. Reviewing approaches to recording staff supervision and oversight of individual cases could be of benefit and provide the ADP with a clearer picture of staff support and quality assurance activity.
- The ADP recognised the need to support staff in delivering trauma informed assessment and support and had undertaken training with some staff to progress this. There could be benefit in evaluating the impact of the training to support continuous improvement in trauma informed practice.

4. Impact on the community

Quality Principle 3.
That is anyone who has a role in improving outcomes for individuals, families and communities affected by problematic drug and alcohol use.

Strengths

- The ADP had a strong foundation in building community capacity and community engagement. A range of initiatives was helping to build and promote positive community capacity through education, training, ROSC activity, mutual aid and whole population approach.
- The success of Recovery Life Café in building recovery capacity was recognised through an award from the Scottish Communities Safety Network in the ‘Strengthening Community Engagement and Resilience’ category.

Areas for improvement

- Staff survey suggested that there could be benefit in the ADP demonstrating more effectively, how it is improving the quality of individual's lives in the wider community. This could enable staff to understand more clearly the wider benefits of the roles they undertake.
- The ADP recognised the benefit in progressing work and continuing to build on their evidence base of prevalence, harms and emerging trends of NPS and in delivering NPS focussed preventative activities.

5. Delivery of key processes

Quality Principle 4.
You should be involved in a strength based assessment that demonstrates the choice of recovery model and therapy is based on your needs and aspirations.
Quality Principle 5.
You should have a recovery plan that is person-centred and addresses your broader health, care and social needs, and maintains a focus on safety throughout your recovery journey.
Quality Principle 6.
You should be involved in regular reviews of your recovery plan to demonstrate it continues to meet your needs and aspirations.
Quality Principle 7.
You should have the opportunity to be involved in an ongoing review of how services are delivered throughout your recovery.
Quality Principle 8.
Services should be family inclusive as part of their practice.

Strengths

- Individuals were meaningfully involved in strength-based assessments. They received responsive support that helped to ensure that key services were identified and accessed without delay.
- Some services strongly promoted the recovery agenda and engaged individuals in wider employment, training and volunteering opportunities. Workers encouraged individuals to connect with community groups.

Areas for improvement

- Whilst staff told us that discussing consent to share information with individuals was built into key processes, analysis of case file reading and service user survey indicated that there could be benefit in this remaining an area of focus for the ADP.
- Case file analysis indicated that there could be benefit in the ADP remaining focused on the quality of assessments, including risk assessments undertaken across services.
- Whilst the majority of recovery plans in the cases that we read were outcome focused, service user survey and individuals that we met indicated that ensuring that all recovery plans are personalised and SMART could strengthen recovery planning.
- The ADP recognised that there could be benefit in providing individuals with a copy of their recovery plan to ensure that they understand and are fully involved in their recovery.
- Whilst staff and individuals were mainly positive about the review process, this was not replicated in the analysis of reviews within case file reading. Less than half of the cases read had a review and of those, and only a third were reviewed at intervals appropriate to the individual's needs. There could be benefit in the ADP further evaluating review processes and recording across ROSC.
- Staff and individuals told us that the opportunity for undertaking shared assessments, recovery planning and reviewing recovery plans was

inconsistent, resulting in duplication and less coordinated support for individuals. There could be benefit in the ADP evaluating processes across services to facilitate joint assessment, recovery planning and review for individuals where this is appropriate.

- Whilst the majority of staff indicated that individuals were informed about independent advocacy services, this was not evident from case file analysis or reflected in responses from individuals. There could be benefit in strengthening understanding of the role of independent advocacy services across the ADP to ensure individuals are as fully involved as possible.
- Whilst the majority of individuals and staff indicated that family inclusive practice was positive within East Dunbartonshire ADP, less than half of the case files read demonstrated that workers were aware of the needs of other family members and sought support for them if this was needed.

6. Policy, service development and planning

Strengths

- East Dunbartonshire ADP had well-established governance arrangements and sound mechanisms in place for reporting progress on its delivery plan.
- The ADP's drug and alcohol strategy was based on a comprehensive needs assessment which was undertaken in 2011. The ADP recognised that it could be beneficial to undertake this exercise again.
- The ADP was continuing to develop ROSC. A ROSC implementation plan was in place with planned actions due for completion by the end of 2016.
- Contract monitoring arrangements were in place and the ADP was building the Quality Principles into service specifications and service level agreements to further support ROSC.

Areas for improvement

- Whilst there was a range of approaches to involving and feeding back to individuals, there was recognition that there could be benefit in developing a defined strategy to underpin stakeholder engagement.

7. Management and support of staff

Quality Principle 3.
You should be supported by workers that have the right attitudes, values training and supervision throughout your recovery journey.

Strengths

- The majority of staff indicated that they had an annual appraisal/performance review with their line manager, which demonstrated that the ADP was supporting professional development for staff.

Areas for improvement

- The ADP recognised that developing a workforce development strategy was a priority and there were plans to progress a workforce development blueprint with Scottish Drugs Forum (SDF) as part of ROSC implementation.

- The staff survey indicated that there could be benefit in continuing to support new staff with effective and timely induction to ensure that they have the knowledge and skills appropriate to their roles.

8. Partnership working and resources

Strengths

- The ADP had a coherent partnership approach and was working collaboratively with stakeholders across all sectors demonstrating a strong commitment to further progressing ROSC.
- There were strong working relationships with appropriate thematic groups associated with ADP interventions such as Child Protection Committee (CPC), Adult Protection Committee (APC), children and families and other public protection agendas.
- Effective collaborative working had led to securing external funds to further support service developments.

Areas for improvement

- The ADP recognised that there could be benefit in further balancing the distribution of resources to support ROSC.

9. Leadership and direction

Strengths

- East Dunbartonshire ADP was collaborative, had sound governance, strategic planning and delivery arrangements with established working relationships to other thematic groups.
- The ADP was well-cited on the strategic and economic complexities framing the progression of ROSC.
- Staff were clear about the ADPs vision, values and aims and agreed that the vision was shared across services. The majority of staff indicated that senior managers communicated well with frontline staff.

Areas for improvement

- Whilst staff were clear about the ADP's vision, staff survey analysis and staff focus group suggested that there would be benefit in involving staff more fully when planning services at a strategic level.

Examples of good practice

As part of the validated self-evaluation process, we asked partners to nominate some examples of good practice which can be shown to have a positive impact on the lives of individuals, families and communities. During the onsite visit we assessed these examples to identify those which we consider would be useful to other alcohol and drugs partnerships across Scotland.

- **Alcohol Screening and Brief Intervention Approaches.** As part of a whole population approach, the alcohol screening and brief intervention strategy for East Dunbartonshire, focused on the development of alcohol brief

interventions (ABI) within a wider range of community settings. There was evidence of a strong partnership approach to supporting staff practice and development in delivering ABI's, which was assisted by third sector employment of an ABI worker. East Dunbartonshire demonstrated strong performance in delivering ABIs and intended to the review the impact on health and wellbeing evidence on alcohol consumption levels.

- **East Dunbartonshire Recovery Life Café.** Recovery Life Café is a model of co-production and was developed following service user consultation. Conclusions from this consultation included the finding that individuals in recovery struggled with relapse outwith traditional service hours. The café offered a peer support network and provided individuals with the opportunity to build on their experiences of recovery in a safe place. The café was initially set up and funded by the ADP and had developed into a fully constituted group with a management committee. Local evaluation had demonstrated positive outcomes to the wellbeing of individuals in recovery. The success of the Recovery Life Café was recognised in 2015 when it received an award in the 'Strengthening Community Engagement and Resilience' category of the Safer Communities Awards run by the Scottish Community Safety Network.

Data and Analysis of the Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug – Survey Summary Results for East Dunbartonshire

The Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Services have been developed to ensure anyone looking to address their problem drug and/or alcohol use receives high-quality treatment and support that assists long term, sustained recovery and keeps them safe from harm.

The Principles are intended to ensure that those who are providing treatment, care, rehabilitation, wider services and support for people recovering from problematic drug and/or alcohol use, know what is expected of them and how to continually improve the quality of the service they provide. They are also intended to ensure that commissioners of services make certain that the quality of drug and alcohol treatment and support services they commission are appropriate to meet the needs and aspirations of the people they serve.

The Care Inspectorate, on behalf of the Scottish Government carried out an online survey in January and February 2016 in order to find out what progress services are making towards putting the Quality Principles into practice. One survey was directed at service staff and the other at service users recovering from problematic drug and/or alcohol use who are receiving treatment from services which provide their care, rehabilitation, and wider services. We wanted to gather the views of both on the eight Quality Principles.

Summary Report

This report consists of two sections, section one provides summary charts for the service users responses and section two provides summary charts for the service staff responses.

Each section is separated into sub-sections referring to a quality principle.

Many of the survey questions invited staff to give a free text answers, and although these answers aren't included in this report they have been read and considered by the Care Inspectorate staff leading on this project.

Percentages presented in the charts are all rounded to the nearest integer and as such, may not always sum to 100.

Data and Analysis of The Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Service User Survey

The survey was split into sections, with each section referring to a quality principle.

Section 1.1 – Quality principle 1: I should be able to quickly access the right drug or alcohol service that keeps me safe and supports me throughout my recovery.

Section 1.2 – Quality principle 2: I should be offered high quality; evidence-informed treatment, care and support interventions which reduce harm and empower me in my recovery.

Section 1.3 – Quality principle 3: I should be supported by workers who have the right attitudes, values, training and supervision throughout my recovery journey.

Section 1.4 – Quality principle 4: I should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on my needs and aspirations.

Section 1.5 – Quality principle 5: I should have a recovery plan that is person-centred and addresses my broader health, care and social needs and maintains a focus on my safety throughout my recovery journey.

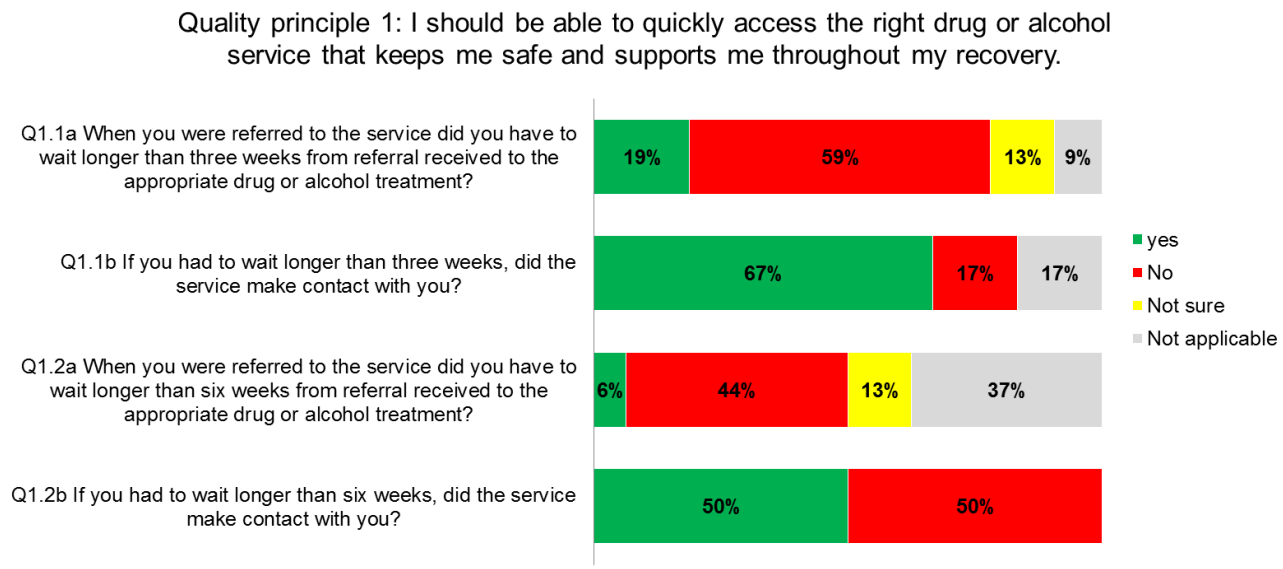
Section 1.6 – Quality principle 6: I am involved in regular reviews of my recovery plan to ensure it continues to meet my needs and aspirations.

Section 1.7 – Quality principle 7: I have the opportunity to be involved in the on-going evaluation of the delivery of services at each stage of my recovery.

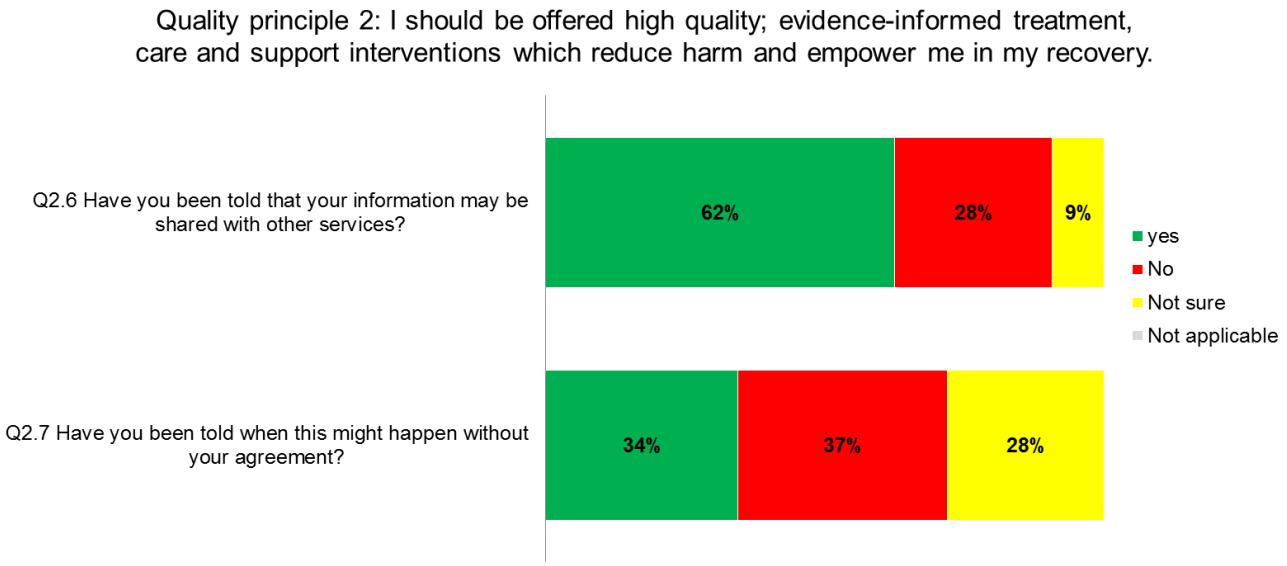
Section 1.8 – Quality principle 8: Services should be family inclusive as part of their practice.

The survey was completed by 33 service users in East Dunbartonshire, although not everyone responded to every question. The responses received were from various demographics which are outlined in Tables 1-4 in Appendix 1. Open comments from service users are provided in Table 1 of Appendix 3.

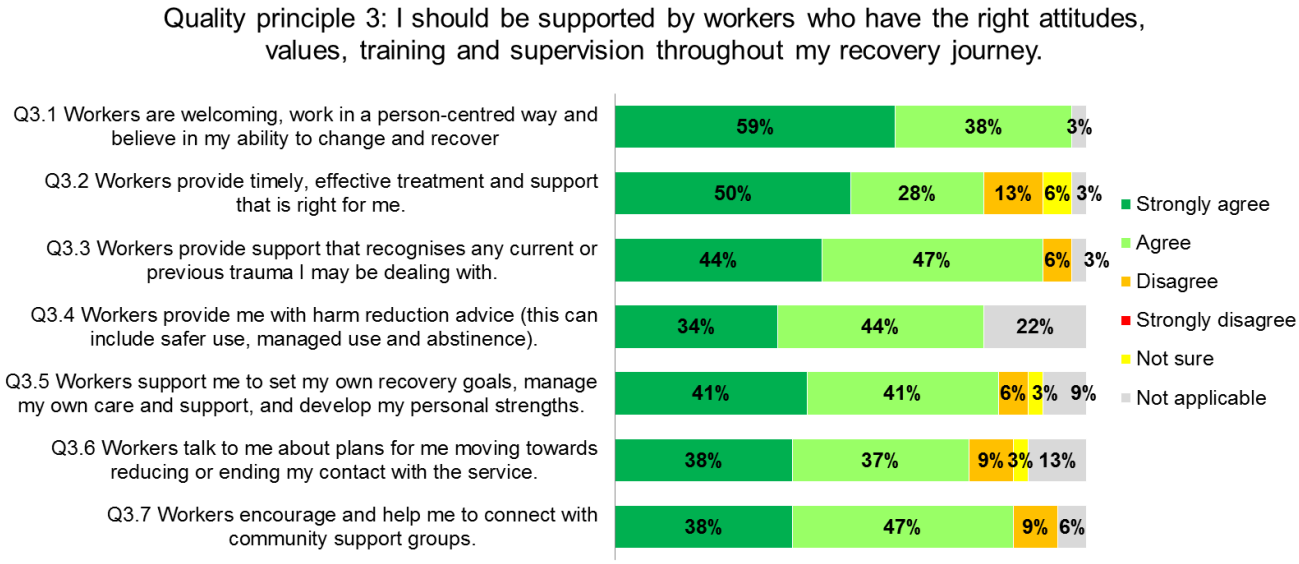
Quality principle 1: I should be able to quickly access the right drug or alcohol service that keeps me safe and supports me throughout my recovery.



