West Dunbartonshire Scrutiny Report

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Introduction

In October 2010 West Dunbartonshire Community Health Partnership (CHCP) was established as a strategic partnership between West Dunbartonshire Council and NHS Greater Glasgow and Clyde (NHSGGC). The social work service in West Dunbartonshire was provided as an integrated part of the Community Health and Care Partnership. It was the CHCP's performance in the delivery of social work services in West Dunbartonshire which was the focus of this report.

Structure of this report

Section	Contents of section
Section 1	Description of the methodology for the Care Inspectorate's initial scrutiny level assessment (ISLA), which we used to risk assess the delivery of social work services in West Dunbartonshire.
Section 2	Synopsis of our risk assessment of social work services in West Dunbartonshire – this section gives our risk assessment for each of our nine risk questions/areas for evaluation. It also includes our overall risk assessment of the council's delivery of social work services.
Section 3	The timing of our scrutiny in West Dunbartonshire
Section 4	Based on our ISLA, this section describes the reasons and supporting evidence as to why we determined not to concentrate our scrutiny on certain areas for evaluation.
Section 5	This is the principal section of the report. It sets out the rationale for our scrutiny activity in respect of two areas for evaluation/risk questions, our detailed scrutiny findings and recommendations for improvement.
Section 6	Our overall conclusion and the list of our recommendations for improvement.
Section 7	The next steps including the requirement for the CHCP to prepare an action plan for the implementation of our recommendations.

1. Methodology

This report was the result of risk assessment and scrutiny work carried out by the Care Inspectorate. We determine how much scrutiny a local authority's social work services needed by carrying out an initial scrutiny level assessment (ISLA). This considered potential areas of risk at strategic and service levels.
The ISLA focused on answering nine risk questions:

1. Is there evidence of effective governance including financial management?
2. Is there effective management and support of staff?
3. Is there evidence of positive outcomes for people who use services and carers across the care groups?
4. Is there evidence of good quality assessment and care management?
5. Is there evidence of effective risk assessment and risk management for individual service users, both in terms of risk to self and public protection?
6. Does the social work service undertake effective self-evaluation resulting in improvement planning and delivery?
7. Is there effective partnership working?

8. Do policies, procedures and practices comply with equality and human rights legislation and are there services that seek to remove obstacles in society that exclude people? and
9. Are there any areas that require urgent attention and improvement?

We carried out the ISLA of the CHCP social work services in West Dunbartonshire during the period from June to August 2012. We did so by:

- scrutiny of 94[1] case records supported by local file readers.
- analysis of some 700 documents provided by the council or sourced by the Care Inspectorate.
- reference to the SWIA (Social Work Inspection Agency) performance inspection report and follow up report (2009 and 2010 respectively) to track progress made on recommendations.
- analysis of key nationally reported performance data.
- consideration of relevant scrutiny findings, in particular the report of the joint inspection of services to protect children published by the Care Inspectorate in March 2012 and findings from inspection reports of regulated care services.
- participation in shared risk assessment activity led by the Local Area Network, including other relevant scrutiny bodies.

[1] Community Care = 50 case records, children and families = 25 case records and criminal justice = 19 case records

2. ISLA findings

Our risk assessment was based on three categories; areas of significant concern, areas of uncertainty and areas of no significant concern[2]. Each of the nine risk questions was considered against these three categories. Based on the evidence available we made the following evaluation:

We evaluated six areas as being areas of no significant concerns. These were:

- Outcomes for people who use services and for carers
- Assessment and care management
- Risk assessment and risk management
- Self-evaluation and improvement
- Partnership working
- Compliance with equality and human rights legislation

We evaluated two areas as being areas of uncertainty. These were governance and financial management and also the management and support of staff.

We did not evaluate any of the risk questions as being an area of significant concern. Given this we did not consider there were any significant areas needing urgent attention or improvement by the CHCP or an immediate scrutiny response by the Care Inspectorate.

Based on the consideration of the nine risk questions, we then assigned an overall risk assessment of one of three levels. We evaluated West Dunbartonshire CHCP's provision of social work services to be Level 1 - low risk, good performance and good improvement work.

We summarised our findings in a report which we sent to the CHCP in August 2012. This also set out a targeted and proportionate scrutiny response of 13 sessions. [3]

3. Timing of scrutiny

We carried out our scrutiny during the week starting 8 October 2012. For logistical reasons two sessions were carried over to the following week.

4. Scope of scrutiny

The scrutiny we undertook was focused primarily on the two areas of uncertainty identified in our ISLA. As such it did not constitute a full inspection of the performance of all activities and responsibilities of the CHCP in relation to social work services. We did not focus the scrutiny on the seven areas where based on the ISLA there were no significant concerns. We provided detailed feedback on these areas in the report we sent to the CHCP in August 2012. As such what follows is a brief summary of our analysis of the six areas.

[2] These categories are consistent with the categories used by Audit Scotland as part of its shared risk assessment approach to scrutiny planning for local authorities. In October 2012, Audit Scotland revised these three categories to scrutiny required, further information required and no scrutiny required. We reflect the revised categories later in the report in the section including the reasons for the scrutiny we undertook.

[3] The amount of scrutiny that the Care Inspectorate carries out in a local authority relates to both the assessed level of risk and also the size of the local authority. For West Dunbartonshire this allowed for up to 15 scrutiny sessions to be completed.

1. Outcomes for people who use services and for carers.

We concluded that West Dunbartonshire CHCP was delivering positive outcomes in most instances for service users and carers across the various care groups.

We reviewed nationally published outcomes and proxy outcomes data. This showed that in many areas the social work services were performing well, and in many instances above or well above the national average.

Adults:
The service was performing well in relation to information relevant to care/reshaping care for older people. For example in West Dunbartonshire in 2010-11:

- 25.5 per 1000 older people were receiving intensive home care (compared to 17.7 nationally)
- 90.6 per 1000, older people were in receipt of a home care service (compared to 58.8 nationally); and
- 32.6 per 1000 older people were supported by the council's in care homes (compared to 36 nationally).

We saw that a pharmacy re-ablement service had been established which provided a detailed medication and medication management assessment for older people being discharged from hospital and receiving home care services. The aim was to support hospital discharge and prevent re-admission. The service was being evaluated using a methodology developed in partnership with the national Joint Improvement Team (JIT). The findings that were available at the time of our inspection were positive in that:

- 77% of carers of people using the service said the involvement of the service had resulted in an improvement in the ability of the service user to manage their medication and
- 80% of home care staff surveyed in a questionnaire said they were aware of the pharmacy re-ablement service and of what it provided.

