

Performance Inspection

West Dunbartonshire Council 2009

Performance Inspection of Social Work Services

West Dunbartonshire Council 2009

Acknowledgement

We would like to thank those who assisted us during our inspection in West Dunbartonshire. We are grateful to the service users, carers, staff and other stakeholders who took the time to complete our questionnaires and participate during our fieldwork, and also to the staff at the council's headquarters for accommodating us.

In particular, we would like to express our thanks to the social work staff who assisted us with the case file audit, and to the inspection co-ordinator and her team who provided valuable support and guidance throughout the inspection.

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Social Work Inspection Agency

The Social Work Inspection Agency (SWIA) is undertaking performance inspections of all Scotland's council social work services. Each inspection focuses on the approach to continuous improvement of the council.

SWIA will monitor the implementation of the recommendations made in this report and will undertake a short follow-up inspection one year after the publication of the report.

SWIA uses a six-point scale in its inspection of council social work services. In this report the inspection team has provided an evaluation in relation to each of the 10 areas for evaluation of the performance inspection model (PIM), as set out in appendix 1.

The evaluation scale

Level	Definition	Description
Level 6	Excellent	Excellent or outstanding
Level 5	Very good	Major strengths
Level 4	Good	Important strengths with some areas for improvement
Level 3	Adequate	Strengths just outweigh weaknesses
Level 2	Weak	Important weaknesses
Level 1	Unsatisfactory	Major weaknesses

The report uses the following words to describe numbers and proportions when we quote findings from our surveys or from our file reading exercise:

almost all	90% or more
most	75% to 89%
majority	50% to 74%
less than half	35% to 49%
some	15% to 34%
a few	14% or less

The comments and evaluations made in this report are based on evidence that has been substantiated from a wide range of sources, that is they are triangulated.

We use quotations from people only where they illustrate widely held perceptions. They are not the views of just one person.

Some comparisons are made with national averages taken from the results of file reading and surveys in all local authorities inspected to date. **We say if West Dunbartonshire's results are significantly above or below the average but where this is not specified the results are comparable with the national average.**

The full set of results for West Dunbartonshire Council from the file reading and the surveys of service users, carers and staff are available on the SWIA website at www.swia.gov.uk. Corresponding results for the other authorities which have been inspected so far are also available.

Summary, evaluations and recommendations

Summary

West Dunbartonshire's social work services delivered positive outcomes for many people who used them. The services were valued by most service users, although to a lesser extent by carers we met during our inspection or who responded to our surveys. In particular, we found some strong evidence of good outcomes for looked after and accommodated children, adults with learning disabilities and adults with acquired brain injuries.

There were high levels of community involvement in social work activities, with Social Work and Health and the council more widely, actively involved in efforts to inform and engage the local community.

Multi-agency working was a real strength with many good initiatives in place. However, some of the key processes around care management and risk management needed attention.

There was a good range and quality of services with a number having obtained Charter Mark status. Along with the Macmillan Carers Service and NHS partners, the service was playing a leading role in the development of an advice and care network nationally to address the relationship between cancer and poverty.

Partnership relationships were positive with other statutory agencies, and also with the independent sector. Some governance arrangements needed to be consolidated.

Staff morale had been adversely affected by contracted single status discussions. However, we found staff to be committed to their work and to be well motivated. Training, supervision and professional development were generally well embedded.

The need for a period of political stability within the council was identified by many people we met during the inspection.

We found both leadership and the service's capacity for improvement to be good.

Evaluations

Areas for evaluation	Rating
Key outcomes for people who use services	Good
Impact on people who use services and other stakeholders	Good
Impact on staff	Good
Impact on the community	Good
Delivery of key processes	Adequate
Policy and service development, planning and performance management	Good
Management and support of staff	Good
Resources and capacity building	Good
Leadership and direction	Good
Capacity for improvement	Good

Recommendations

Key outcomes for people who use services

Recommendation 1

Social Work and Health should move quickly to complete the action it has started to ensure it systematically defines and measures outcomes for all groups of service users and carers.

Impact on people who use services and other stakeholders

Recommendation 2

Social Work and Health should complete its strategy for self-directed care as a matter of priority and extend personalisation across its services.

Impact on staff

No recommendations

Impact on the community

No recommendations

Delivery of key processes

Recommendation 3

The service should take steps to make sure that those offenders placed on community service orders begin work placements within the timescales set out in National Standards.

Recommendation 4

Social Work and Health should review its mechanisms for approving the more expensive packages of care to ensure decisions are made within appropriate timescales and that there is an effective and consistent approach to resource management.

Recommendation 5

Social Work and Health should ensure that there are regular reviews of the care arrangements which adults using services receive. These should involve a care manager where appropriate and should follow a consistent format.

Recommendation 6

The service should follow national guidance and should find ways to introduce more independence in the chairing of reviews of all looked after and accommodated children.

Recommendation 7

Social Work and Health should ensure staff have a proper understanding of risk, are aware of the risk assessment tools they should use and have up-to-date training in using them.