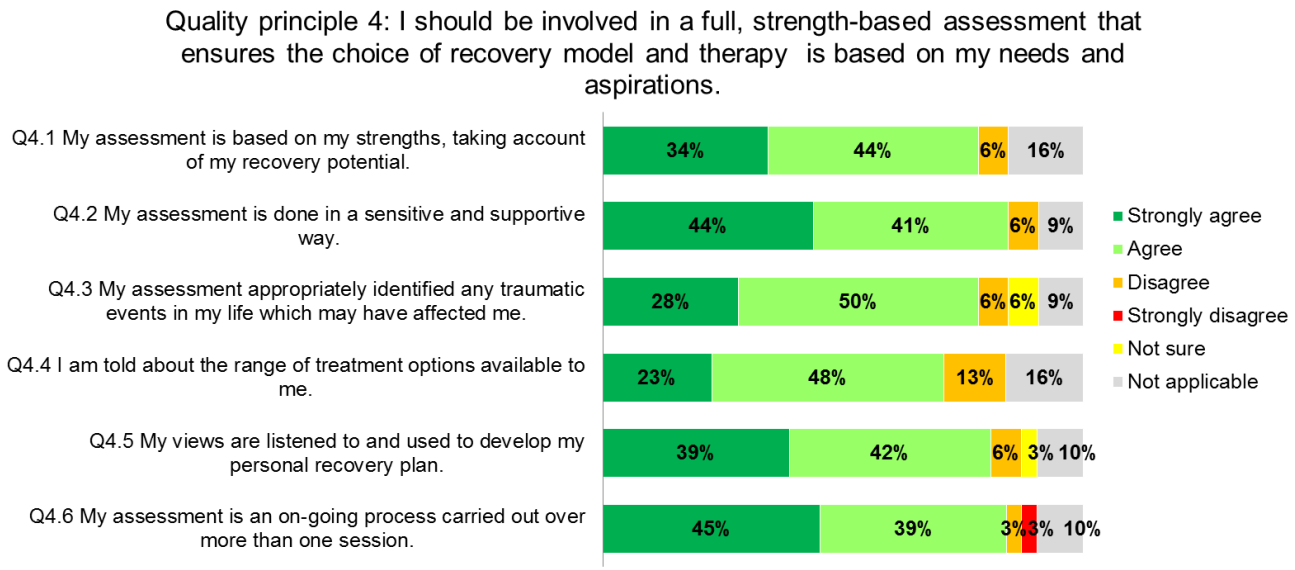
Quality principle 2: I should be offered high quality; evidence-informed treatment, care and support interventions which reduce harm and empower me in my recovery.

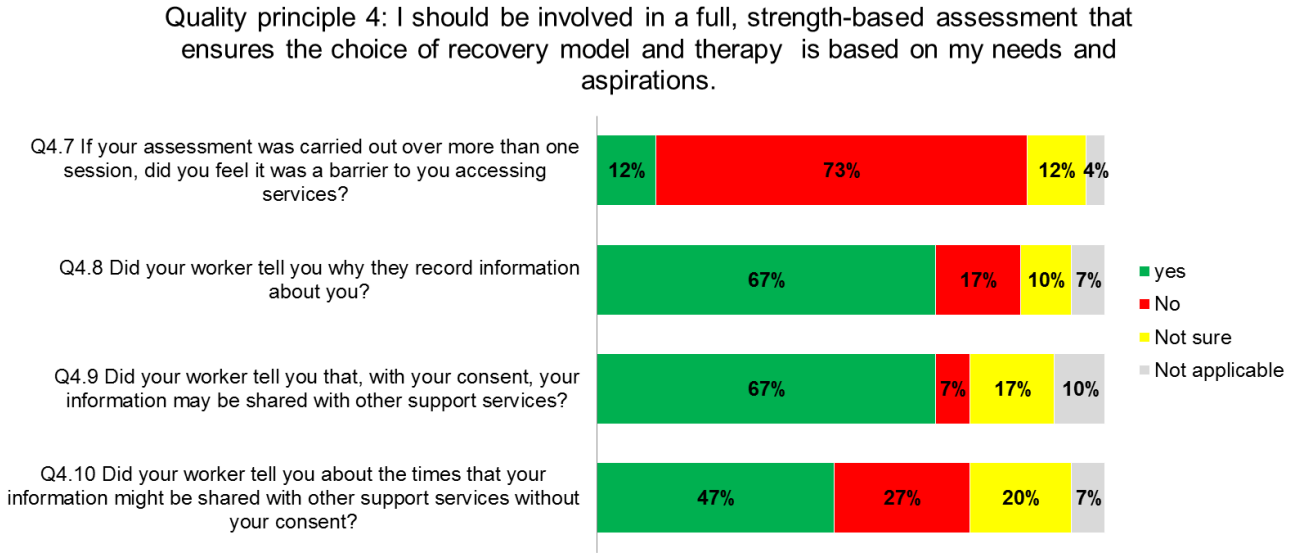


Quality principle 3: I should be supported by workers who have the right attitudes, values, training and supervision throughout my recovery journey.

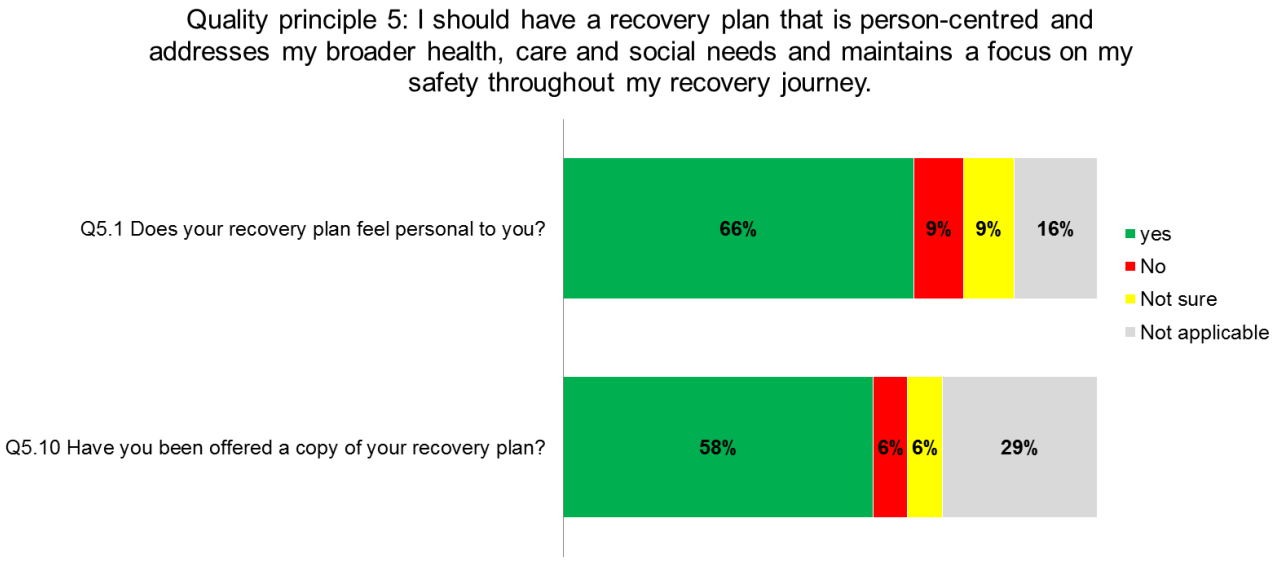


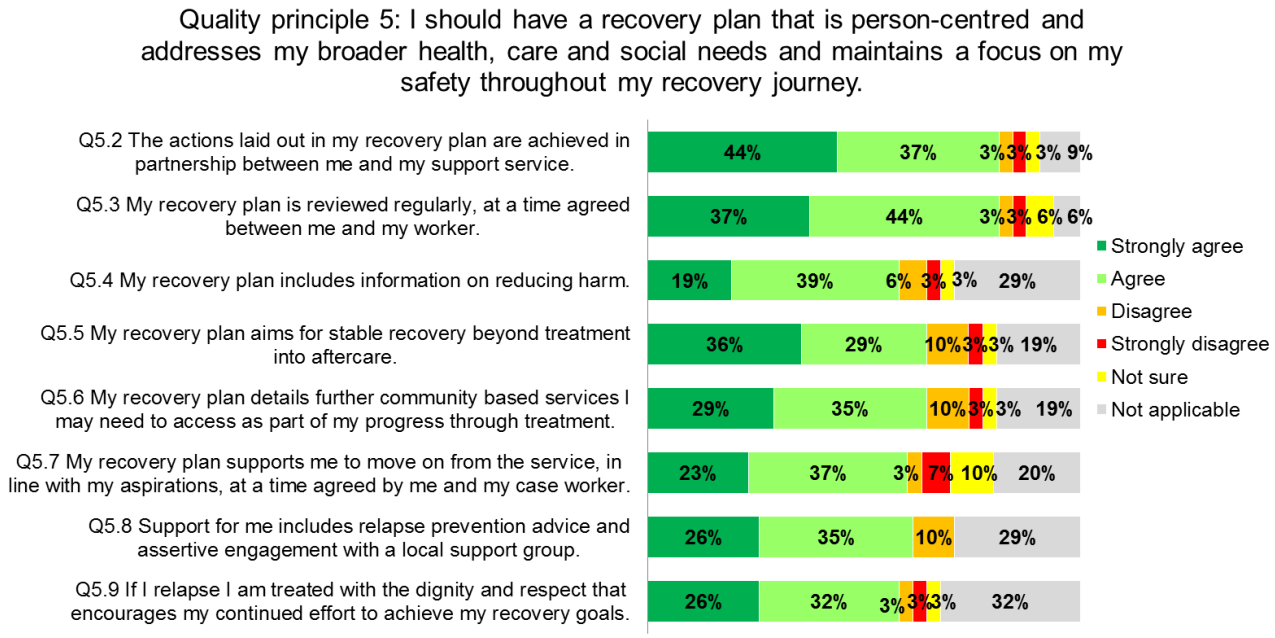
Quality principle 4: I should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on my needs and aspirations.



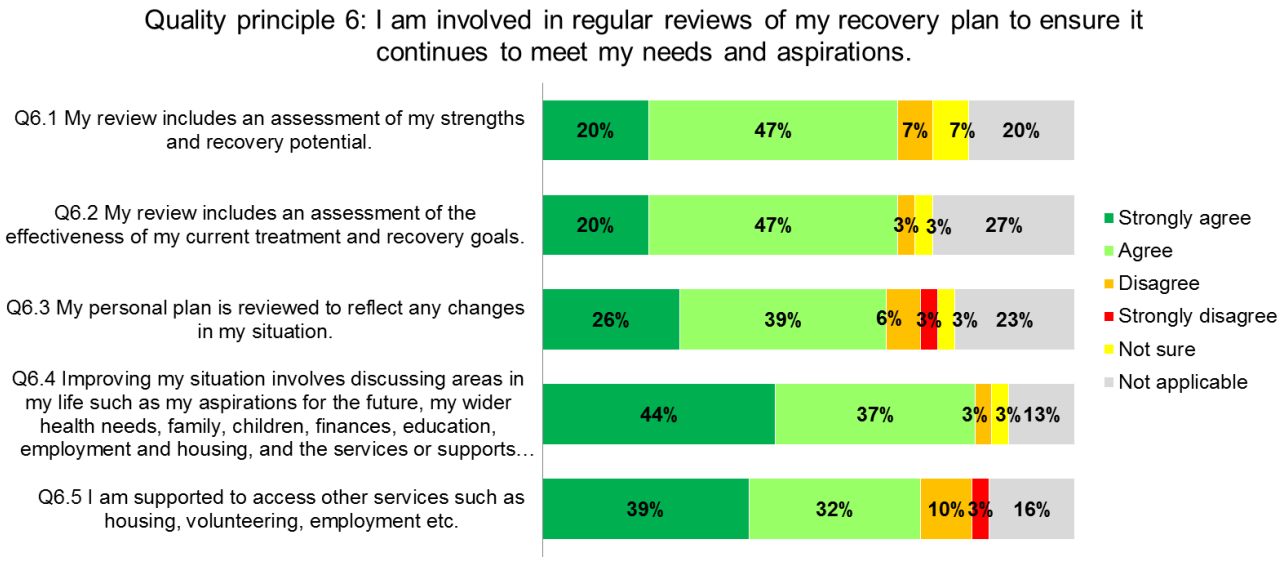


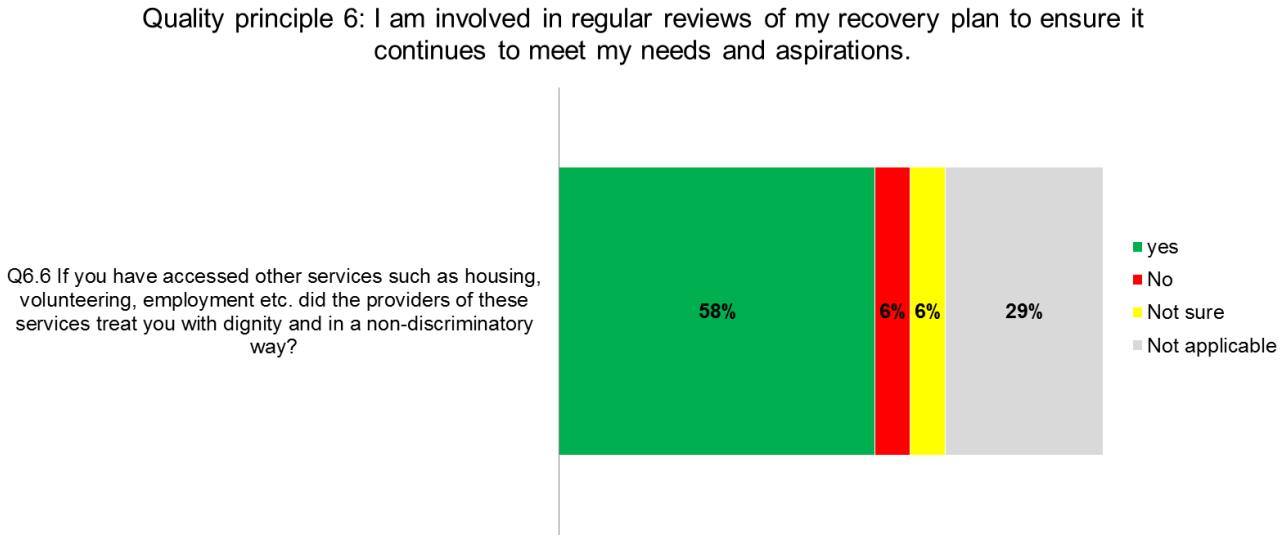
Quality principle 5: I should have a recovery plan that is person-centred and addresses my broader health, care and social needs and maintains a focus on my safety throughout my recovery journey.