Children and families:
Most of the outcomes data in respect of children's services was positive. In 2010/11:

- 100% of the care leavers eligible for aftercare were receiving an aftercare service and 52% were in employment, education or training (compared to 22% nationally).
- West Dunbartonshire was ranked 9th out of 32 councils for the average educational attainment tariff score for looked after children. It was ranked 8th out of 30 councils for the exclusions from school of looked after children.

The findings from our file reading in relation to outcomes were generally positive. For example, 93% of files had evidence of positive outcomes for the service user and in 60% of files improvements were mostly attributable to effective social work.

An impressive range of service user questionnaire information was submitted and some of this related to outcomes. The majority of the respondents who had used CHCP social work services reported this had made a positive difference to their lives

or the lives of people they cared for. A survey of unpaid carers showed that 81% of carers (who responded) considered that the support they received from social work services enabled them to continue in their role as a carer.

We held three focus groups of people who use social work services within West Dunbartonshire as part of the ISLA.[4] The participants were generally positive in what they said about the positive difference the social work services made to their lives.

2. *Assessment and care management*

The file reading results applicable to assessment and care management were generally very positive and there were comprehensive supporting policies and procedures in place. There were no significant differences in the results across the three care groups. For example:

- 99% of files contained an assessment and in 94% of files, the timing of the assessment was in keeping with the needs of the person using the service.
- In terms of quality, 80% of assessments were evaluated as good, very good or excellent.
- 95% of files where a care plan was considered necessary had one and, 95% of these care plans were up to date.

The CHCP had also undertaken a case file audit in advance of our file reading and we saw that its findings in terms of the areas for improvement were similar to our ISLA file reading findings, namely;

- the need for good chronologies.
- improved recording of worker supervision and decision making.

We read a lot of documentation which confirmed good quality policy and procedures which, if applied, should support effective assessment and care management practice. There was evidence of quality assurance processes and activity and also information showing that service demand was being monitored.

3. *Risk assessment and risk management*

Risk management policies and procedures were comprehensive, clear and fit for purpose. There was additional guidance about risk for some specific client groups, such as older people and people with mental health problems. Evidence was provided which confirmed the dissemination of procedures and the provision of supporting training. A range of risk assessment and risk management tools used by staff were submitted.

The file reading results in relation to risk assessment and management were largely very positive. The main exception was the chronologies where we identified the need for improvement in their quality as a tool to support effective risk assessment.

Protection risk

[4] The focus groups were with adults with learning disabilities, carers of adult service users and parents of children with a disability

- 95% of files which should have included a risk assessment had one and in 95% of these the timing of the assessment was appropriate. In 84% of the assessments their quality was good or better.
- 92% of the files which should have contained a risk management plan did so and in 87% of the files the plan was up to date. 67% of these plans were evaluated as good and better.
- In 93% of the files, all concerns regarding risk had been dealt with adequately.

Non protection risk

- 84% of relevant files had a risk assessment;
- 71% had an up to date risk management plan.
- In 77% of files all concerns about risk had been dealt with adequately.

The Care Inspectorate published the report in March 2012 of its joint inspection of services to protect children (CP2). The four quality indicators considered as part of the national performance framework were all evaluated as very good in West Dunbartonshire.

As with child protection and the work of the Child Protection Committee, we were provided with a lot of information on adult protection and the work of the adult support and protection committee.

We also saw documentation showing that the Criminal Justice Social Work Partnership had a high-risk offender performance improvement plan which was subject to regular monitoring.

There was evidence of information sharing protocols and practices. This demonstrated a good understanding of consent and data protection issues. There was also evidence about the provision of clear public information on how to contact services on public protection matters.

4. *Self-evaluation and improvement*

There was a strong focus on self-evaluation within the CHCP and we were provided with a lot of information confirming activity in this area. This included high level and service specific PSIF assessments (Public Service Improvement Framework), and exercises to obtain feedback from people who used services. There was also evidence of action plans being developed and their progress being monitored and reported by the CHCP and as part of its reporting arrangements.

The council was an early adopter of the PSIF (Public Service Improvement Framework) and the former social work and health department undertook a “high level” PSIF self-evaluation in early 2009. The CHCP itself completed a PSIF self-evaluation in mid 2011 and Quality Scotland facilitated a self-assessment by the Senior Management Team in Feb/March 2012. Senior managers understood that this was the first time a corporate PSIF had been undertaken by an integrated partnership in relation to the breadth of its NHS health and council social care responsibilities.

We were provided with a good amount of information and some supporting evidence of the CHCP’s and the council’s commitment to self-evaluation. The 2012-15 Assurance and Improvement Plan (AIP) noted that the local area network “have

commented positively on the council's commitment to improvement and their self-awareness regarding performance".

The CHCP had completed PSIF assessments on its mental health, learning disability and homecare services. We were provided (as examples) with some of the prioritised areas for improvements from these self-assessments and saw that there were reporting and monitoring arrangements in place. There was a programme in place for further self-evaluations.

We saw examples of exercises to obtain feedback from people who used services. These included mental health service users and parents and carers involved with the child protection services.

We saw the CHCP had a comprehensive performance management framework. In line with the governance arrangements of the CHCP, quality assurance processes took place both within the CHCP and via the Health Board and Council arrangements. Efforts had been made, especially via the Covalent management information system to bring together performance reports. We saw some evidence of how performance management had been used to identify problem areas (i.e. delayed discharges of older people affected by adult with incapacity considerations).

There was a strong emphasis on service improvement in the documentation provided. This included the CHCP's three good practice submissions which were:

- visual impairment pharmacy resource development.
- tackling alcohol misuse through collaborative leadership.
- the acquired brain injury service.

The CHCP submitted a significant amount of supporting documentation for the submissions. This pointed to good outcomes being achieved to which the involvement of people who use the services and carers had been central, as had the involvement of staff and other stakeholders. This was confirmed by presentations given to Care Inspectorate staff in July 2012 which highlighted how close partnership working between health care and social work staff within the CHCP had been significant factors in these service developments. We concluded that all three of the CHCP's submissions met the criteria[5] to be considered as good practice examples and we provide further information on them at the end of this report.

5. *Partnership Working*

We were provided with a great deal of information and evidence which indicated a strong commitment to effective partnership working. The establishment of the CHCP was a key reflection of the approach to partnership adopted by the council and the NHS Health Board in West Dunbartonshire.

In our file reading exercise the results for partnership/collaborative working were positive. The average result was 85% for the questions on there being an appropriate level of partnership working at the various stages of involvement with the

[5] Sector leading practice: Innovative and promote improvement; Positive outcomes.

service user. Information derived from inspections of the council's registered services also pointed to good operational collaborative working. Care Inspectorate staff involved with the council's registered services said they had positive links with the CHCP in respect of contract monitoring arrangements.