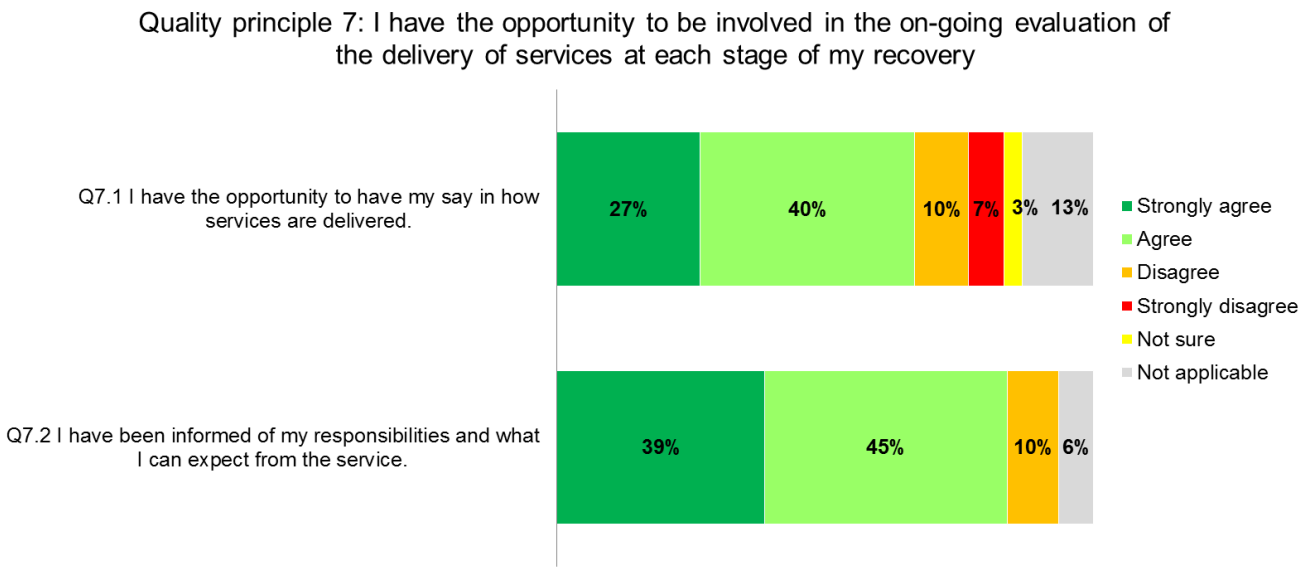


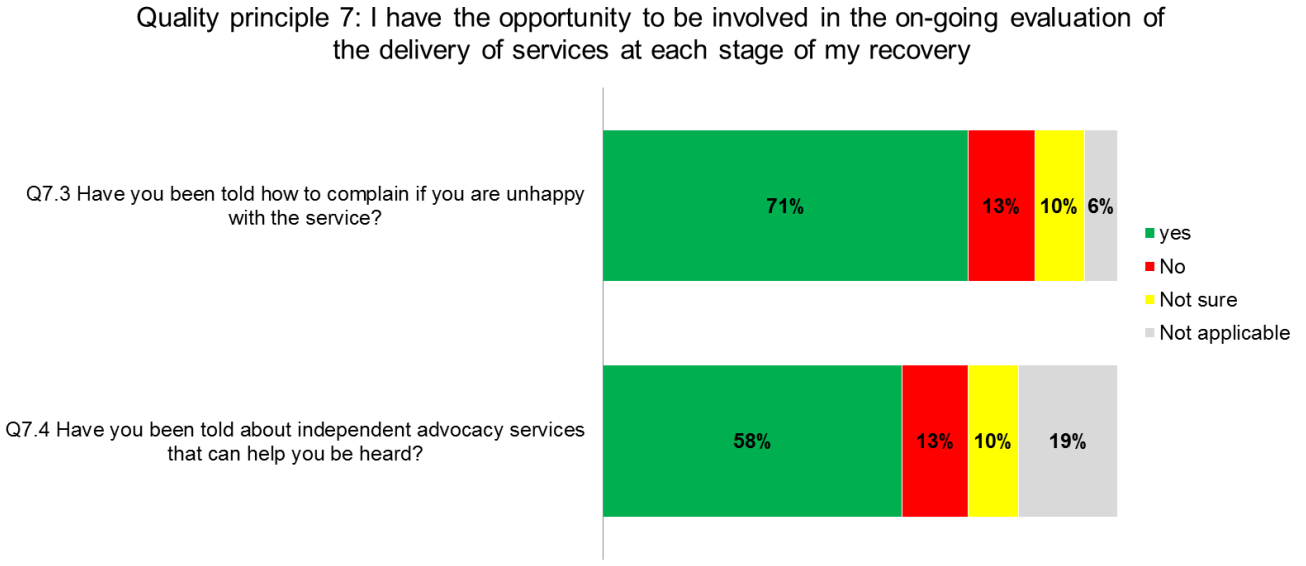
Quality principle 6: I am involved in regular reviews of my recovery plan to ensure it continues to meet my needs and aspirations.



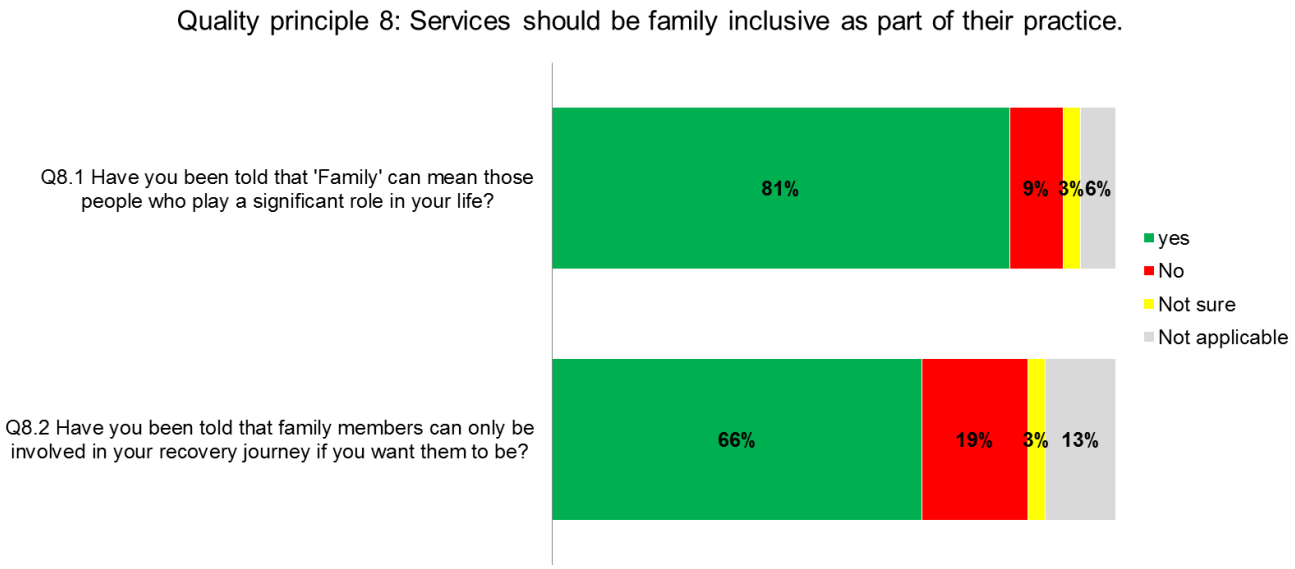


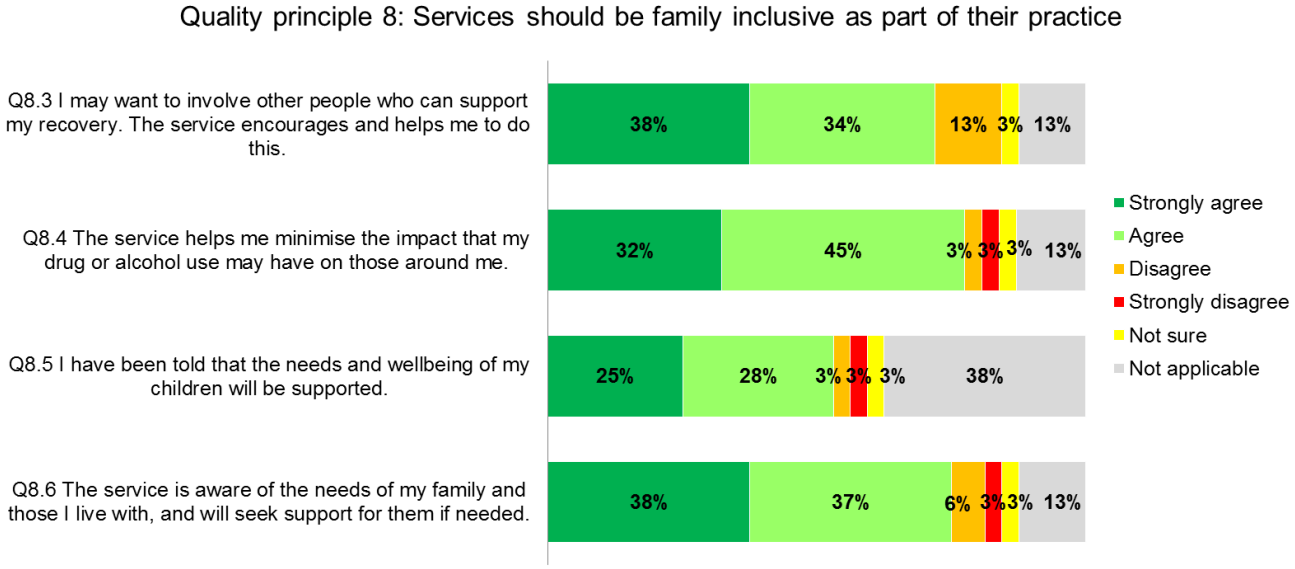
Quality principle 7: I have the opportunity to be involved in the on-going evaluation of the delivery of services at each stage of my recovery.





Quality principle 8: Services should be family inclusive as part of their practice.





Data and Analysis of The Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Service Staff Survey

The staff survey was split into sections, with each section referring to a quality principle or group of quality principles.

Section 2.1 – Quality principle 1: People accessing a service should be able to quickly access the right drug or alcohol service that keeps them safe and supports them throughout their recovery.

Section 2.2 – Quality principle 2: People accessing a service should be offered high-quality; evidence-informed treatment, care and support interventions which reduce harm and empower them in their recovery.

Section 2.3 – Quality principle 3: People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey.

Section 2.5 – Quality principle 4: People accessing a service should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on their needs and aspirations.

Section 2.6 – Quality principle 5: People accessing a service should have a recovery plan that is person-centred and addresses their broader health, care and social needs, and maintains a focus on their safety throughout their recovery journey.

Section 2.7 – Quality principle 6: People accessing a service should be involved in regular reviews of their recovery plan to ensure it continues to meet their needs and aspirations.

Section 2.8 – Quality principle 7: People accessing a service should have the opportunity to be involved in the on-going evaluation of the delivery of services at each stage of their recovery.

Section 2.9 – Quality principle 8: Services should be family inclusive as part of their practice.

Section 2.10 – Quality principle 3: People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey.

Section 2.11 – Quality principle 2: People accessing a service should be offered high-quality; evidence-informed treatment, care and support interventions which reduce harm and empower them in their recovery.

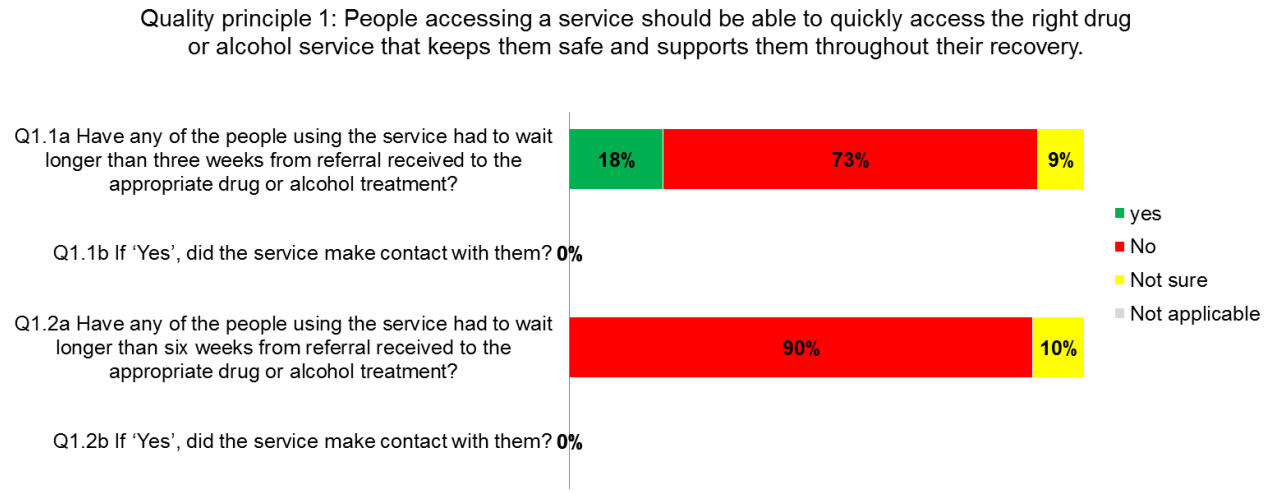
Section 2.12 – Quality principle 3 & 7: (3) People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey; (7) People accessing a service should have the

opportunity to be involved in an on-going evaluation of the delivery of services at each stage of their recovery

The survey was completed by 11 staff members in East Dunbartonshire, although not everyone responded to every question. The responses received were from various sectors which are outlined in Tables 1 in Appendix 2. All of the respondents said they work directly with people who access the services. Open comments from service staff are provided in Table 2 of Appendix 3.

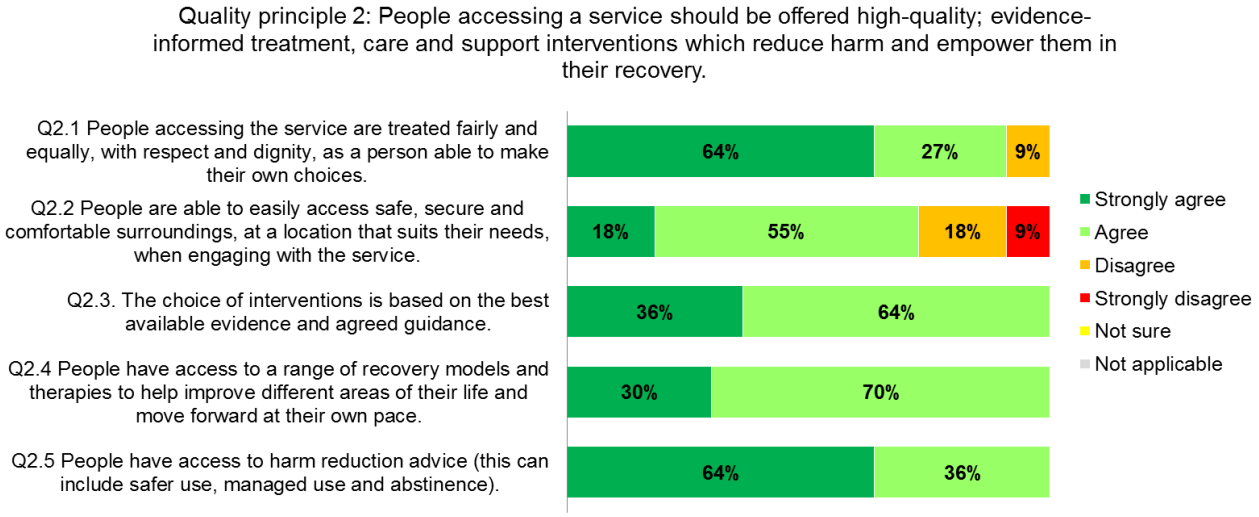
.

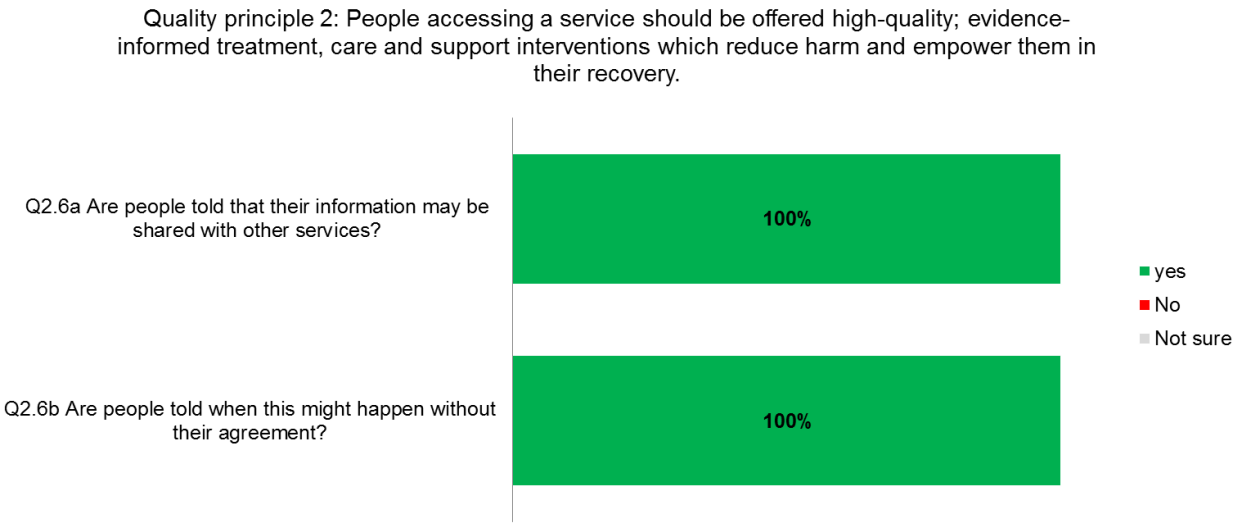
Quality principle 1: People accessing a service should be able to quickly access the right drug or alcohol service that keeps them safe and supports them throughout their recovery.