The CHCP's integrated strategic plan was the main overarching plan for the CHCP. The latest version we saw was for 2012-13 and it included elements of partnership planning to be further developed, e.g. with Alzheimer's Scotland to support people with dementia and their carers.

There was evidence of partnership arrangements with the third sector, an example of this being with MacMillan Cancer Care with whom there had been a close relationship around the delivery of palliative care support for a number of years.

We were provided with a wealth of information and evidence showing a considerable commitment to and activity around the involvement of service users and carers. Particular strengths appear to be:

- community engagement, including via the Public Partnership Forum which had an enhanced remit across the span of the CHCP's health and social care responsibilities.
- a pro-active approach to consultation.
- a positive commitment to advocacy and well-regarded advocacy services.
- extensive involvement of volunteers.

A number of people who use services and carers we met at the focus groups had been involved in service planning and events. A number spoke positively about this.

6. *Equality*

All of the evidence we analysed indicated that West Dunbartonshire Council and the CHCP social work services had made significant efforts to comply with equality and human rights legislation. There was a comprehensive equality strategy and implementation of this was monitored. The equality strategy underpinned all of the equality-related activity within the council and CHCP social work services.

The CHCP had delivered equality training for staff and this included training on the completion of equality impact assessments (EIAs). It submitted a wide range of EIAs on CHCP services related to its social work responsibilities. These were comprehensive, competently produced documents.

Our file reading results were very positive in respect of social work staff trying to overcome the communication and other barriers experienced by some equality groups, such as people with learning disabilities and people with dementia. In 87% of files there was evidence that in dealings with the individual potential barriers had been addressed.

5. Scrutiny Findings

5.1 Governance and financial management

Reasons for scrutiny
From the information we received as part of our ISLA, it was not always clear how the governance and financial management arrangements for social work services within West Dunbartonshire had been affected by the establishment of the CHCP. The CHCP provided a range of health care services, social work services and integrated services. The documentation submitted reflected this and it was not always easy to see the position as it applied specifically to social work services. As such, there were a number of points upon which we required clarification and/or further information. In particular we needed to:

- explore the arrangements for strategic planning and whether these were as streamlined and integrated as they could be.
- clarify the financial position of CHCP social work services including any key financial pressures and the likely extent of any savings requirements.
- confirm the CHCP's and council's plans in respect of its care homes for older people given that these had been under review for a protracted period.

Scrutiny findings

Governance
The CHCP was responsible to two "corporate parents", namely West Dunbartonshire Council and NHS Greater Glasgow and Clyde. This was reflected in the CHCP Committee which comprised of six NHS representatives and six elected members from the council. The committee was chaired by an elected member with an NHS non-executive board member as vice chair. Senior managers in the CHCP, as well as having to report and be accountable to the CHCP Committee, also had to do likewise to meet the individual governance requirements of the council and the NHS. This meant for example that the CHCP Director reported directly to the Chief Executives of both the council and NHSGGC.

From the documentation provided and from our scrutiny, we saw that the governance and planning arrangements to support the CHCP had evolved since its establishment in October 2010. Action had been taken wherever possible to streamline and integrate activities and processes. The CHCP committee was seen as central given its partnership nature and efforts had been made to try and ensure that council and NHS requirements were able to dovetail with this. We met with senior elected members who were on the CHCP Committee. They said there had been a lot of duplication in papers presented at committees in the early stages, but this had improved over time. They had noticed that reports had become more integrated over time and they had recently been able to move from a bi-monthly cycle of CHCP and council Committees to a quarterly one. They said that from an elected member's perspective being part of a CHCP had resulted in there being a better focus on and understanding of the health implications of social issues and social work services

In terms of strategic planning, we saw that the CHCP had inherited a position where there was a rolling programme of annual plans for the former social work and health department. Similarly, the former Community Health Partnership had produced annual development plans as per the NHSGGC corporate planning process. We saw

that the CHCP had taken action to pull together the particular requirements of its corporate parents through an integrated planning process; and had produced the first integrated CHCP strategic plan for 2011/12. The second integrated plan for 2012/13 which we had seen in draft form had been formally approved by the CHCP Committee at the time of our scrutiny. We read the plan and saw that it had been informed by some analysis of local health and social care needs. It contained a clear list of strategic actions which the CHCP required to take forward. Integrated plans of this nature are not yet common place in Scotland. We concluded that the CHCP had moved relatively quickly in developing its integrated strategic plan and the processes to support this.

We held a number of interviews with senior managers in West Dunbartonshire who impressed as being committed to partnership working and the CHCP. Irrespective of whether they had a "health" or "social work" background, they saw themselves as accountable for and committed to the development of the range of services provided within the CHCP. They recognised the reality of being accountable to the two corporate bodies, but did not describe this as being a particular frustration, especially as much of the early duplication and dual reporting had been resolved. For example, the SMT was about to attend its third Organisational Performance Review where the performance of the CHCP would be jointly scrutinised by both the council and the NHS Health Board. These sessions were co-chaired by the Chief Executives of both NHSGGC and WDC. For performance management purposes an integrated suite of key performance indicators had been agreed.

The CHCP had submitted its joint response to the Scottish Government's consultation on its proposals for health and social care integration. Amongst other things, the response suggested that the government should consider adding an operating model based on the West Dunbartonshire approach to the two options included in the consultation paper. It also argued in favour of the new partnerships including "all care groups". During scrutiny senior managers confirmed that these responses were based on what they viewed as being the positive experience and benefits from the CHCP in West Dunbartonshire to date.

Financial management and resource management
We met with senior managers in the CHCP and also with senior corporate managers with responsibility for finance and for the council's assets. This allowed us to clarify the financial position for Council social work responsibilities as discharged through the CHCP; and to get an update on the approach being taken towards determining the future of the council's care homes for older people.

We were aware from the Assurance and Improvement Plan 2012-15 that West Dunbartonshire Council had taken steps in recent years to improve its financial position including increasing its financial reserve levels which had previously become close to depletion. Information submitted for the ISLA indicated that financial matters were given sufficient organisation priority and it was evident that finance and resources were discussed regularly at senior management team meetings. During the scrutiny we heard from staff at all levels that historically social work services had been relatively well resourced within the council. From financial information provided and from comments made by staff, this impressed as having continued since the establishment of the CHCP which had delivered its services within budget each year to date. It was on target to do the same in 2012/13.

Within the council, budget gaps were initially dealt with by the finance team, on a corporate basis. Potential savings and targets were identified (often based on a percentage cut of individual service budgets) but importantly the analysis and prioritisation took place at corporate management team level – where plans were "sieved" and prioritised. This process appeared to be working well across the council.

Over the recent past, the financial budget had been relatively static, but this position was significantly more favourable than other services within the council. Spending pressures (for example in learning disability services) had been built in to the base budget where appropriate. Demographic pressures in the form of the rising elderly population were impacting on West Dunbartonshire at a slower rate than elsewhere in Scotland.

The Council's main financial issues were not expected to materialise until 2015/16. This gave the council some time to plan – and senior managers indicated that there remained a number of significant opportunities for cost reduction in the back office rather than in front line service delivery.

Senior managers said the structure of the CHCP prevented "cost-shunting" between the Council social work service and NHS community health budgets, as although the budgets were separate they were managed by the same staff members. Having a single manager responsible for services, including budgets at the head of service level allowed an element of financial planning and service development which might well not otherwise have been possible.

Based on our scrutiny, we concluded that whilst CHCP social work services in West Dunbartonshire, as elsewhere, faced significant financial challenges, it remained relatively well resourced. We saw documentation which suggested that there were not major difficulties in terms of people having to wait to have their needs assessed or services provided. In adults services we saw that community care assessments were not restricted only to people with critical or substantial needs in terms of the eligibility criteria (as is the case in some councils). This was also confirmed during staff focus groups. We concluded that the relatively well resourced nature of the social work services within the CHCP provided part of the explanation for this.

As part of our scrutiny we sought some specific further information about the council's care homes for older people of which there were six. In the SWIA performance inspection of 2009 reference was made to a "protracted best value review" which was underway at the time. We noted as part of our ISLA that the council continued to operate the six care homes and that the grades they received at inspections for the quality of their environment had declined. We further noted that the council was once again giving consideration to care home provision for older people, including the council's role as a provider. There were also significant implications for the day care support provided to older people and their families as three of the care homes also provided day care. A detailed business case addressing this was being developed.

We discussed this issue with senior managers and with elected members. There was an acknowledgement that the care home estate was approaching a position

whereby they would no longer be fit for purpose[6] and that a strategic decision should have been made sooner.

A number of reasons for the delay were presented:

1. The care homes had historically been highly regarded by older people who used them, their families and by their local communities.
2. Despite the growing problems with the condition of the estate, the homes continued to be well regarded.
3. Given the above, there was ambivalence and uncertainty in terms of the council's attitude to whether or not it should continue to be a provider or significant provider of residential care for older people.
4. The deteriorating economic position in recent years, both nationally and locally, combined with the significant difficulties experienced by some independent sector providers had also caused second thoughts by both the council and the CHCP towards an approach largely based on "outsourcing".

From our discussions, it was evident that there remained some variable views about the best model on which to proceed, but there was also a recognition that substantive decisions could not be deferred any longer. In September 2012, the council agreed at committee that proposals for the care homes should be fast tracked so that any capital expenditure considerations could be taken account of as part of the budget setting considerations in February 2013. We read a committee report prepared in November 2012 which stated that "the status quo is no longer an option".

This report included two options:

- Option 1 which would involve the closure of all six of the care homes and their replacement by two 90-bedded care homes (and associated daycare provision) run by the council. The report estimated that the new facilities would take some three years to build and become operational. This would require borrowing of some £20 million.

- Option 2 which would involve the closure of five of the six care homes with the beds involved being replaced by purchasing from the independent sector.

The report recommended Option 1. A key factor in this was identified as being uncertainty about the likelihood of sufficient take up and delivery by the independent sector in the current economic climate. In addition this option would allow the council to retain a staff group with the necessary skills to respond in the event of future difficulties/closures of independent sector provision.

We saw that the options were supported with appropriate consideration of their potential advantages and disadvantages, as well as of the financial, people, community implications and an overall risk analysis. We concluded that a substantive decision was overdue and was now an imperative. We could understand the reasons why Option 1 was being recommended at this point in time. However, it was the significantly more expensive of the two options and the report acknowledged that many of the costs involved could have been avoided had a decision been made

[6] Of the six existing care homes, only one, even with some investment has been assessed as having a viable long term future.

sooner. The Care Inspectorate is aware that other councils have taken action over recent years to close their own care homes, purchase any necessary replacement from the independent sector and invest consequential savings in other services to support older people in the community. We concluded that the delay had therefore, at least in part represented a missed opportunity.

Prior to the publication of this report we received confirmation that the CHCP Committee at its meeting of 21 November 2012 had approved Option 1 as recommended. We concluded that it was positive a decision had been taken about the way forward given the recognition that the status quo was not a viable position.

The Care Inspectorate will closely monitor future progress on this matter.

Recommendation 1
West Dunbartonshire Council and the CHCP must move quickly to implement the recent decisions on the future of its existing care homes and day services for older people. They must do so in a manner which is in line with their strategic priorities, including the need to "improve care for and promote independence for older people".

Chief Social Work Officer
In our ISLA we read a number of documents which indicated that recognition and consideration had been given to the important role of the Chief Social Work Officer (CSWO) and how this could best be secured within a CHCP arrangement. The CSWO (also the Head of Children's Health, Care and Justice Services) was a member of the CHCP's senior management team.

The CSWO was in fact the one member of the SMT who had a professional qualification as a social worker. The previous CSWO retired in June 2012, prior to which there was a three month handover period with the new CSWO (an external appointment). This arrangement was very unusual, if not unprecedented, and suggested further recognition by the CHCP of the importance of this role. This was confirmed during scrutiny by the Director of the CHCP who said that it had been a conscious decision to take action to ensure that there was continuity in having a CSWO in place at the head of service level. From focus groups, it was clear that the new CSWO had already established a visible presence despite being in post for a short period. She herself said the hand over period had been very helpful in allowing her to get to know the service and to meet staff and key partners.

The scrutiny we undertook and the further information provided by the CHCP allowed us to address the areas of uncertainty we had from the ISLA in respect of governance and financial management. Overall, we concluded the CHCP was functioning effectively in these areas. It is important however, that timely and positive action is now taken in line with our recommendation on the care homes for older people.

5.2 The management and support of staff

Reasons for scrutiny
The documentation submitted suggested a strong commitment by the CHCP to the promotion of staff health and wellbeing. The CHCP had played a leading role in the in the council achieving the Health Working Lives (HWL) Gold Award from the

Scottish Centre for Health Working Lives in 2011; and the CHCP (across both its NHS and council staff and sites) receiving the Gold HWL Award during the time of the scrutiny.