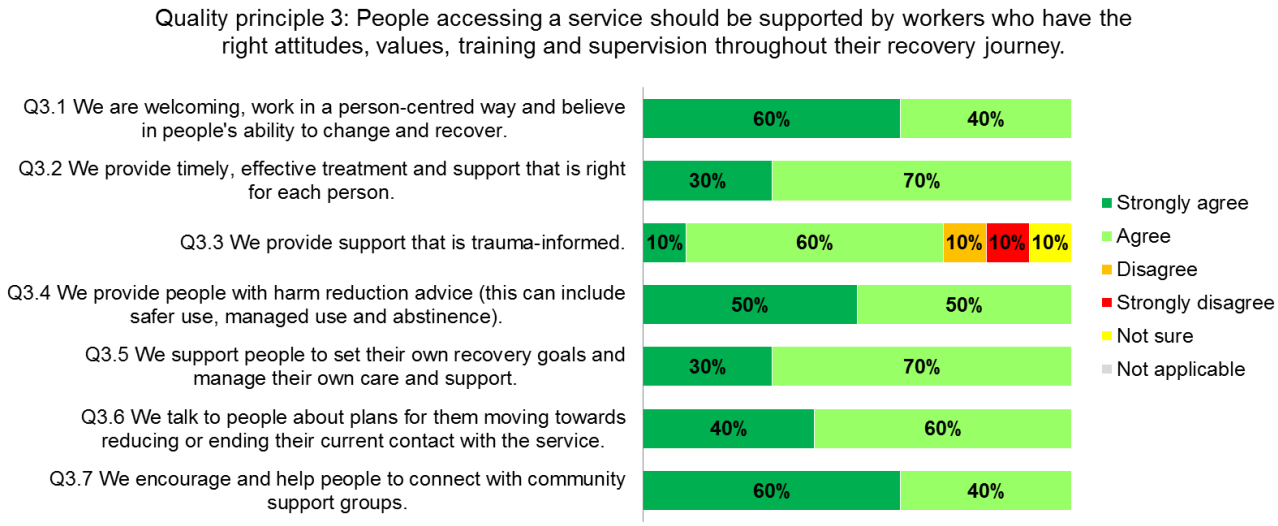
Note: Less than 5 responses to Q1.1b and no responses received to Q1.2b

Quality principle 2: People accessing a service should be offered high-quality; evidence-informed treatment, care and support interventions which reduce harm and empower them in their recovery.

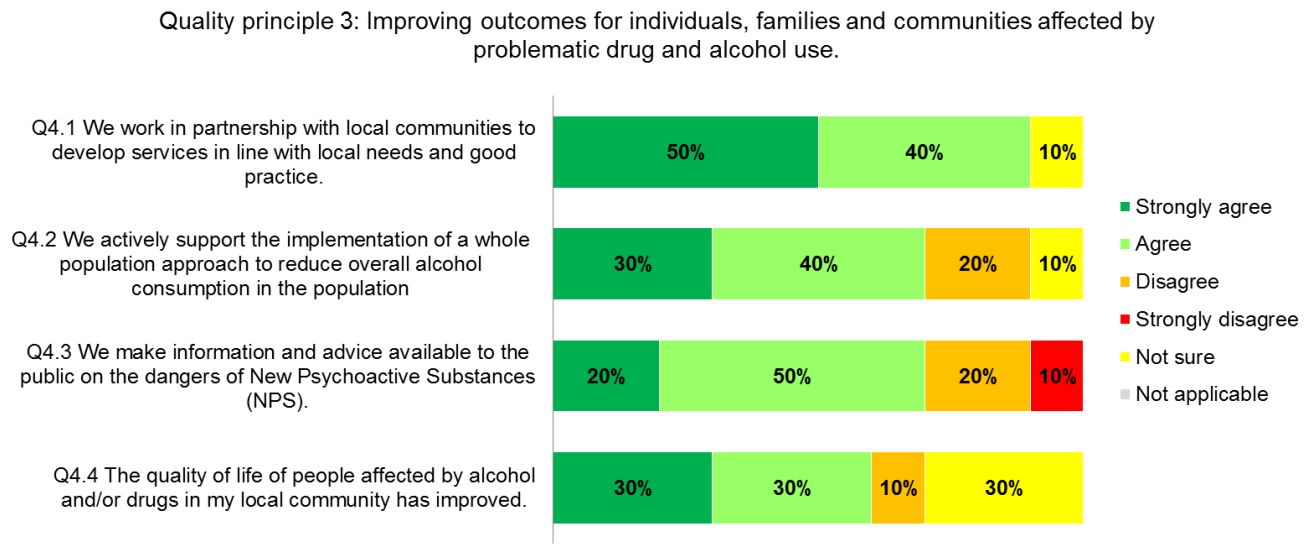




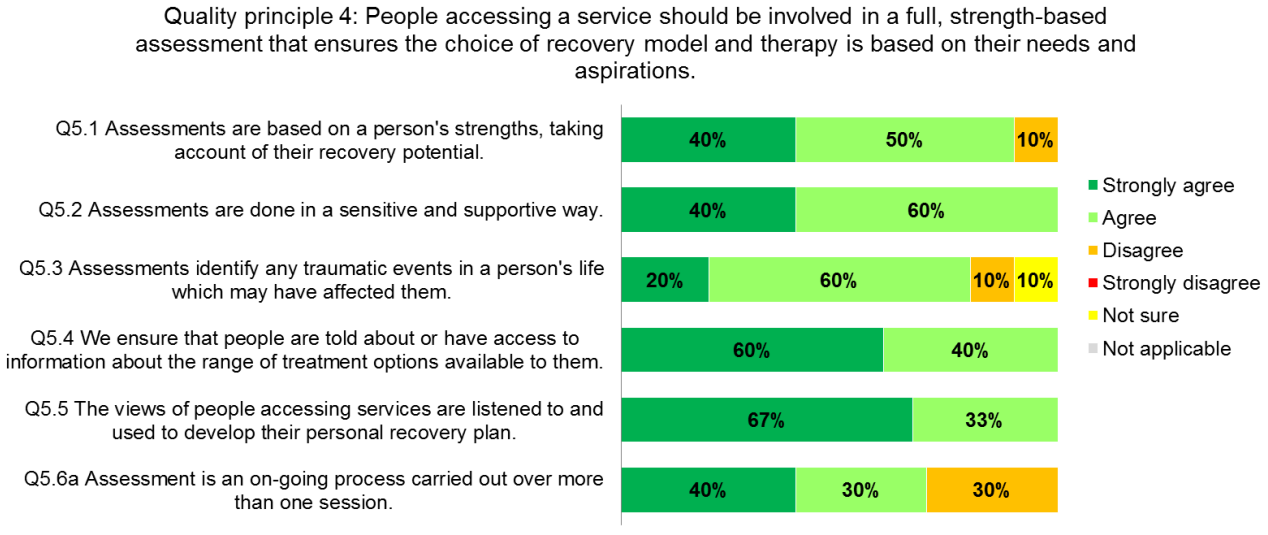
Quality principle 3: People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey.

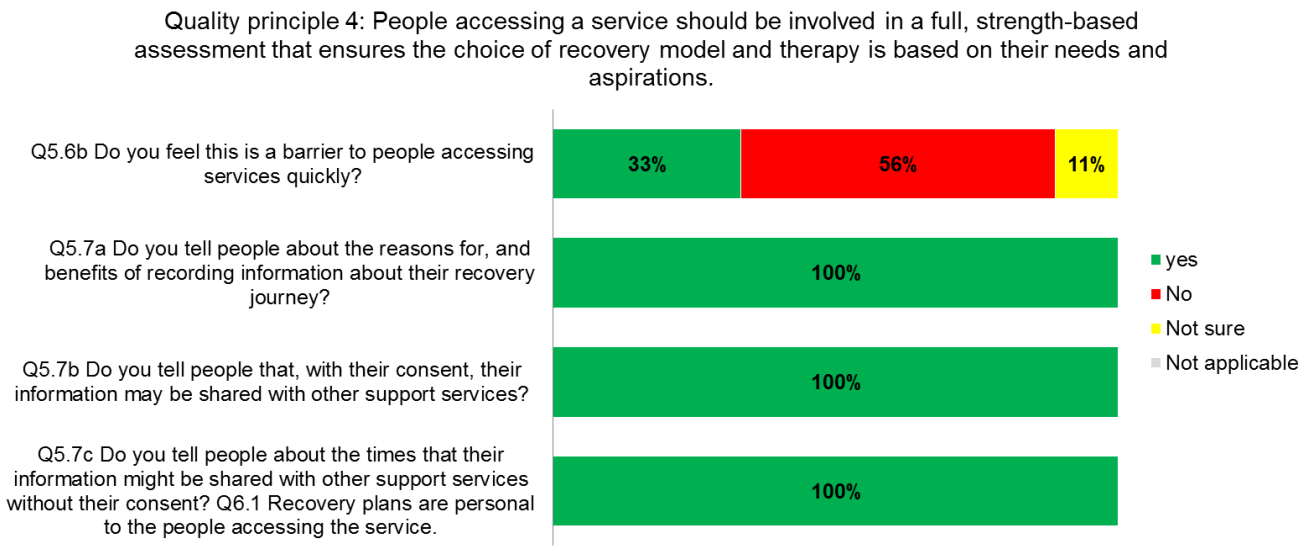


Quality principle 3: Improving outcomes for individuals, families and communities affected by problematic drug and alcohol use.

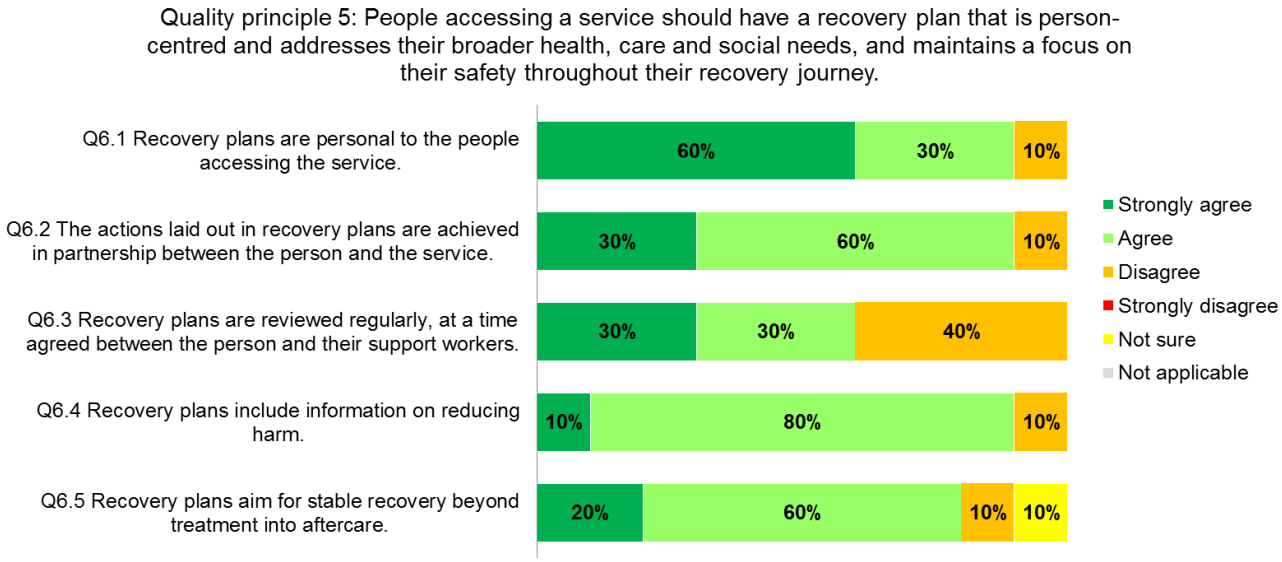


Quality principle 4: People accessing a service should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on their needs and aspirations.





Quality principle 5: People accessing a service should have a recovery plan that is person-centred and addresses their broader health, care and social needs, and maintains a focus on their safety throughout their recovery journey.



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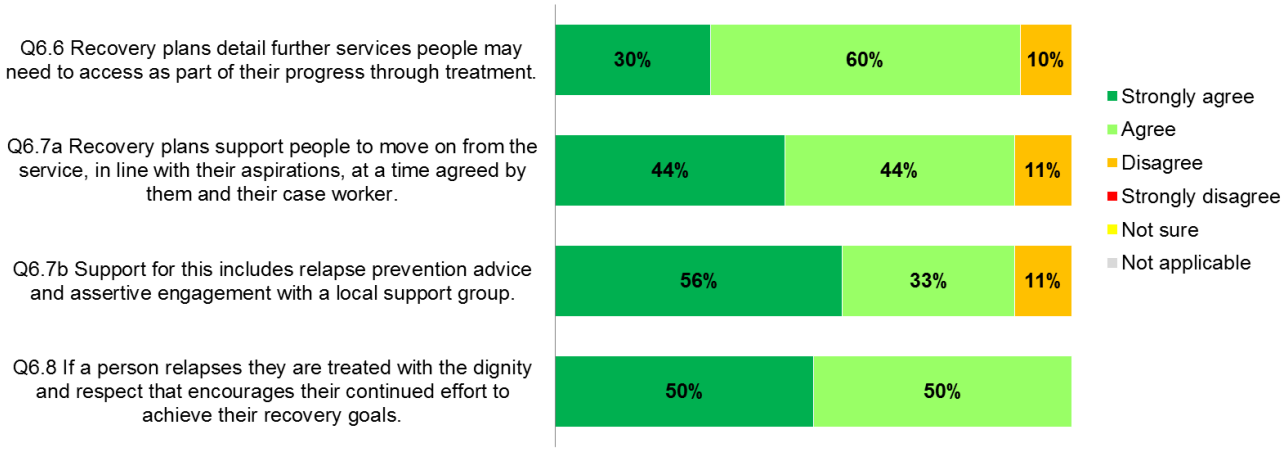

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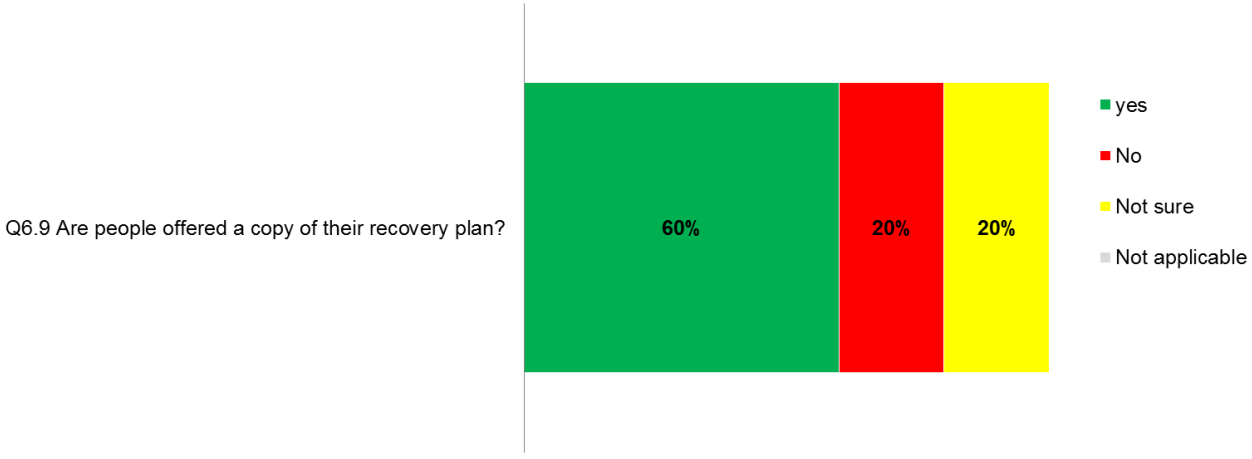
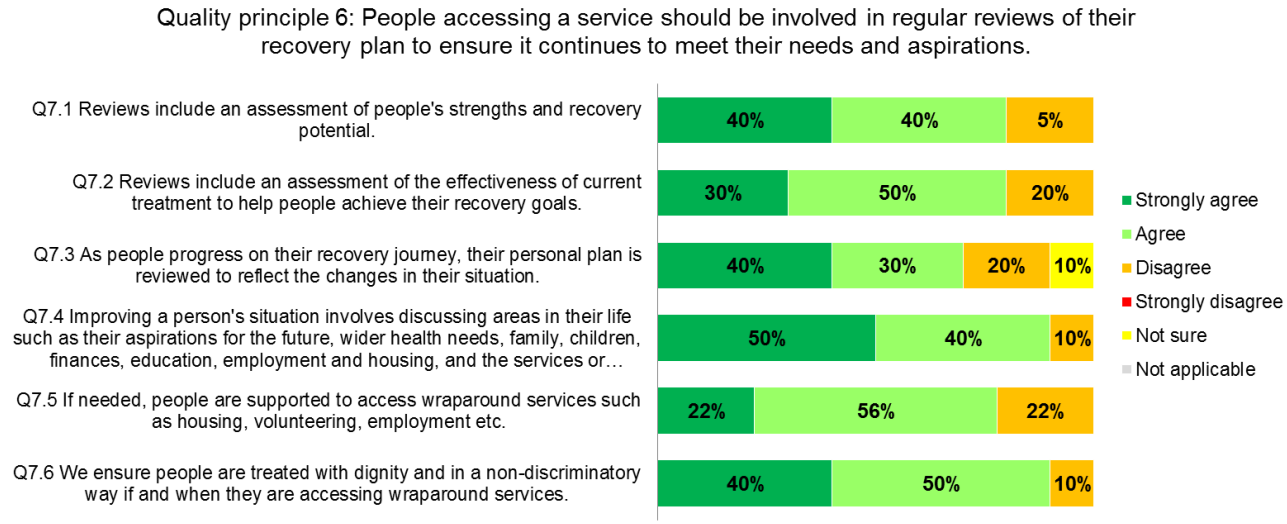
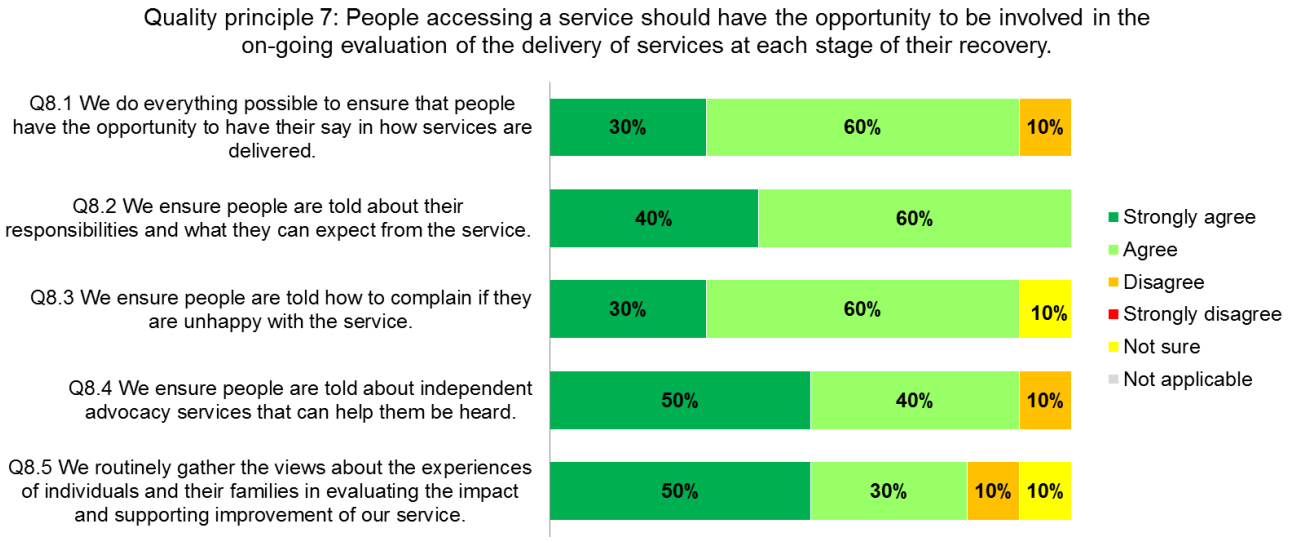