However, there were a number of areas relating to the management of support where we were uncertain of the position and on which we needed to further information in order to clarify this. These included recruitment and retention, aspects of staff development, and the CHCP's approach to medium and longer term workforce planning.

We had also noted there had been an increase in staff sickness absence and that a recent staff survey reflected some negative responses around communication, vision and the management of change.

Scrutiny findings

Vacancy and absence management
We were able to clarify the position in respect of recruitment and retention. The CHCP provided further information which confirmed that it employed just over 1,100 staff (on a full time equivalent basis) of whom some 600 were social work staff employed by West Dunbartonshire Council. We saw information showing the vacancies which had arisen during 2010, 2011 and 2012 and that the numbers were relatively small. For example, at the time of our inspection some thirty posts had become vacant during 2012. The vacancy position over this three year period were consistent. At focus groups, both staff and managers said that there was a stable workforce with little turnover. Managers and staff described recruitment processes as operating smoothly in the main.

Inspections of regulated services by the Care Inspectorate had identified a significant number of acting up arrangements in the council's care homes for older people. This was of some concern given the importance of effective management and leadership in the provision of good quality care. It was a factor in the decrease in grading for the quality of management leadership arising from the inspections of some of the care homes. Managers we met during our scrutiny indicated that this had been addressed. The next inspections of these care homes will provide an opportunity to confirm this.

For the ISLA we saw there were comprehensive policies and procedures in place for managing absence. However, despite this figures provided on council-employed staff sickness absence had suggested that this was an issue for the CHCP social work service. For example, the number of days lost per full time equivalent council-employed staff member rose from 13.4 days in 2010/11 to 14.9 days in 2011/12 (equivalents to some 6.5 %). This was significantly above the five year corporate council target which had recently been reduced to 7 days (to be achieved by March 2017) and which was equivalent to just under four per cent.

During our scrutiny, managers confirmed that sickness absence remained a significant problem and a challenge. Overall there had been an upward trend with absence at the time of the scrutiny running at over six per cent and over two per cent above the target. The absence levels of the social work council-employed staff in the CHCP were also higher than their NHS-employed colleagues. Managers, including corporate HR (Human Resources) managers said that long-term absence, rather than short-term absence accounted for by far the greatest proportion of the total

absence. Residential care and home care had the highest absence levels (as is often the case in social work services); although homecare managers said the absence levels in their service had been falling.

Managers at all levels said that they were required to report regularly on staff absence. The council had revised its absence management procedures and managers we met said the revised procedures were an improvement as they ensured a more consistent approach to staff than had been the case previously. For example, staff were now automatically referred to the occupational health service after 21 days of absence. An audit had been completed at the time of our scrutiny (but not yet reported) of the CHCP's compliance with the procedures. The Director of the CHCP said the service's approach to absence was a balance between taking a hard line given the comparatively high absence levels and recognition that the health profile of the staff group was at least in part a reflection of the generally poor health profile of the wider West Dunbartonshire population.

This latter point was also one of the reasons why the CHCP and the council had placed a considerable focus and effort in engaging with the Healthy Working Lives initiative[7]. One aspect of the initiative is the opportunity to participate in a structured award programme. Involvement in the initiative in West Dunbartonshire went back to 2007 and the CHCP had led the work required to achieve the HWL Gold Award by the council in 2011, alongside the CHCP achieving it itself in 2012. Staff we met at focus groups spoke positively about the initiative and cited examples such as running groups which they said had helped improve their health behaviours and wellbeing. A staff health and wellbeing survey was being undertaken at the time of our scrutiny. The Director of the CHCP said that its findings would establish a baseline against which the impact of HWL would be able to be measured in future.

Staff morale and development

The performance inspection in 2009 found that staff were generally positive about working in the former social work and health department in West Dunbartonshire. Surveys of staff during 2010 (and published early 2011) that we saw for the ISLA included some findings which seemed less positive. For example, 46% of respondents did not agree that there was clear communication from the top of the organisation and 35% did not agree that their contribution was valued. However, we were not entirely clear from the survey whether these were the views of social work council-employed staff or NHS-employed staff in the CHCP or both. We wanted to clarify this and also to explore staff morale in staff focus groups.

During our scrutiny managers confirmed that there are two mains staff surveys which involve CHCP staff:

1. A corporate council survey which social work staff in the CHCP can complete.
2. A national NHS staff survey which health staff in the CHCP can complete.

Senior Managers said that being part of two larger surveys was a reality which they had to live with. They had no plans to introduce an additional survey for all staff in the CHCP as both surveys allowed (albeit separately) the views of council-employed social work and NHS-employed staff in the CHCP to be identified. Although the two

[7] Health Working Lives is a national initiative designed to help employers, employees and all our partner agencies come together to create a much healthier and more motivated workforce.

surveys were different, the range of questions asked was broadly similar and allowed some indicative comparisons to be made.

Senior Managers also confirmed that the findings we had considered as part of the ISLA (and which are referred to above) were based on the views of Council-employed staff in 2010. By comparing the two surveys, the CHCP identified a number of common themes, including the following areas for improvement which we noted were included in the CHCP's current workforce plan:

- to ensure all staff have a personal development plan or equivalent (45% of council-employed staff who responded did not agree that they had a personal development plan in place).
- to increase the provision of feedback to staff on their performance, including the recognition.
- to further increase the visibility and accessibility of senior managers.

At our focus groups the staff (and managers) we met spoke positively about working for the CHCP in West Dunbartonshire. For the most part they said staff morale in the teams they worked in was good. A number had worked in other local authorities and said their experience in West Dunbartonshire compared favourably. The size of the authority was commonly identified as a factor in this, with it being not too big, but not too small. Staff said that as well as their line managers, they were able to contact more senior managers when they needed to. They also identified the relative stability of the workforce and the ability to access resources on behalf of their service users as positives.

In the focus groups children and families staff spoke about there being good team support, both from colleagues and managers. In criminal justice, morale had been found to be poor at the time of the performance inspection. Staff and first line managers we met said team morale had improved since then. They said that some new staff coming into the service had played a part in this.

Community Care staff were generally positive, especially those working in the integrated/specialist teams (addictions, learning disability and mental health teams). Staff in locality teams were less positive. In large part this was due to the reconfiguration of these teams. Staff said there had been uncertainty about what the new and integrated locality teams would look like and the length of time the restructuring process had taken. It was now confirmed that there would be a specialist integrated hospital discharge team, an integrated team for the over 65s and the same for the under 65s. The new teams were scheduled to be in place in early 2013. Senior managers acknowledged that the review process had been significantly delayed (in part due to sickness absence of key senior staff) and the process had been unsettling for staff. Staff recognised this and whilst some staff dissatisfaction remained (especially amongst those staff whose remit and/or location would change), there appeared to be a general acceptance that the new structure for the locality teams made sense.