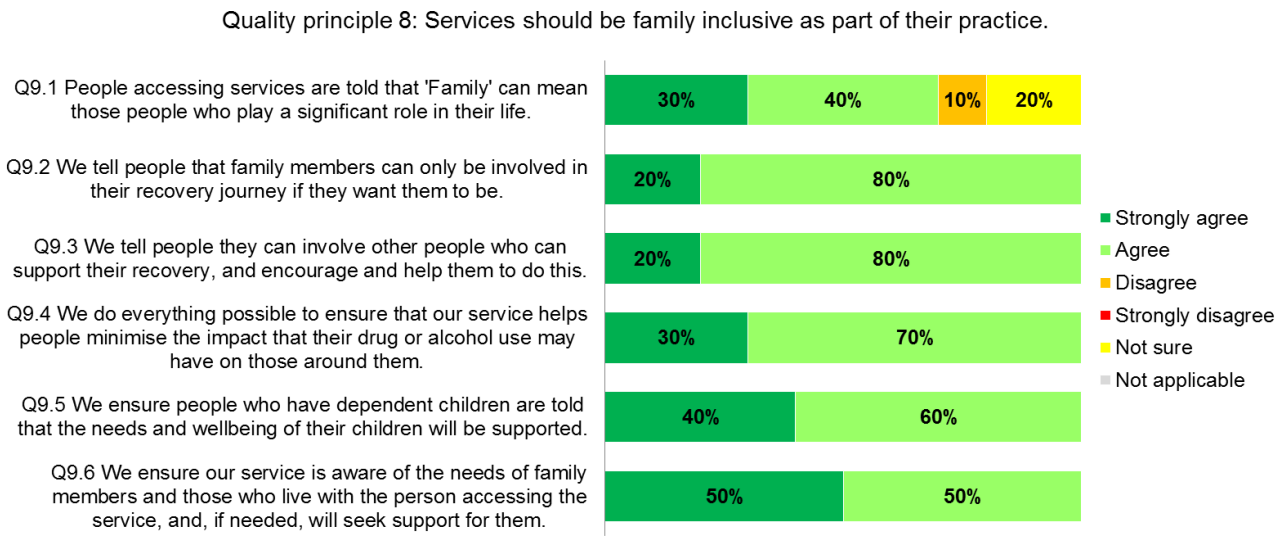
Quality principle 6: People accessing a service should be involved in regular reviews of their recovery plan to ensure it continues to meet their needs and aspirations.



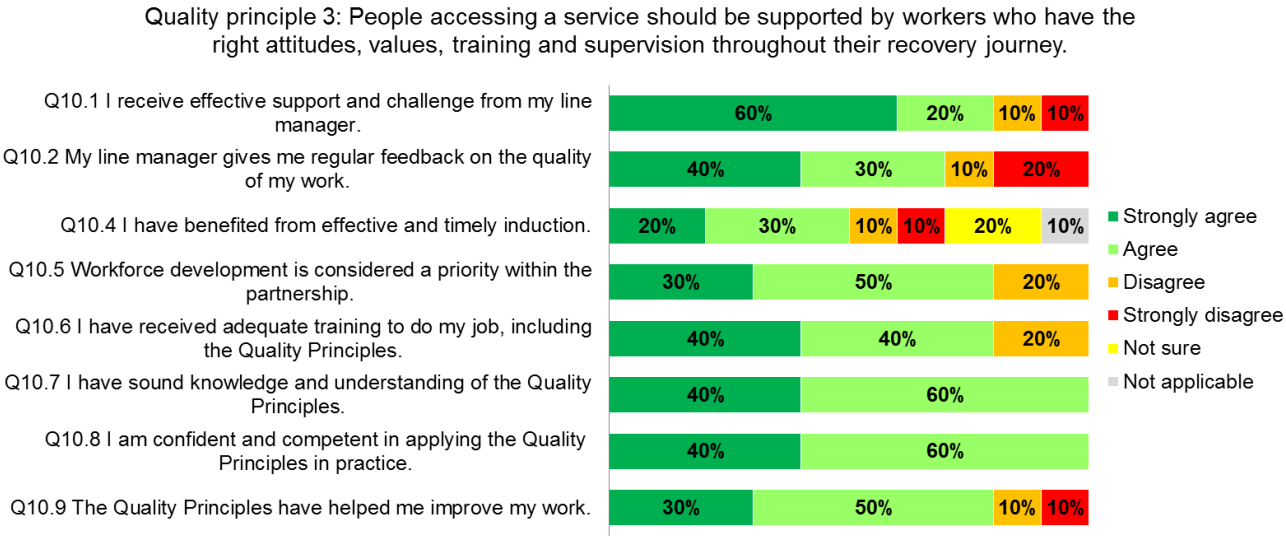
Quality principle 7: People accessing a service should have the opportunity to be involved in the on-going evaluation of the delivery of services at each stage of their recovery.

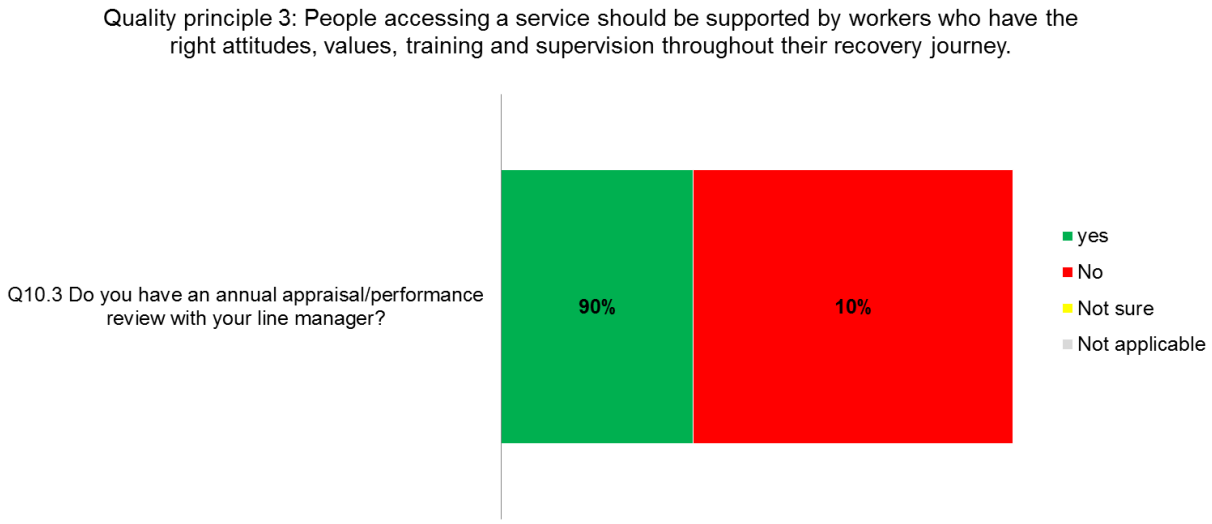


Quality principle 8: Services should be family inclusive as part of their practice.



Quality principle 3: People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey.





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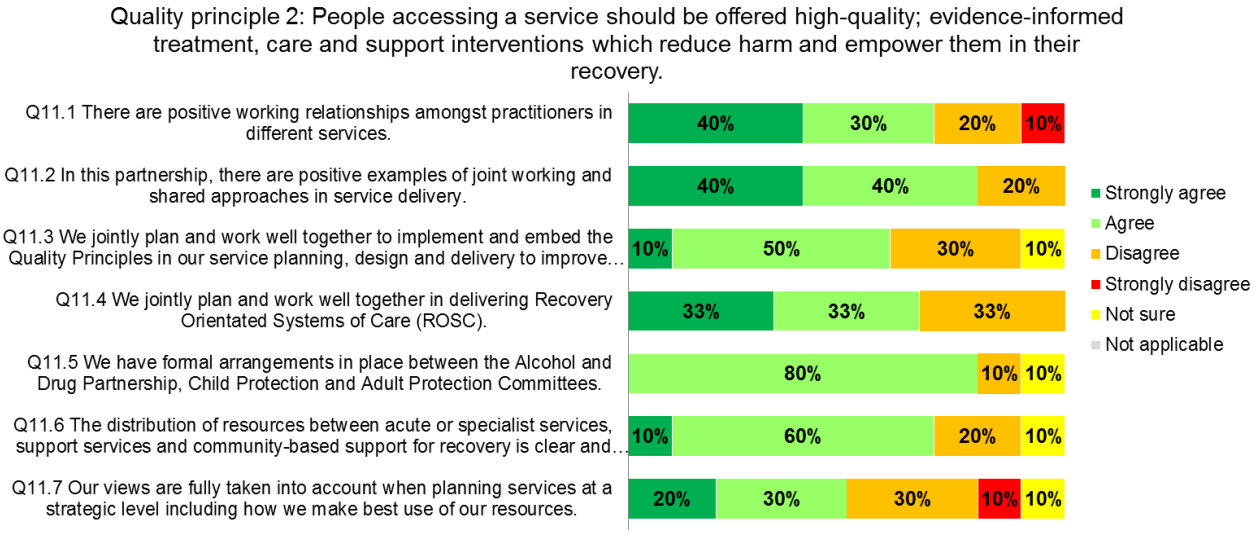
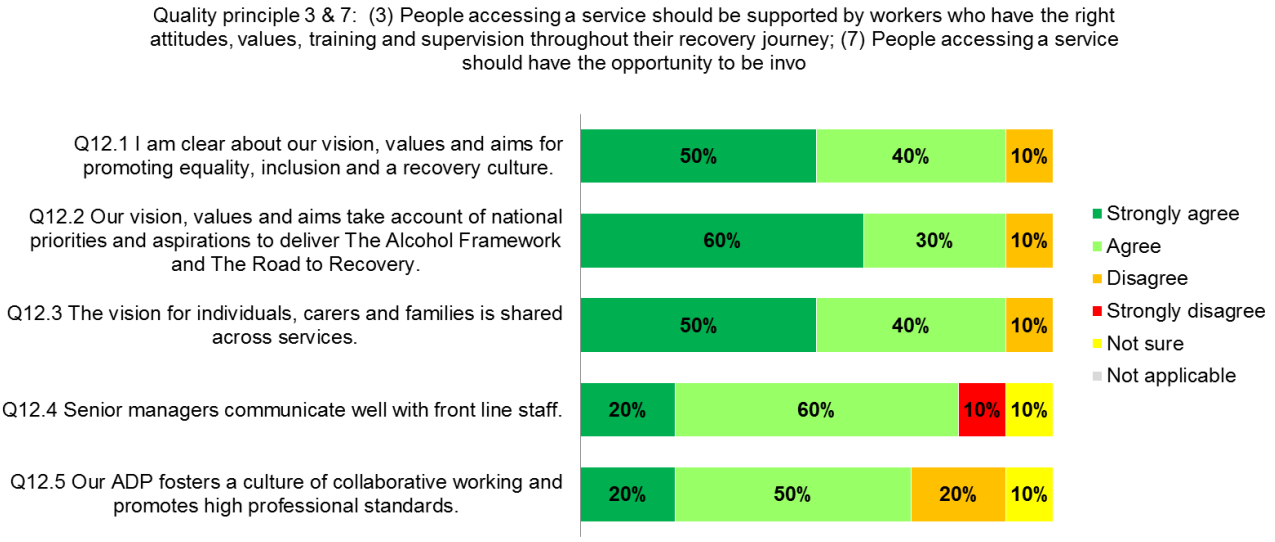
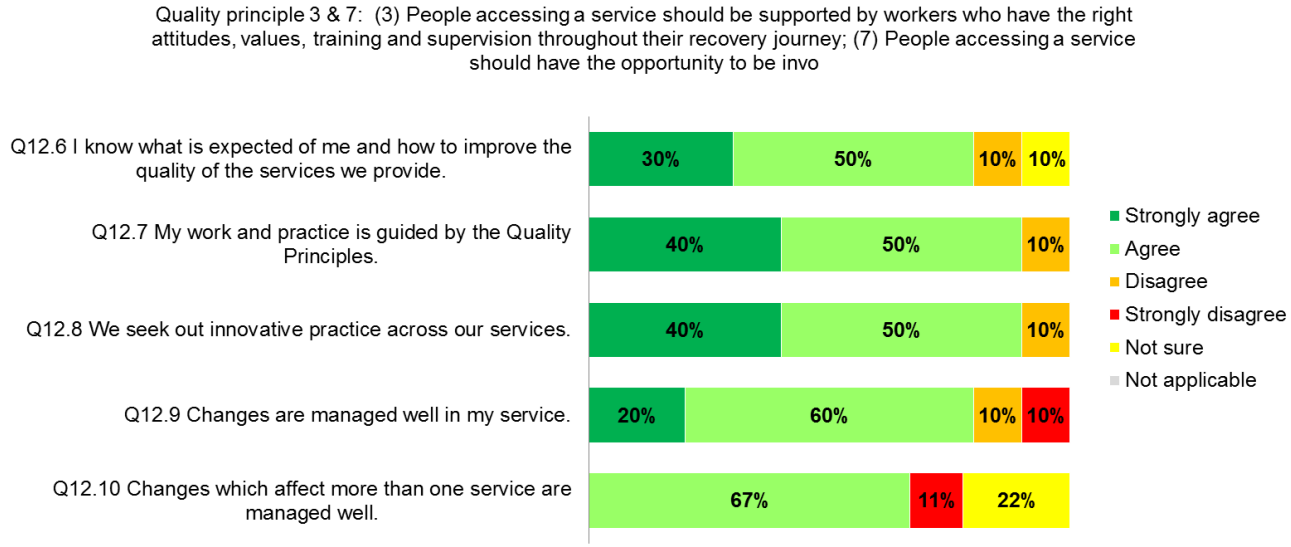


Quality principle 3 & 7: (3) People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey; (7) People accessing a service should have the opportunity to be involved in an on-going evaluation of the delivery of services at each stage of their recovery





Appendix 1

Table 1 Survey responses grouped by sex.