The council-employed staff we met were generally positive or neutral about the impact of having become part of the CHCP. They said they had always had good joint working arrangements with NHS community health colleagues and these had either continued or been enhanced within the CHCP. The impact had been limited for criminal justice and children and families staff as their teams at the front line level remained essentially single agency, social work teams. Many community care staff

were already part of integrated teams before the CHCP and for others the move into such teams was still being implemented.

The 2010 West Dunbartonshire Council staff survey included a number of questions around staff wellbeing. Some of the responses from CHCP Council-employed staff social work staff were positive. For example 74% of respondents said the council was good at promoting equality and diversity. However, we noted that 22% of respondents to this question (totalling 82 employees) said they had experienced some form of bullying, harassment or victimisation in the previous year. We raised this at focus groups and interviews. Most, but not all staff were aware of this finding as were most first line managers. Middle managers and above were all aware of it. Everyone we spoke to expressed surprise at the finding and said they did not recognise bullying as being an issue or in anyway part of the culture of the former social work and health service or the now CHCP. Some were aware of related issues historically in other parts of the council and wondered whether the finding was a reflection of these. Senior corporate HR managers said they were aware of only two grievances relating to bullying allegations in the previous two years and that these had been against colleagues rather than managers.

As well as containing aggregated statistical information, the council staff survey also included anonymised comments from individual staff members. There were seventy eight such comments of which one referred to bullying. The person said that although they had not experienced bullying themselves, they had observed in their workplace. Comments we received from both staff and managers during our scrutiny did not suggest a bullying culture. However, bullying and harassment at work is a serious issue and the statistical findings alone from the staff survey were sufficient to mean that the CHCP should not be in any way complacent about this.

The discussions we had with staff and managers at focus groups presented a more positive picture overall about staff morale than was suggested by some of the survey findings. However, the CHCP had considered these findings and had identified areas for improvement. Senior managers said that actions in response to these had been incorporated within both the CHCP Strategic Plan and CHCP Workforce Plan. They had not however, prepared a specific and SMART [8]action plan to address the findings of the staff surveys. Given the critical nature of some of these, we concluded that they should.

Recommendation 2
The CHCP should develop SMART action plans to address the areas for improvement arising from the most recent staff surveys and from future surveys.

We were able to clarify the position regarding how well embedded the arrangements were in support of the CHCP's policies for supervision and learning and development. The council had recently introduced a new format for its personal development plans (PDPs). At focus groups both staff and front line managers said the new format was an improvement on the previous version as it was simpler at was clearer in how it linked realistic objectives to the development needs of the individual and the requirements of the service. Most also said that they either had a PDP in the new format or had a date pending when their existing PDP would be reviewed using the new format. However, based on the focus groups there were still some staff who

[8] SMART – Specific, Measurable, Attainable, Relevant and Time -Bound

had been without a PDP for some time. Senior Managers said that they now received monthly reports showing the position in terms of how many staff had up to date PDPs and that these could be broken down to the level of individual staff members.

They did not have a similar system in place to monitor that social work supervision was taking place in line with the frequency required by the supervision policy. At focus groups front line staff all generally spoke positively about the level of informal support provided by their line managers. However, there was more variability when staff spoke about having regular formal supervision. Based on the focus groups, this appeared to be more of an issue in the criminal justice team and in the community care locality teams.

During our earlier file reading exercise we had looked for evidence of the impact of social work supervision and we identified this as an area requiring improvement. The CHCP acknowledged this at the time and during scrutiny senior managers confirmed that they now planned to audit this and to monitor performance in a similar manner to which they were already doing for PDPs. Given the important role of supervision in supporting safe and effective social work practice we concluded that the CHCP needed to put these arrangements in place quickly.

Recommendation 3
The CHCP should take action to quickly put in place monitoring arrangements to ensure that social work supervision is taking place in line with the requirements of the supervision policy. This should include its frequency.

The performance inspection had found that the action taken by the former social work and health department to develop a wide ranging approach to staff development was a strength. It included an effective local practitioner's forum and other supporting arrangements, such as "Lectures at Lunch" which were open to all staff. In our ISLA, we saw evidence to show there were staff development forums in a number of areas. However, there was no supporting evidence to show that these were part of a coherent approach and some key staff groups did not appear to be included, for example frontline fieldwork staff and residential staff. Staff at our focus groups confirmed that were some staff development forums, for example for substance misuse, and for, adult support and protection. However, they indicated that these were rather ad hoc and that some other arrangements, such as the lunchtime lectures had fallen by the wayside to some extent. The CSWO confirmed the current arrangements were rather piecemeal and could usefully be reviewed. We concluded that the CHCP should do this in order to ensure that there is a coherent approach to the use of practitioner forums.

Workforce planning
The former social work and health department had a workforce development plan in place at the time of the Performance inspection. Documentation provided for the ISLA showed that there was a Workforce Plan which contained a useful position statement and a summary of priorities for action. However, the plan only covered 2012 – 13 and we wanted to explore what was being done to support longer term workforce planning.

Our scrutiny confirmed that the Workforce Plan was a plan for the CHCP's workforce as a whole. The plan for 2012/13 was the first time that an integrated plan covering

both NHS and WDC staff had been completed for the CHCP. Senior Managers said that developing the plan had been quite challenging, partly because to their knowledge there very few, if any such integrated plans already in place in Scotland. They said that some of other CHCPs had been in contact with them in order to learn from their experience. The plan included some details of the actions required to implement CHCP priorities which included a significant workforce component. The adult mental health and public protection were examples of this. They considered that the one year nature of the plan was sensible given it was the first plan. In addition some national considerations and developments, such as the Scottish Government's proposals on health and social care integration and for children and young people made it difficult to plan too far ahead at this stage.

We saw that the CHCP had undertaken some work and actions which would help inform longer term workforce planning. This included developing a profile, including an age profile of the CHCP's workforce and action to develop a single approach to staff and practice governance.

We concluded that the approach the CHCP had taken towards workforce planning was sensible. It was positive that it had developed its first integrated workforce plan and was committed to refining this during 2013. Whilst the need to plan for the long term was clearly understood by the service and it had an eye to this, it was reasonable they were waiting until some of the uncertainties referred to above had been resolved before proceeding further with detailed long term planning.

As a consequence of the further information provided by the CHCP and of our scrutiny, the areas of uncertainty which we had about the management and support of staff were largely addressed. Whilst we have identified some areas for improvement we concluded that the CHCP's overall approach was a sound one.