Sex	Count of respondents
Male	17
Female	8
(blank)	8
Total	33

Table 2 Survey responses grouped by Age Band.

Age band	Count of respondents
0-15	0
16-29	7
30-44	10
45-59	4
60-74	2
Unknown	10
Total	33

Table 3 Are you receiving the service to address:

Issue(s)	Count of respondents
Alcohol issue only	11
Drug issue only	10
Both alcohol & drug issues	3
(blank)	9
Total	33

Table 4 Survey responses by Ethnic Group.

Ethnic Group	Count of respondents
Any other White Ethnic Group	0
Arab, Arab Scottish or Arab British	0
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	0
Black, Black Scottish or Black British	0
Caribbean, Caribbean Scottish or Caribbean British	0
Mixed or Multiple Ethnic Groups	0
Other Ethnic Group	0
Pakistani, Pakistani Scottish or Pakistani British	1
White Gypsy/Traveller	0
White Irish	0
White Other British	3
White Polish	0
White Scottish	27
(blank)	2
Total	33

Appendix 2

Table 1 Survey responses grouped by sector.

Sector	Count of respondents
Health service	1
Voluntary sector	4
Social Care / Social Work Service	5
Third sector	0
Other	1
Private sector	0
Total	11

Appendix 3

Table 1: Service User Comments

Section 1.1 - Quality principle 1: I should be able to quickly access the right drug or alcohol service that keeps me safe and supports me throughout my recovery.	East Dunbartonshire were very slow to help - it took longer than 6 months for my husband. My son also had to wait for months.
	I don't feel the EDAD's service is supportive, if I didn't have an addiction worker I wouldn't have any support as the EDAD's service is only really a prescription service and doesn't address any issues as they don't have time.
	Very quick access Glasgow council on alcohol I received a phone call from counsellor within a few days.
Section 1.2 – Quality principle 2: I should be offered high quality; evidence-informed treatment, care and support interventions which reduce harm and empower me in my recovery.	(in regards to last two questions) - Only social work as I have a child, not aware of my information being shared with anyone else. Child protection.
	Counsellor spoke with me about child and adult protection and how certain information could be shared if applicable.
	E.D.C taken too long to offer support etc., not always sure who is there to help.
	I attend counselling and counsellor has explained to me when information should be shared .
	My partner is the person with the alcohol issue.
	No continuity of worker.
Section 1.3 – Quality principle 3: I should be supported by workers who have the right attitudes, values, training and supervision throughout my recovery journey.	Counsellor has always involved me in my recovery at all times and he noticed that my friends are important to me and encouraged me to continue to spend time with them.
	Guest speakers come to the group which is great, I have volunteered as a result of one such speaker.
	It all depends on the worker involved - they are not always suited to the client i.e. age, interests etc.
	My counsellor does not put pressure on me to end our sessions. He lets me talk of my own goals.
	My worker was very sensitive to my past traumas and the effect they had had on my life, and I never felt judged because of my alcohol problem but felt I was listened to and supported with anything I was struggling with.
Section 1.4 – Quality principle 4: I should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on my needs and aspirations.	child/adult protection.
	Depending on the worker and how good they are at their job or if they are even interested.
	I have always felt listened to and my counsellor kept me informed of my assessment. It did not really feel like an assessment at all.
	My partner is the person with the alcohol misuse. EDAS offer me support as the person that lives with the alcoholic.

Section 1.5 – Quality principle 5: I should have a recovery plan that is person-centred and addresses my broader health, care and social needs and maintains a focus on my safety throughout my recovery journey.	Continued support is not always given, sometimes you feel as there are too many people needing help.
	Didn't get a recovery plan done at all and if there is one I've not been involved or informed.
	I haven't relapsed but I'm sure I would still be treated with respect and dignity.
	my counsellor helps me to back at all aspects of my life
	When I have struggled I have been treated with respect and encouraged to keep fighting my addiction.
Section 1.6 – Quality principle 6: I am involved in regular reviews of my recovery plan to ensure it continues to meet my needs and aspirations.	Counsellor has advised me that we will work on all aspects of my life and how important my assessment plan is.
	I was helped to sort out housing, debt payments and benefits which I would never have been able to do myself at the time. I was supported in any area where I needed help. I have been supported in helping my children so that we can rebuild out family life.
	Partner is person with alcohol misuse. Support is offered to me through EDAS as the partner/person living with the alcoholic.
Section 1.7 – Quality principle 7: I have the opportunity to be involved in the on-going evaluation of the delivery of services at each stage of my recovery.	I am very happy with service and my counsellor said on or first session that there is a complaints procedure .
Section 1.8 – Quality principle 8: Services should be family inclusive as part of their practice.	(In relation to questions regarding children and family)- They know but no help or support was given only when it was too late, I felt that there is no way the support there should be for kids.
	Glad things are moving forwards and families are being more involved.
	In all the years I have supported my husband and now my son I have NOT had any support or guidance from the service (family most definitely forgotten about).
	My friends are very important to me and this has been discussed in my counselling.
	Support group for family has really helped me and my son.
	The family worker had helped me a lot but I wish I had been told about her much earlier in the process.
	We look at all issues in my life and my counsellor support my wellbeing at all times.
	Without this service I don't think I would have been able to help myself at the start. My support worker listened to me and did everything possible to help me begin my recovery. With her help I have been able to get through my relapse and start again.

Table 2: Service Staff Comments

Section 2.1 – Quality principle 1: People accessing a service should be able to quickly access the right drug or alcohol service that keeps them safe and supports them throughout their recovery	I think more constant flow of referrals
	Room for improvement when it comes to staff levels of stress as they are trying to make these targets.
	Stick to timescales although the admin of waiting times is difficult.
Section 2.2 – Quality principle 2: People accessing a service should be offered high-quality; evidence-informed treatment, care and support interventions which reduce harm and empower them in their recovery.	Difficulty accessing rooms for meetings with people who use services. Changeable/faulty heating system makes a number of rooms in the building extremely uncomfortable.
	Some challenges over resources both staffing and accommodation.
Section 2.3 – Quality principle 3: People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey.	I think that connections between agencies could improve.
	Working to be flexible and person centred can be challenging within a health and social work system.
Section 2.5 – Quality principle 4: People accessing a service should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on their needs and aspirations.	Assessment are not based on addiction there is great room for improvement .
	Strong on consent. Improvement required on the person's journey through the system.
Section 2.6 – Quality principle 5: People accessing a service should have a recovery plan that is person-centred and addresses their broader health, care and social needs, and maintains a focus on their safety throughout their recovery journey	I think links could be better with statutory and voluntary.
	Recovery plans are based on social work for older people and disability.
	We lack a consistent approach to recovery plans; we are looking to improve on this.
Section 2.7 – Quality principle 6: People accessing a service should be involved in regular reviews of their recovery plan to ensure it continues to meet their needs and aspirations.	When it comes to drug and alcohol use people within wraparound services treat people with 2 heads and look down on them.
	Our role isn't to access voluntary work etc but we are working locally to create a ROSC JOURNEY.

Section 2.8 – Quality principle 7: People accessing a service should have the opportunity to be involved in the on-going evaluation of the delivery of services at each stage of their recovery.	I feel that more could done with promoting services.
	We regularly work with SDF to gather views. We are planning a qualitative person centred follow up card.
Section 2.9 – Quality principle 8: Services should be family inclusive as part of their practice	We are very strong on children affected and family support services.
Section 2.10 – Quality principle 3: People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey.	I think there needs a stronger ADP focus and drive on workforce development.
	I am unclear who my line manager is at present due to organisational change.
Section 2.11 – Quality principle 2: People accessing a service should be offered high-quality; evidence-informed treatment, care and support interventions which reduce harm and empower them in their recovery.	This is an area that I think improvements need to be made.
	I think the relationship with Child Protection could be clearer.
Section 2.12 – Quality principle 3 & 7: (3) People accessing a service should be supported by workers who have the right attitudes, values, training and supervision throughout their recovery journey; (7) People accessing a service should have the opportunity to be involved in an on-going evaluation of the delivery of services at each stage of their recovery	I feel that more clear directions should be given to services as some services provide similar to others.
	Work on ROSC is positive.

Alcohol and Drug Partnerships
Validated Self-Evaluation
File Reading Analysis
East Dunbartonshire

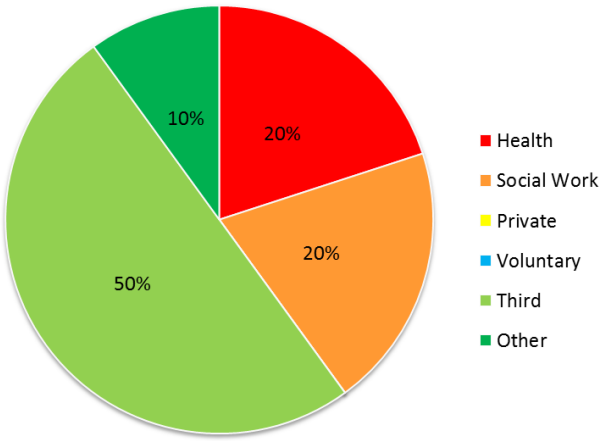
Adele Seabourne & Sophie Siegel May 2016

East Dunbartonshire Alcohol and Drug Partnerships Validated Self-Evaluation Analysis

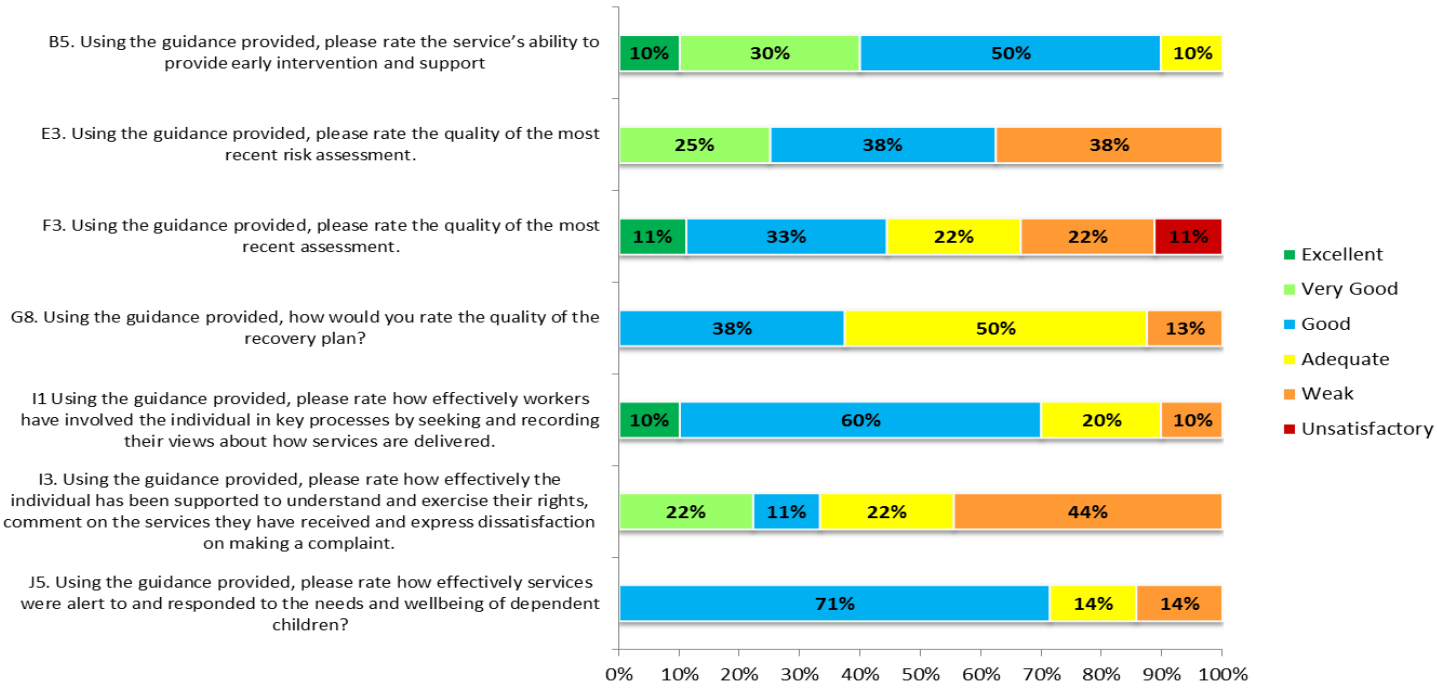
Please note:

- Percentages have been rounded and may not total 100% for some of the responses due to rounding error.
- Only minor spelling and punctuation amendments have been made to the file readers' recorded comments.
- There were several opportunities for file readers to make comments. However file readers have occasionally made a comment rather than recording a response to a specific question. These comments have not been included in this report.

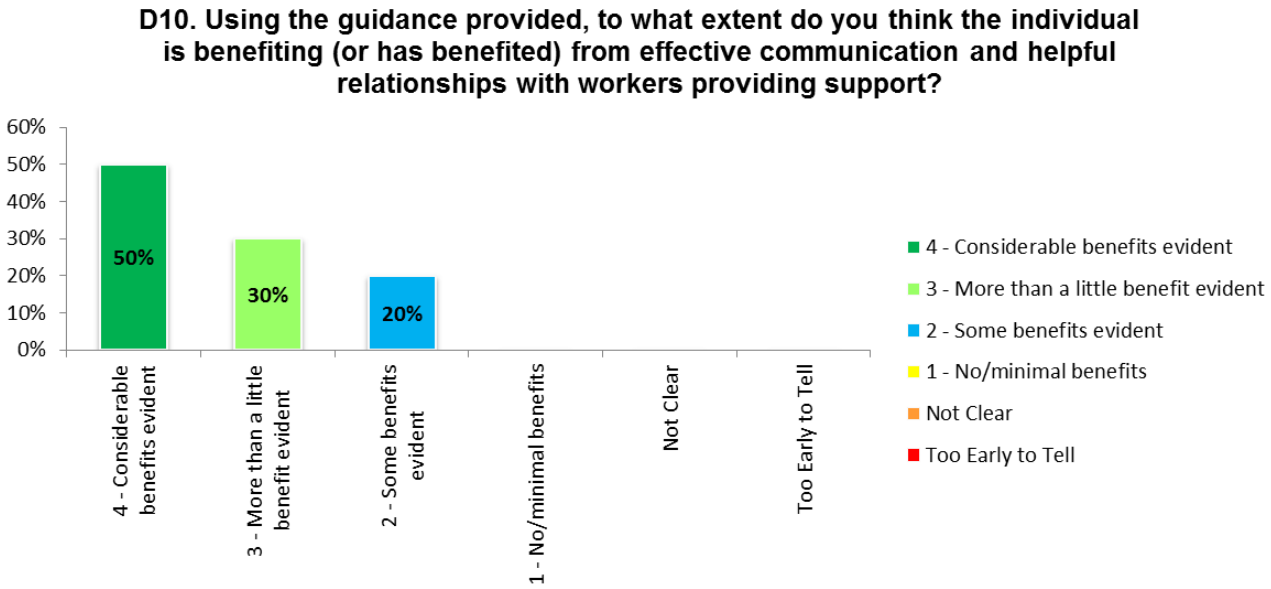
Summary of type of case files that were read in East Dunbartonshire ADP



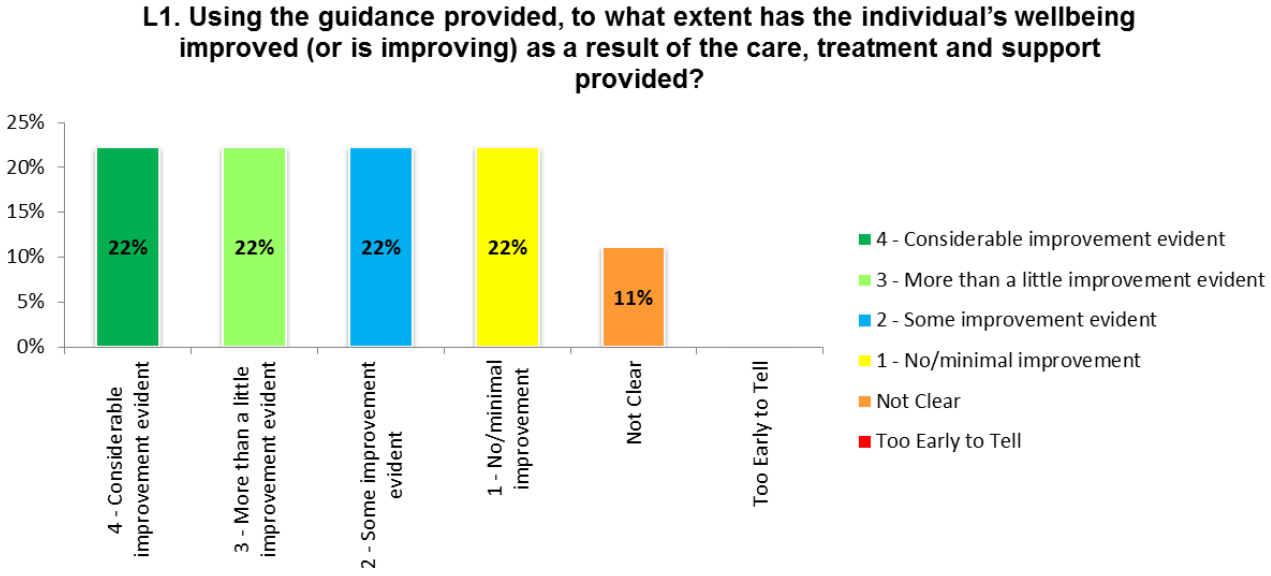
Summary of responses to opinion questions in East Dunbartonshire ADP



Summary of benefits of effective communication and relationships for East Dunbartonshire ADP



Summary of Recovery Outcomes for East Dunbartonshire ADP



Section A: Case Type Information:

A5 Type of case file read

	Frequency	%
Health	2	20%
Social Work	2	20%
Private	0	0%
Voluntary	0	0%
Third	5	50%
Other (please specify)	1	10%
Total	10	100%

Other: Not specified

A6 Age of Individual

	Frequency	%
Under 16	0	0%
16 – 17	0	0%
15 – 25	2	20%
26 – 39	4	40%
40 – 55	2	20%
55+	2	20%
Total	10	100%

A7 Gender

	Frequency	%
Male	5	50%
Female	5	50%
Total	10	100%

A8 Is Ethnicity Recorded

	Frequency	%
Yes	10	100%
No	0	0%
Total	10	100%

A9 Please select ethnicity

	Frequency	%
White Scottish	9	90%
With Other British	0	0%
White Irish	0	0%
White Gypsy/Traveller	0	0%
White Polish	0	0%
Any other White Ethnic Group	0	0%
Mixed or Multiple Ethnic Groups	0	0%
Pakistani, Pakistani Scottish or Pakistani British	0	0%
Indian, Indian Scottish or Indian British	1	10%
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	0	0%
Chinese, Chinese Scottish or Chinese British	0	0%
African, African Scottish or African British	0	0%
Other African	0	0%
Caribbean, Caribbean Scottish or Caribbean British	0	0%
Black, Black Scottish or Black British	0	0%
Other Caribbean or Black	0	0%
Arab, Arab Scottish or Arab British	0	0%
Other Ethnic Group	0	0%
Not Known	0	0%
Total	10	100%

A10 What are the individual's needs?

	Frequency	%
Alcohol issues only	2	22%
Drug issues only	5	56%
Both alcohol and drug issues	2	22%
Total	9	100%

No response = 1

Section B: Intervening Early/Access to services:

B1 Did the individual using the service have to wait longer than three weeks from referral received to the appropriate drug or alcohol treatment?

	Frequency	%
Yes	0	0%
No	9	90%
Not Clear	1	10%
Total	10	100%

B2 If you answered yes to B1, did the service make contact with the service user to explain the reason for the delay?

Based on question B1 the following question was not answered

B3 Did the individual using the service have to wait longer than six weeks from referral received to the appropriate drug or alcohol treatment?

	Frequency	%
Yes	0	0%
No	9	90%
Not Clear	1	10%
Total	10	100%

B4 If you answered yes to B3, did the service make contact with the service user to explain the reason for the delay?

Based on question B3 the following question was not answered

B5 Using the guidance provided, please rate the service's ability to provide early intervention and support

	Frequency	%
6 Excellent	1	10%
5 Very Good	3	30%
4 Good	5	50%
3 Adequate	1	10%
2 Weak	0	0%
1 Unsatisfactory	0	0%
Total	10	100%

Section C: Access to care, treatment and support:

C1 Did the individual have access to a range of recovery treatments and therapies to help them improve different areas of their life and move forward at their own pace?

	Frequency	%
Yes	9	90%
No	0	0%
Not Clear	1	10%
Total	10	100%

C2 Is there evidence that the individual had access to harm reduction advice (this can include safer use, managed use and abstinence)?

	Frequency	%
Yes	8	80%
No	2	20%
Not Clear	0	0%
Total	10	100%

C3 Is there evidence that the individual's consent has been sought to share information with other services?

	Frequency	%
Yes	6	60%
No	2	20%
Not Clear	2	20%
Total	10	100%

C4. Is there evidence that the individual was told when information might be shared without their agreement?

	Frequency	%
Yes	6	60%
No	1	10%
Not Clear	3	30%
Total	10	100%

Section D: Person-centred care and support:

D1 Has the individual had regular, meaningful contact with those workers who have provided treatment and support?

	Frequency	%
Yes	10	100%
No	0	0%
Not Clear	0	0%
Too early to tell	0	0%
Total	10	100%

D2 Is there evidence that workers have provided timely, effective treatment and support that is right for the individual?

	Frequency	%
Yes	8	80%
No	0	0%
Not Clear	2	20%
Too early to tell	0	0%
Total	10	100%

D3 Is there evidence that workers have provided support that recognises any current or previous trauma that the individual may be dealing with?

	Frequency	%
Yes	5	56%
No	1	11%
Not Clear	2	22%
Too early to tell	1	11%
Total	9	100%

Not applicable = 1

D4 Is there evidence that workers have provided harm reduction advice such as safer use, managed use and abstinence?

	Frequency	%
Yes	6	60%
No	3	30%
Not Clear	1	10%
Too early to tell	0	0%
Total	10	100%

D5 Is there evidence that the individual has control over the kind of support they receive (co-production)?

	Frequency	%
Yes	8	80%
No	0	0%
Not Clear	2	20%
Total	10	100%

D6 Is there evidence that the individual has been supported to set their own recovery goals and self-manage their recovery?

	Frequency	%
Yes	8	80%
No	2	20%
Total	10	100%

D7 What services are providing this support?

	Frequency	%
Health	7	70%
Social Work	6	60%
Private Sector	0	0%
Voluntary Sector	1	10%
Third Sector	5	5%
Other (please specify)	2	2%
Total	10	

The total percentage of services providing support is greater than 100% as multiple responses possible

D8 Is there evidence that workers have spoken to the individual about plans for them moving towards reducing or ending their current contact with the service?

	Frequency	%
Yes	2	33%
No	3	50%
Not Clear	1	17%
Too early to tell	0	0%
Total	6	100%

Not applicable = 3
No response = 1

D9 Have workers encouraged and helped the individual to connect with community support/recovery groups?

	Frequency	%
Yes	6	67%
No	1	11%
Not Clear	1	11%
Too early to tell	1	11%
Total	9	100%

Not applicable = 1

D10 Using the guidance provided, to what extent do you think the individual is benefiting (or has benefited) from effective communication and helpful relationships with workers providing support?

	Frequency	%
4 - Considerable benefits evident	5	50%
3 - More than a little benefit evident	3	30%
2 - Some benefits evident	2	20%
1 - No/minimal benefits	0	0%
Not Clear	0	0%
Too Early to Tell	0	0%
Total	10	100%

Section E: Assessing and managing risks to reduce harm:

E1 Is there evidence in the records that an assessment has been made of risks to, or presented by, the individual?

	Frequency	%
Yes	8	80%
No	2	20%
Total	10	100%

Based on question E1 the following questions were answered for 8 cases

E2 Is the timing of the most recent risk assessment in keeping with the risk experienced/presented by the individual?

	Frequency	%
Yes	7	88%
No	1	13%
Total	8	100%

E3. Using the guidance provided, please rate the quality of the most recent risk assessment.

	Frequency	%
6 Excellent	0	0%
5 Very Good	2	25%
4 Good	3	38%
3 Adequate	0	0%
2 Weak	3	38%
1 Unsatisfactory	0	0%
Total	8	100%

E4 In respect of assessment of risk please record Key Strengths:

- Adult protection procedures.
- Clear evidence that relevant risk factors have been assessed. Fairly clear statement of risk factors. Fairly clear indication of protective factors and informal support network likely to reduce harm and mitigate risk. Views of the individual have been taken into account. Brief mention of childhood trauma. Evidence of assessment of relationship between substance misuse and risk issues. Options for reducing/mitigating risk clearly identified. Issues which prevent engagement and increase risk clearly stated.
- Clearly identifies risks. Clearly identifies links between alcohol / drug use. Mental health issues in relation to risk. Clearly identifies risks to self and others. Clearly identifies links between alcohol/drug use and mental health issues in relation to risk. Excellent chronology of significant events - including history of support. Good evidence that the views of the individual and relevant family members have been obtained and taken account of. Protection plan clearly details support to be provided aimed at reducing and/or mitigating risk of harm. Clear evidence of ongoing up to date systematic review of risk management plan. Evidence of appropriate multi professional input into risk assessment and protection plan.
- Comprehensive, easy to read format.
- Risk assessment completed and management plan generated in relation to risk. Care plans current in relation to issues raised in risk assessment for alcohol use and self harm evidence of this being discussed with individual, agreed and signed by individual.

In respect of assessment of risk please record Areas for Development:

- Increase detail and analysis of risk factors, including options to reduce/mitigate harm. Include views of person, relevant others, and other agencies. Include recommendations and key actions within management plan.
- Risk assessments should reflect all risks identified in assessments or during ongoing consultations re signs/symptoms of concern. safety plan not explicit enough. Integration working not evident.
- Addiction focussed interventions.
- Although there is evidence that up to date knowledge and theory generally informs the risk assessment, this could have been more explicitly stated and analysed in order to provide a more focussed approach to the intervention required to reduce and / of mitigate risk of harm. Although the most recent risk assessment remains relevant, there is a possible need to update it to take account of progress and changes in the individuals circumstances.
- Ensure risk assessment actions are updated from previous safety plans. Lack of detail makes it unclear to determine if actions from other services have been completed, including actions required from a CPCC. All risks identified in the assessment have not been addressed in the safety plan. Risk assessment is solely from the workers perspective and does not include the individual or information from other agencies involved. More detail and analysis required in respect of risks identified and actions required to mitigate against harm.
- Include view of carer/families as appropriate.
- No specific reference to knowledge/theory/research. Separate risk and vulnerability and violence and aggression risk assessments. Slightly confusing. "tick box" format of risk assessments possibly results in lack of detail specific to the individuals circumstances. Individual safety plan not completed.
- Risk assessment designed around individual not the worker.

Section F: Assessing Needs:

F1 Does the individual have an assessment in the primary file?

	Frequency	%
Yes	9	90%
No	1	10%
Total	10	100%

Based on question F1 the following questions were answered for 9 cases

F2 Is there evidence of any difficulty in accessing services quickly because of delays in the individual being assessed for key services?

	Frequency	%
Yes	1	11%
No	8	89%
Total	9	100%

F3 Using the guidance provided, please rate the quality of the most recent assessment.

	Frequency	%
6 Excellent	1	11%
5 Very Good	0	0%
4 Good	3	33%
3 Adequate	2	22%
2 Weak	2	22%
1 Unsatisfactory	1	11%
Total	9	100%

F4 In respect of needs assessment please record Key Strengths:

- Assessment clearly builds on and updated previous assessments, providing up to date picture of the individual's circumstances and needs. Assessment clearly details current support situation at the date of assessment. Assessment addresses specific communication needs of file individual. Assessment shows evidence of multi professional input. Assessment shows evidence of up to date knowledge, theory and research, especially in relation to the interrelationship between the individual's health issues and alcohol and drug use. Assessment shows some evidence that the individuals strengths and recovery capital has been considered.
- Assessment is sufficient to lend to an initial improvement plan. Assessment seems to be based on assessment of recovery capital which is presumably in recovery orientatedl system of care.
- Assessment of recovery capital scored system and visual tool to see progress.
- GP and addiction team assessment comprehensive for physical health, blood, sexual health and nutrition and mental health.
- Identification of risks (adult support and protection).
- Short, specific with an immediate action plan.

In respect of needs assessment please record Areas for Development:

- Initial assessment does not appear to be an assessment; list of demographic information only. Assessment of recovery capital is badged under recovery plan, however is this populated objectively or subjectively (not needs based). Unable to ascertain how scores were arrived at.
- A summary sheet for easy reading, summarising current problem protective factors risks.
- Addiction focussed interventions.
- Assessment provides no information with regard to whether other agencies are involved in the individuals support. Then is little indication as to how the ARC scores have been assessed, apart from the file notes.
- Needs assessment is an initial assessment for this specific service only and is limited in scope, detail and analysis.
- Needs assessment is an initial assessment for this specific service only and is limited in scope, detail and analysis.
- No specific considerations of possible traumatic events in the individual's life. No specific mention of SOSC. Assessment needs to be updated to take account of progress and changes in the individual's circumstances.
- Summary of assessment with further detail.

Section G: Recovery/Care Plan:

G1 Is there a recovery plan in place?

	Frequency	%
Yes	8	80%
No	2	20%
Total	10	100%

Based on question G1 the following questions were answered for 8 cases

G2 Is the recovery plan up to date?

	Frequency	%
Yes	6	75%
No	2	25%
Total	8	100%

G3 Is the recovery plan SMART?

	Frequency	%
Yes	1	13%
No	7	88%
Total	8	100%

G4 If no, please describe why the plan is not SMART?

	Frequency	%
Not Specific	2	25%
Not Measureable	1	13%
Not Achievable	1	13%
Not Reliable	1	13%
Not Time Bound	4	50%
Total	8	

The total percentage of services providing support is greater than 100% as multiple responses possible

G5 Does the recovery plan set out the desired outcomes for the individual?

	Frequency	%
Yes	6	75%
No	2	25%
Total	8	100%

G6 If no, please describe in what way(s) the plan is not outcome focussed:

- Goals are not person centred and do not detail the persons aspirations in detail to their specific circumstances.
- No specific care plan or action plan from recovery capital. No specific goals however progress review does.

G7 Is there evidence that the individual is offered a copy of their recovery plan?

	Frequency	%
Yes	3	38%
No	5	63%
Total	8	100%

G8 Using the guidance provided, how would you rate the quality of the recovery plan?

	Frequency	%
6 Excellent	0	0%
5 Very Good	0	0%
4 Good	3	38%
3 Adequate	4	50%
2 Weak	1	13%
1 Unsatisfactory	0	0%
Total	8	100%

Section H: Implementing and reviewing the plan:

H1 Do reviews include an assessment of the effectiveness of current treatment or interventions towards achieving the individual's recovery goals?

	Frequency	%
Yes	5	50%
No	4	40%
Not Clear	1	10%
Too Early to Tell	0	0%
Total	10	100%

H2 Is there evidence that workers supporting the individual are working to agreed actions in the plan?

	Frequency	%
Yes	6	60%
No	1	10%
Not Clear	3	30%
Too Early to Tell	0	0%
Total	10	100%

H3 Is there evidence that the plan is reviewed at intervals appropriate to the individual's needs that reflect any changes in their situation?

	Frequency	%
Yes	3	30%
No	3	30%
Not Clear	3	30%
Too Early to Tell	1	10%
Total	10	100%

H4 Does the plan address other areas in the individual's life identified from their assessment including wider health needs, family, children, finances, education, employment and housing?

	Frequency	%
Yes	5	50%
No	3	30%
Not Clear	2	20%
Too Early to Tell	0	0%
Total	10	100%

H5 Is there an appropriate level of partnership/collaborative working in implementing the plan for the individual?

	Frequency	%
Yes	6	75%
No	2	25%
Total	8	100%

Not applicable = 1
No response = 1

H6 Is there evidence of any difficulty in implementing key actions in the individual's plan because of delays in providing key services, following assessment?

	Frequency	%
Yes	0	0%
No	9	100%
Total	9	100%

No response = 1

H7 Are the records of reviews included in the primary file?

	Frequency	%
Yes	4	44%
No	5	56%
Total	9	100%

No response = 1

Section I: Involvement:

I1 Using the guidance provided, please rate how effectively workers have involved the individual in key processes by seeking and recording their views about how services are delivered.

	Frequency	%
6 Excellent	1	10%
5 Very Good	0	0%
4 Good	6	60%
3 Adequate	2	20%
2 Weak	1	10%
1 Unsatisfactory	0	0%
Total	10	100%

I2 Is there evidence that individuals are told about their responsibilities and what they can expect from the service?

	Frequency	%
Yes	7	70%
No	3	30%
Total	10	100%

I3 Using the guidance provided, please rate how effectively the individual has been supported to understand and exercise their rights, comment on the services they have received and express dissatisfaction on making a complaint.

	Frequency	%
6 Excellent	0	0%
5 Very Good	2	22%
4 Good	1	11%
3 Adequate	2	22%
2 Weak	4	44%
1 Unsatisfactory	0	0%
Total	9	100%

No response = 1

I4 Is there evidence that the individual has been told about independent advocacy services that can help them be heard?