5.3 Other scrutiny findings

As areas of uncertainty, governance and financial management, and the management and support of staff provided the main focus for our scrutiny. In contrast, we did not focus on those areas evaluated in the ISLA as being of no significant concern. However, within these there were a few specific points which we wanted to pursue and which we were able to do during the scrutiny sessions we had already planned and within the amount of scrutiny time available to us. We discussed with the CHCP in advance, we comment on these below:

Outcomes - Pathway Planning
Most of the outcome data we saw in respect of children's services was positive. However, the information in respect of care leavers was mixed.

On the positive side in 2010/11 – 100% of care leavers eligible for aftercare were receiving an aftercare service and 52% were in employment, education or training (compared to 22% nationally). Less positively, pathway planning performance was less good (and had declined from the time of the performance inspection) with only 23% of care leavers having a pathway plan (compared to 57% nationally).

During scrutiny, staff and managers and managers all acknowledged the importance of proper planning to support young people leaving care. They said the following about pathway planning.

- Front line children and families staff said most young people leaving residential care did have a pathway plan. This could be more difficult for young people in long term foster placements who sometimes saw their foster carers as having the main role in helping them plan for their future. The staff also said that finding the time to do this work properly could be challenging.
- Middle managers said they had experienced data collection problems in recording whether pathway plans were in place. They also said that staff had to strike a balance between encouraging young people to actively engage in plans for leaving care without giving young people the impression they were being chased to move on.
- The CSWO also said that an IT issue was partly responsible for the drop in the number of reported pathway plans as a consequence of a change to the IT system. They knew that staff are working with the relevant young people, but did not know whether the young people had pathway plans in place or underway. They were in the process of completing a manual audit of this.

At the time of our scrutiny there had been two recent suicides of young women. They had both previously been looked after and accommodated and one of whom relatively recently so. The CHCP was undertaking a review on a multi-agency basis of the circumstances of the young people. It had agreed to share the findings of this with the Care Inspectorate.

The deaths of these young people are a tragic reminder of the vulnerability of many young people who leave care. It is important that the CHCP ensures effective pathway planning is provided to young people preparing to leave care. The Care Inspectorate maintains an on-going engagement with councils and their social work services through link inspector arrangements. The link inspector for West Dunbartonshire will continue to engage with the CHCP in respect of this, and to monitor its performance, through these established arrangements.

Assessment and Care Management – GIRFEC[9]

In the ISLA phase, we were uncertain about aspects of the implementation and embedding of GIRFEC from the documentation. We saw that CHCP social work and health care staff along with council education staff had recently completed a self-assessment to consider how well GIRFEC principles were embedded in practice. The findings were largely positive. In contrast we read about the introduction of a Single Agency Assessment (SAA) and the Integrated Assessment Framework (IAF). It was unclear where the implementation of these had reached. The SAA seemed to be very new. In addition minutes of the GIRFEC group referred to the need for clarity on the named person and training for staff. There was an IAF pilot, but it was not clear how this was being taken forward.

During our scrutiny, staff and managers confirmed that some aspects of GIRFEC were further advanced and embedded than others. The CSWO confirmed that the named person and lead professional had not yet been implemented. The GIRFEC strategic group was in the process of reviewing the existing working groups and forums to support GIRFEC and this combined with a staff survey which was underway would allow the training needs of staff to be re-visited. They were also revising aspects of their assessment framework. This had evolved over time and staff we met in focus groups said they had been able to contribute to this. They were completing significant numbers (some 140 in the previous three months) of

[9] GIRFEC – Getting It Right For Every Child

comprehensive assessments. This now included a risk and resilience matrix and staff said having risk assessment and risk management included within a single comprehensive assessment was a positive development.

Partnership Working – Commissioning Strategies and Feedback from Providers.
We read a range of integrated commissioning strategies for the key individual care groups, for example for older people, people with learning disabilities and for substance misuse and criminal justice services. However, we also noted that the commissioning strategies for children's services and mental health services were still to be completed. Our scrutiny confirmed that work was on-going to complete these two integrated commissioning strategies. Both have now been completed and approved by the CHCP Committee (with copies submitted to the Care Inspectorate). In addition the CHCP had also completed its first integrated strategy for carers (2012-2017)

We held a focus group with third sector providers in order receive feedback from them on their views of local social work services and the CHCP in West Dunbartonshire. The focus group was well attended and views expressed were largely positive. They referred to good inclusive and trusting relationships with the relevant CHCP staff and managers. Most were involved in groups locally and felt able to work in partnership with the local authority to develop services. Many could cite examples of small developments to their service which they had developed in partnership with CHCP staff. Some said CHCP staff had been helpful in supporting them to access funding from other sources.

They said that commissioning was still not done with them as equal partners but they understood the stress that the service was under. Not all the providers had Service Level Agreements, but all had services specifications.

6. Recommendations for improvement

The findings of our ISLA suggested that the CHCP social work services in West Dunbartonshire were generally performing well and had a solid focus on improvement. There has been no reason to revise this view based on our scrutiny. In addition, the areas about which we had some uncertainty and required further information have largely been resolved to our satisfaction. We have identified some specific areas for improvement and have made recommendations on these. Given that there are similarities between the areas for improvement identified by this scrutiny and the CHCP's own self-evaluation activity, the following recommendations are designed to complement and re-enforce the CHCP's own improvement agenda

Recommendation 1
West Dunbartonshire Council and the CHCP must move quickly to implement the recent decisions on the future of its existing care homes and day services for older people. It must do so in a manner which is in line with the council's strategic priorities, including the need to "improve care for and promote independence for older people".

Recommendation 2
The CHCP should develop SMART action plans to address the areas for improvement arising from the most recent staff surveys and from future surveys

Recommendation 3
The CHCP should take action to quickly put in place monitoring arrangements to ensure that social work supervision is taking place in line with the requirements of the supervision policy. This should include its frequency.

7. Next steps

We expect the CHCP to consider the contents of this report and to provide a SMART action plan to address its recommendations. The link inspector will liaise with the CHCP on the action plan and maintain regular contact to monitor progress on implementing the action plan. The link inspector will also continue to offer support for self-evaluation activity. Information from the scrutiny report will feed into the annual review of the local authority's assurance and improvement plan as part of the shared risk assessment

Richard Fowles
Senior Inspector

Appendix 2 Good Practice

West Dunbartonshire - Tackling alcohol misuse

Alcohol misuse is a major health problem in West Dunbartonshire which has the third highest recorded level of alcohol related deaths in Scotland.