	Frequency	%
Yes	2	20%
No	8	80%
Total	10	100%

Section J: Family Inclusive:

J1 Is there evidence that the individual has been told that family members can only be involved in their treatment/recovery journey if they want them to be?

	Frequency	%
Yes	1	10%
No	2	20%
Not Clear	7	70%
Total	10	100%

J2 Is there evidence that workers have advised and supported the individual to involve others who can support their recovery?

	Frequency	%
Yes	8	80%
No	0	0%
Not Clear	2	20%
Total	10	100%

J3 Is there evidence that workers have helped the individual to minimise the impact that their drug or alcohol use may have on those around them?

	Frequency	%
Yes	4	40%
No	1	10%
Not Clear	5	50%
Total	10	100%

J4 Where there are dependent children, is there evidence that the individual has been told that the needs and wellbeing of their children are a primary concern?

	Frequency	%
Yes	5	71%
No	2	29%
Total	7	100%

Not applicable = 3

J5 Using the guidance provided, please rate how effectively services were alert to and responded to the needs and wellbeing of dependent children?

	Frequency	%
6 Excellent	0	0%
5 Very Good	0	0%
4 Good	5	71%
3 Adequate	1	14%
2 Weak	1	14%
1 Unsatisfactory	0	0%
Total	7	100%

J6 Where appropriate, is there evidence that workers were aware of the needs of other family members and sought support for them if this was needed?

	Frequency	%
Yes	2	40%
No	1	20%
Not Clear	2	40%
Total	5	100%

Not applicable = 5

Section K: Supervision and Quality Assurance:

K1 Is there evidence that the key worker has opportunities to discuss their work with a supervisor, manager or other appropriate staff?

	Frequency	%
Yes	4	40%
No	6	60%
Not Clear	0	0%
Too Early to Tell	0	0%
Total	10	100%

K2 Is there evidence that the key worker's case file record is reviewed regularly by their manager, supervisor or staff with quality assurance responsibilities?

	Frequency	%
Yes	0	0%
No	6	60%
Not Clear	4	40%
Too Early to Tell	0	0%
Total	10	100%

Section L: Impact and Outcomes for Individuals:

L1 Using the guidance provided, to what extent has the individual's wellbeing improved (or is improving) as a result of the care, treatment and support provided?

	Frequency	%
4 - Considerable improvement evident	2	22%
3 - More than a little improvement evident	2	22%
2 - Some improvement evident	2	22%
1 - No/minimal improvement	2	22%
Not Clear	1	11%
Too Early to Tell	0	0%
Total	9	100%

No response = 1

L2 Please note key areas of strengths and/or development under the following recovery indicators:

Substance Use

Strengths:

- Clear evidence of reduction overall in substance use of reduction in related risk of harm.
- Generally stable and abstinent.
- Individual has been supported to become abstinent.
- Individual testing negative for all substances. Moved forward to DTTO.
- Individual has been able to reduce alcohol intake.
- Reducing methadone prescription aiming for detox, volunteering.
- Service recognition on that substance misuse impacting on functioning leading to ASP procedures. Patient choice.

Area for Development:

- Continues problematic substance use impacting on well-being, functioning and relationships.
- Focus on ambivalence re substance misuse.
- Need evidence through assessment and risk assessment.
- Need for updating of assessment with the purpose of refocused recovery plans in relation to substance use.
- Not clear what plans there are for intervention to sustain abstinence.
- Release prevention techniques and evidence based treatments.
- STAR recovery toll enable holistic review of needs / strengths.

Self Care & Nutrition

Strengths:

- Acknowledgement of weight gain healthier opinions on a budget considered.
- Clear evidence that the individual has become more independent in this area.
- Engages more with services to gain support and motivation.
- Improving in self esteem looking to care for others as volunteer.
- Limited positive impact leading to ASP procedures.
- No issues.
- No issues identified.

Area for Development:

- Focus on nutritional deficits in relation to cognitive impairment.
- Input from dietitian.
- Nutrition appears to have gone from good to poor - no action reported.

Relationships

Strengths:

- Individual has managed to maintain relationships.
- Nursing notes mention difficulties with mood but feels she is coping better.
- Risks identified in relation to personal relationships leading to ASP procedures.
- She is building bridges with mum and sister as disassociated herself from previous associates.
- Social work and health assisting in medication, relationship appear more stable than previous.
- Some evidence that key relationships have improved.

Area for Development:

- 6 monthly summaries to outline improvement.
- Evidence of conflict with relationships (peers and staff).
- Exploration of relationships with daughter and other family members.
- Improvement in waiting times to see psychologist.
- Relationships continue to be strained.

Physical Health & Wellbeing

Strengths:

- Clear evidence that the individual is being supported to sustain good physical health and wellbeing.
- Engaging with nurse for abscesses on legs. Motivated to join gym.
- Individual has been supported to maintain physical health and wellbeing.
- no reference to this.
- Physical health assessment has highlighted gaps in health. Advice given and taken in relation to sexual health.
- Supported to access health services (GP/hospital) as required. Limited positive impact in relation to choice to continue drinking resulting in ASP procedures.
- Underlying health issues have been acted upon rather than ignoring as she previously did.

Area for Development:

- Assist to achieve abstinence.
- Health assessment including BBV and vaccination programme.
- Outcomes recovery tool to grade improvements.
- Physical health remains a concern.
- Regular attendance at medical appointments and receiving treatment for identified health issues.

Mental Health & Emotional Wellbeing

Strengths:

- Able to participate in service user feedback and give views and opinions. Attending yoga.
- Limited positive impact resulting in ASP procedures.
- Mental health appears to have stabilised.
- No reference to this.
- Now taking antidepressants illicit drug free and moved house - feels much better.
- Ongoing intervention seems to be helping the individual to maintain stable mental health and emotional wellbeing.
- Self harm and alcohol evidenced to be reduced.
- Some evidence that the individuals health has stabilised.

Area for Development

- Decrease in anxiety levels.
- Formal assessment of mental health (including cognitive). Capacity last assessed 2013.
- Health assessment following initial assessment. Is there other notes?
- Measured approach to plot improvement (STAR recovery tool).
- Mental health continues to fluctuate.
- Need for further assessment to identify intervention aimed at sustaining mental and emotional wellbeing is needed.
- Ongoing mental health assessment.
- Some positive evidence that key services such as psychology autism specialist + O.T have fallen away to a certain extent. Possible need for reassessment of need in this report.

Occupying Time & Fulfilling Goals

Strengths:

- Attend SMART recovery group, certificate of completion for tools for living x 2 courses, volunteers.
- Clear evidence that support has focussed on supporting the individual to appropriately occupy his time and fulfil goals.
- Family social work support have enabled individual and partner to work more effectively together with child and have better coping skills.
- Individual is unemployed.
- Keeping herself to herself to avoiding people who may lead to relapse.
- Regular attendance / support at The Foundry.
- Reluctance of individual engage. Focus on practical social needs as required.

Area for Development

- Assist to achieve abstinence. Consideration of referral to recovery networks (limited due to ongoing alcohol use).
- File demonstrates a focus on recovery outcomes but basic assessments and action plans are missing not completed.
- Need to further assessment to identify intervention aimed at helping the individual achieve goals is needed.
- no goals identified.
- There is a clear recognition that future intervention needs to develop this area of work further.

Housing & Independent Living

Strengths:

- Appropriate housing secured.
- Individual buying new hoover for house, pride in home and self improved.
- Lives with partner and children - no problems, no need for support, managing well.
- Living in a different area in a better environment.
- Major progress achieved in that individual has successfully moved into an independent tenancy.
- No issues identified.
- Temporary improvement for individual (limited in relation to ongoing alcohol consumption and no significant periods of abstinence). Assisted to access utilities (gas/electric)

Area for Development:

- Capacity assessment.
- Clarity of mothers address as not clear where mother lives.
- Clear recognition that future intervention needs to focus on developing the individual's independent living capacity.
- No screening tool apparent in relation to child - age of child?
- Support to budget and plan for crisis prior to crisis.

Offending

Strengths:

- Complying with Drug Treatment and Testing Order.
- Individual has reduced offending behaviour.
- No evidence of any recent offending.
- No indication of further offending. Undertaking necessary action determined in CPO.
- No issues identified.
- Statutory criminal justice involvement.

Area for Development:

- Maintenance of this.
- Need to document and address all offending high risk offending behaviours mentioned. Not formally addressed.
- Systems in place to continue progress once order completed.

Money Matters

Strengths:

- Accessed Scottish welfare fund. Benefits addressed.
- Assisted to attend medical.
- Clear evidence that the individual received considerable support in this report.
- Current rent up to date although previous rent arrears - drug debt.
- Individual has become more relaxed with accepting help in relation to money/budgeting.

Area for Development:

- Care plan or recovery tool needed to monitor development.
- Clear understanding that money management intervention is needed.
- Debt issues remain an issue and impacting significantly - requirement for food vouchers.

Children

Strengths:

- Children safe and contact arranged. Engaging with children.
- Evidence that the individual has supervised contact with his child regularly.
- Family support involvement has enabled the individual to maintain regular contact with child, and be involved in community groups.
- Increased contact with child.
- No dependent children.
- No issues identified.
- Yes, only mentioned in nursing notes and initial assessment.

Area for Development:

- Maintaining positive relationship and contact with child.
- Need for further assessment and intervention with regard to supporting the individual to safely develop and enhance his parenting skills.

Section M: Comments and General Assessment:

Please enter any additional, relevant comments about aspects of practice in this case. Include any services making exceptional contribution to improving outcomes for the individual and any examples of good practice:

Key Strengths:

- Clear evidence of very effective and robust risk assessment, risk planning, risk management and regular review of risk management processes. Clear evidence of appropriate multi professional working in order to address substance use and mental health issues. Clear evidence that intervention has succeeded in reducing risk to the individual and his family. Clear evidence that progress has been made through intervention in achieving positive outcomes for the individual and his family in respect of all recovery outcomes. Good evidence that services have worked together to maintain the individual in support. Evidence that social work service have appropriately demonstrated leadership in ensuring that communication has been maintained with the individual, key family members and other relevant support agencies e.g. health and voluntary staff.
- Collaborative working evident in relation to child protection and parenting issues.
- Comprehensive notes in relation to the child and observational visits. Risk assessment a working document which has evolved to management plans and care plans.
- Developing of positive relationship between the worker and the person allowing sensitive challenge when progressing care plan.
- Frequent contact with service user in planned / unplanned way.
- Information sharing, confidentiality, service agreement and induction process for individual where all these areas are explained: treatment, recovery orientated, using a number of community resources and opportunities. Individuals are encouraged to be involved in a number of activities, education, recovery cafes, yoga. Individuals encouraged to give service user feedback on a regular basis. File audited and clear tick boxes, however, basic information missing (appears to be).
- Multi agency working. Risk assessment - comprehensive easy read format. Assessment: short specific with immediate action plan. Contact sheet "boldly" directs individual reading to areas discussed e.g. harm reduction, health discussion, housing.
- Patient views/choices considered. Risks managed. Positive working relationships with service user.
- Regular involvement and engagement with the person.

Areas for Development:

- A comprehensive recovery tool to plot and monitor improvement developments and act as a visual clue of achievement.
- Although the individual seems clearly to have benefitted and continues to benefit from the service provided, the file does not really reflect of demonstrate how this has been achieved. The assessment process is really unclear and there is no clear recovery plan evident on the file with regard to risk assessment, although risks are identified. There are different risk assessments tools which I found a bit confusing. There is no clear risk management plan in the file.
- An initial assessment but this is not expanded to give an overview of holistic needs. Child Protection no concerns but no parental screening tool apparent or information easy accessible in relation to child. Recovery plan in recovery capital tool, this needs to be clear, specific information in a format that people reading notes needs to understand.
- Assessments, risk assessments and care plans robust. However focus is on adults support and protection (not addiction specific) due to complexities and risks associated with this particular case. Practical supports (house cleans arranged). Service approach good (assertive outreach/telephone contact despite service users non engagement). Update of

consent to share information. Multidisciplinary discussion and input required (access health team). Focus on substance misuse (motivational interviewing and other evidence based approaches).

- Availability of updated recent assessment. Clearer recording of collaboration between agencies and identification of lead agency. Multi-agency review of care as appropriate - this was unclear. Extend care plan to cover all areas of individuals life. Support offered to family - not detailed. Opportunities for assessment to support carer/family.
- Clarity of the purpose of lone working risk assessment - purpose appears to be risk assessing suitability of undertaking home visits although the information presented is about the person.
- Lone worker risk assessment around risks to workers, not person cantered in relation to individual. Recovery plans need to be signed by individual and worker, dated, date of next review and whether individual has agreed to plan - completed with worker or worker only. Has the individual been offered a plan. Details about what the individual can expect from the service and complaints procedure need to be documented.
- Possibly a more systematic and consistent application of theory and research, especially with regard to the interrelationship between the individuals mental health and substance use might facilitate a more focussed approach to future intervention. This might indicate a need for further psychological assessment / intervention and / or the involvement of specialist services. The risk assessment, standardised shareable assessment, outcome focussed support plan and risk management / protective plan need to be updated in order to provide a new focus on future interventions.
- Recovery plan - plans were not dated or signed therefore unable to ascertain timeframe for plans. Collaborative working not evident from the information available in respect of addressing the persons problematic substance use therefore unable to ascertain if changes to the persons wellbeing has been as a result of care, treatment and support.
- Robust assessment process requires to be developed with appropriate documentation.

Emerging Themes:

- I generally did not think that the file evidenced the effectiveness of the interventions provided.
- Limited focus on specific interventions related to substance misuse due to focus on practicalities associated with adult support and protection procedures (risk management and associated task). Need to focus on robust assessment of alcohol use, physical health/bloods/regular breathalyser readings, health input.
- Person has been known to services long-term therefore initial date of referral and initial contact unclear in terms of meeting waiting time targets.
- Recording of interagency working, including contributions to assessment and management and recovery planning.
- Recording of monitoring of staff and review of case management.
- There is very positive evidence of effective multi agency working in risk assessment / management and support planning throughout this file. There is a need for increased clarity in relation to the need for updating core assessments and support plans. Although there is evidence that the risk management and support plans have been regularly reviewed, neither has been updated within the last 2 years. There needs to be better guidance with regard to procedures for updated assessments and support plans.
- Violence/aggression risk assessment not in place. Poor assessment / scoring of risks. Risk assessments relating to risk. (1 of which details individual risks and what would appear to be service/buildings/staff risk. Recommend forms for separate categorised risk. No robust assessment documentation. Little evidence of integrated multiagency working. Service use goals unclear. Recovery capital - what is the scoring process. Unclear if assessed jointly by staff member and service user (subjective or objective).

Report Notes

Q5A 'Other' was selected as the response but was not specified by 1 file reader

QL2 This question was not answered with one of the response options but a written comment was made by 1 file reader

Various hand written comments were made throughout the paper file reading templates for this ADP area. Comments made in other places than the dedicated comments boxes are not included in this analysis.

East Dunbartonshire Health & Social Care Partnership Board

Distribution List:

Name	Designation	
Councillor Rhondda Geekie	Chair - EDC - Elected Member	1
Councillor Anne McNair	EDC - Elected Member	1
Councillor Michael O'Donnell	EDC - Elected Member	1
Ian Fraser	Non-Executive Board Member	1
John Legg	Non-Executive Board Member	1
Ian Ritchie	Non-Executive Board Member	1
James Hobson	Interim Chief Officer - East Dunbartonshire HSCP	1
Adam Bowman	Acute Services Representative	1
Fiona Borland	HSCP Communications	1
Sandra Cairney	Head of Strategy, Planning & Health Improvement	1
Jean Campbell	Chief Finance & Resources Officer, HSCP	1
Fiona McCulloch	Planning & Performance Manager	1
Andy Martin	Head of Adult & Primary Care Services	1
Paolo Mazzoncini	Chief Social Work Officer	1
Graham Morrison	Clinical Lead Representative	1
Linda Tindall	Organisational Development Lead, HSCP	1
Jamie Robertson	Chief Internal Auditor HSCP	1
Karen Donnelly	EDC Chief Solicitor & Monitoring Officer	1
Martin Cunningham	Corporate Governance Manager	3
Wilma Hepburn	Professional Nurse Advisor - NHS	1
Gordon Thomson - Ceartas	Voluntary Sector Representative	1
Martin Brickley	Service User Representative	2
Chris Shepherd	Carers Representative	2
Andrew McCready	Trades Union Representative	1
Gillian Cameron	Trades Union Representative	1
		29

For Information (Substitutes):

Name	Designation
Councillor Ashay Ghai	EDC - Elected Member
Councillor Gillian Renwick	EDC - Elected Member
Councillor Manjinder Shergill	EDC - Elected Member