West Dunbartonshire Local Licensing Forum (LLF) accepted a proposal from the Alcohol and Drug Partnership to gather comprehensive data to inform the Licensing Board's Overprovision Policy. The CHCP is the lead agency for the ADP in West Dunbartonshire on behalf of the local Community Planning Partnership.

A Short-life Working Group linked to both the ADP and the LLF was established and led by a representative from the CHCP. Group membership consisted of representatives from the CHCP, ADP, LLF, Strathclyde Police, Strathclyde Fire and Rescue Services and West Dunbartonshire Council Regulatory Services. Agreement on the scope of evidence required was agreed and comprehensive evidence gathered. Key points included:

- alcohol related deaths and hospital admissions
- percentage of Criminal Justice and Children cases with addiction
- percentage of population addicted to alcohol
- alcohol related crimes and incidents
- trading capacity of on- sale premises
- percentage sobriety of arrestees
- percentage sobriety of those convicted of violent crimes
- alcohol as a factor in domestic abuse
- link between alcohol problems and house fires
- noise and nuisance linked to licensed premises
- number of on and off-sales premises
- survey of where persons bought alcohol.

Data collection was helped by the fact that locally the Council's social work responsibilities and the NHS community health functions had recently combined within the CHCP.

The result of this multi-agency approach was the production of an evidence-backed policy which contained a presumption that any new pub, off-sales (including supermarkets) and nightclub would be refused in 15 out of 18 areas of the authority. This was the first such policy in the UK to use comprehensive health and other data to control the availability of alcohol in an area. The implementation of this Policy has been welcomed by local licensees and has been fully supported by local politicians.

There is evidence that new applicants for licences have been discouraged from applying. The policy has now been in place for over a year. When the CHCP presented its submission to the Care Inspectorate they said that the approach taken has attracted considerable local support, including from local politicians and local licensees. There was some speculation that the policy might be subject to legal challenge, but this has not materialised.

We saw that the policy had attracted media interest both locally and nationally, and also from other Alcohol and Drug Partnerships. The CHCP submitted this initiative to the 2013 COSLA Excellence Awards: at the conclusion of this scrutiny process it had just been confirmed that the initiative will at least be recognised with a COSLA Bronze Award.

We concluded that the development of this policy and its implementation represented a good example of collaborative leadership in an effort to tackle a significant social order. We were impressed with how the policy was based on the extensive use of local data collection and research

Appendix 3 Good practice

Visual Impairment Pharmacy Resource Guide

In October 2009 the former West Dunbartonshire CHP was approached by a local umbrella organisation for vision impaired people (VIP) in West Dunbartonshire, who outlined difficulties encountered by vision impaired people in the safe use of prescribed medications. Amongst other actions, the idea of producing a resource that would enable pharmacists to help this vulnerable group of patients to use and take their medicines safely was discussed and agreed.

A multi-disciplinary, multi-agency steering group - including service users - was brought together to develop the proposed resource. In April 2011, a resource - "Let's see if we can help" - was launched which had two main elements:

1. a written guide of "hints and tips", covering ways to help people take their medicines, labelling and identification of medicines, and links to further information.

2. a pack containing samples of stickers, pictograms, and aids such as bump-ons, together with information about stockists.

The CHCP said that it had developed this resource along with the Third Sector and service users. We saw that this was the case when the work done in this area was presented to the Care Inspectorate. The Third Sector representatives present and in particular a local group – Focus and service users were able to describe their involvement. We heard how the development of the resource included exploring with service users the difficulties they faced in taking their medication, and methods they used to make it easier. The experiences of service users were also sought as part of a comprehensive evaluation of the resource. Indicative feedback suggests that awareness of these issues has risen and that community pharmacists' practice is changing as a result. For example:

- early feedback showed that over 50% of pharmacists locally had used the guide.
- focus' contact with local pharmacists and service users indicated a positive response to the guide and an improved experience for service users.
- there was positive feedback from service users at Gartnavel Hospital eye clinic where the guide was being used.

We heard that the resource has aroused interest from a range of health professionals in diverse settings and areas. As well as with pharmacists locally it had been promoted locally amongst district nurses and home care staff. It was also attracting interest as part of the national sensory impairment strategy.

We were impressed with the guide[10] and the manner in which the CHCP had worked in partnership in its development with service users and the Third Sector. We considered that it provided a useful focus and tool in promoting self-care and equalities.

[10] The resource can be accessed via: http://www.wdchcp.org.uk/our-services/community-health-and-care/pharmacy-services/

Appendix 4 Good practice

Acquired Brain Injury Service

Based on national prevalence data, it is estimated there are some 300 people in West Dunbartonshire who are affected by an acquired brain injury. This is often a traumatic and life changing experience for the individual for and their families.

The ABI (Acquired Brain Injury) service was working with approximately 60 people with ABI at the time of our inspection. In West Dunbartonshire the most common cause of ABI are assaults and falls, often associated with alcohol and drugs.

The service had developed since 1995 when Rehabilitation Scotland published evidence highlighting the need for specialist ABI services. The service in West Dunbartonshire had grown since then and at the time of our inspection it comprised of:

- a service co-ordinator
- a consultant clinical neuropsychologist
- a social worker
- a support worker
- a strategy and planning officer and
- a clerical worker

The aim of the service was to provide community based integrative assessment and rehabilitation for individuals who had experienced an acquired brain injury and their families. The service said that it saw working in close partnership with the people who used its services as being essential in it achieving this aim: This was both as part of developing person centred and flexible support plans for individuals with ABI and also in terms of broader self development.

A reflection of this approach had been the establishment of a service user group, the Brain Injury Experiences Network (BIEN) who described themselves as “survivors not victims. BIEN members provided peer support to people affected by ABI and their families. They also acted as co-trainers in brain injury awareness and carers support training.

We saw the ABI service had worked effectively in a partnership with BIEN on a number of developments. These included:

- the completion of an ABI strategy for West Dunbartonshire.
- the development of a resource pack called “The Journey” which had recently been produced in DVD format.
- the development of SIGN[11] Guidance for ABI rehabilitation.
- membership of the planning committee of the World Brain Injury Conference 2012.

[11] The Scottish Intercollegiate Guidelines Network (SIGN) develops evidence based clinical practice guidelines for the National Health Service (NHS) in Scotland.

We met some of the BIEN members at a presentation during our inspection. They all spoke positively about the ABI service in West Dunbartonshire and the how it worked with them in real partnership. This was consistent with the most recent inspection of the ABI service where the service was graded as excellent against the following two statements:

- ensuring that service users and carers participate in assessing and improving the quality of the care and support provided by the service; and
- enabling service users to make individual choices and ensure that every service user can be supported to achieve their potential.

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