Recommendation 8

Social Work and Health should make more strenuous efforts to make suitable working arrangements for women placed on community service orders.

Policy and service development, planning and performance management

Recommendation 9

Social Work and Health should operate a systematic process to manage policy development and review. This should include an exercise to prioritise policy gaps and policies requiring updating. Timescales should be set to reflect the agreed priorities and monitoring arrangements put in place.

Recommendation 10

Social Work and Health should develop a more detailed and SMART operational plan for its criminal justice services as a matter of priority.

Recommendation 11

The service should review its reporting and management of complaints to interpret trends and ensure the lessons learned improve practice. It should also ensure that it responds to all social work complaints within the statutory timescale of 28 days.

Management and support of staff

No recommendation

Resources and capacity building

Recommendation 12

In advance of decisions about the way forward on integrated structures, partners should ensure that existing partnership governance arrangements are updated to cover all joint services under single management. They should also develop joint financial systems and reporting arrangements.

Recommendation 13

The service should take a strategic approach to the purchase and direct provision of services. This should include the development of written commissioning strategies, improved purchasing processes and systematic monitoring and review arrangements.

Leadership and direction

No recommendations

Capacity for improvement

No recommendations

CHAPTER 2

Context

Introduction

The inspection of West Dunbartonshire Council social work services took place between June and November 2008. Our inspection team consisted of eight SWIA inspectors, four sessional inspectors, one carer inspector and one associate inspector.

During the inspection we read a wide selection of material about the council and the social work services it provided or commissioned. We analysed questionnaires received from staff, adults who use services, carers and stakeholders. Together with some staff from West Dunbartonshire Council social work services we spent four days examining case files. The team then spent a further two weeks in West Dunbartonshire looking at services as part of a fieldwork exercise. During fieldwork, we spoke to people who use services, their carers and people who were responsible for delivering or arranging services. We met with representatives from a range of organisations and groups as well as councillors and other stakeholders. We also visited places providing social work services and people's homes when they received services there. As a result, we collected an extensive range of evidence that informed the content, evaluation and recommendations contained in this report.

This report is not a detailed description of all the social work services in West Dunbartonshire. It gives an overview and concentrates on the work being undertaken with people who need assistance and the areas where improvements are needed. It does not duplicate the inspection of services which are regulated by the Scottish Commission for the Regulation of Care (Care Commission) and Her Majesty's Inspectorate of Education (HMIE). In order to achieve this, the Care Commission and HMIE provided us with information about their inspection reports from West Dunbartonshire.

Area profile

West Dunbartonshire has a population of 91,090¹ and covers 159 square kilometres from the southern shores of Loch Lomond in the west, to the northern banks of the Clyde in the east. Geographically, West Dunbartonshire is one of the smallest authorities in Scotland with a population density of 573 people per square kilometre. There are 3 main centres of population: Clydebank, Dumbarton and Alexandria, with over half of the population living in the Clydebank area.

With the decline of traditional industries, the area has experienced a series of challenges. West Dunbartonshire is one of the most deprived local authority areas in Scotland.²

1 General Register Office for Scotland, Mid-2007 Population Estimates

2 Scottish Government, Scottish Index of Multiple Deprivation 2006

The population of West Dunbartonshire has decreased by 2.4% since 2001, while overall Scotland's population has increased by 1.6%.¹ From the 2006-based population projections, the population of West Dunbartonshire is due to decrease by 2.4% by 2016 and decrease by 6.1% by 2026 (Note: both changes relate to the 2006 population). The equivalent Scotland figures are an increase of 3.0% by 2016 and an increase of 4.8% by 2026.

In West Dunbartonshire, 62.9% of the population are of working age which compares with a Scotland figure of 62.7%.¹ The working age population is due to decrease by 1.4% by 2016 and decrease by 7.7% by 2026.³ The equivalent Scotland figures are an increase of 2.8% by 2016 and an increase of 3.1% by 2026. The main employers in the area are the service industries: distribution, hotels and restaurants; and public administration, education, health and other services.

The current unemployment rate is around 5.5% compared to the Scottish average of 3.5%.⁴ Poverty levels are high with around 23% of people claiming some form of benefit – the third highest in Scotland and the proportion of dependent children in families claiming key benefits in 2005 was 24% – compared to the Scottish average of 19%.

The percentage of the population under the age of 16 is 18.1% (Scotland's figure is 17.8%). West Dunbartonshire's under 16 population is due to decrease by 9.3% by 2016 and decrease by 14.2% by 2026.³ The equivalent Scotland figures are a decrease of 2.8% by 2016 and a decrease of 3.8% by 2026.

The percentage of the population over the age of 65 is 19.0% (Scotland figure is 19.5%).³ The population of those over 65 is due to increase by 0.9% by 2016 and increase by 7.1% by 2026. The equivalent Scotland figures are an increase of 9.1% by 2016 and an increase of 18.4% by 2026. More specifically, West Dunbartonshire's 75+ population is due to increase by 8.8% by 2016 and increase by 38.8% by 2026. The equivalent Scotland figures are an increase of 21.4% by 2016 and an increase of 62.7% by 2026.

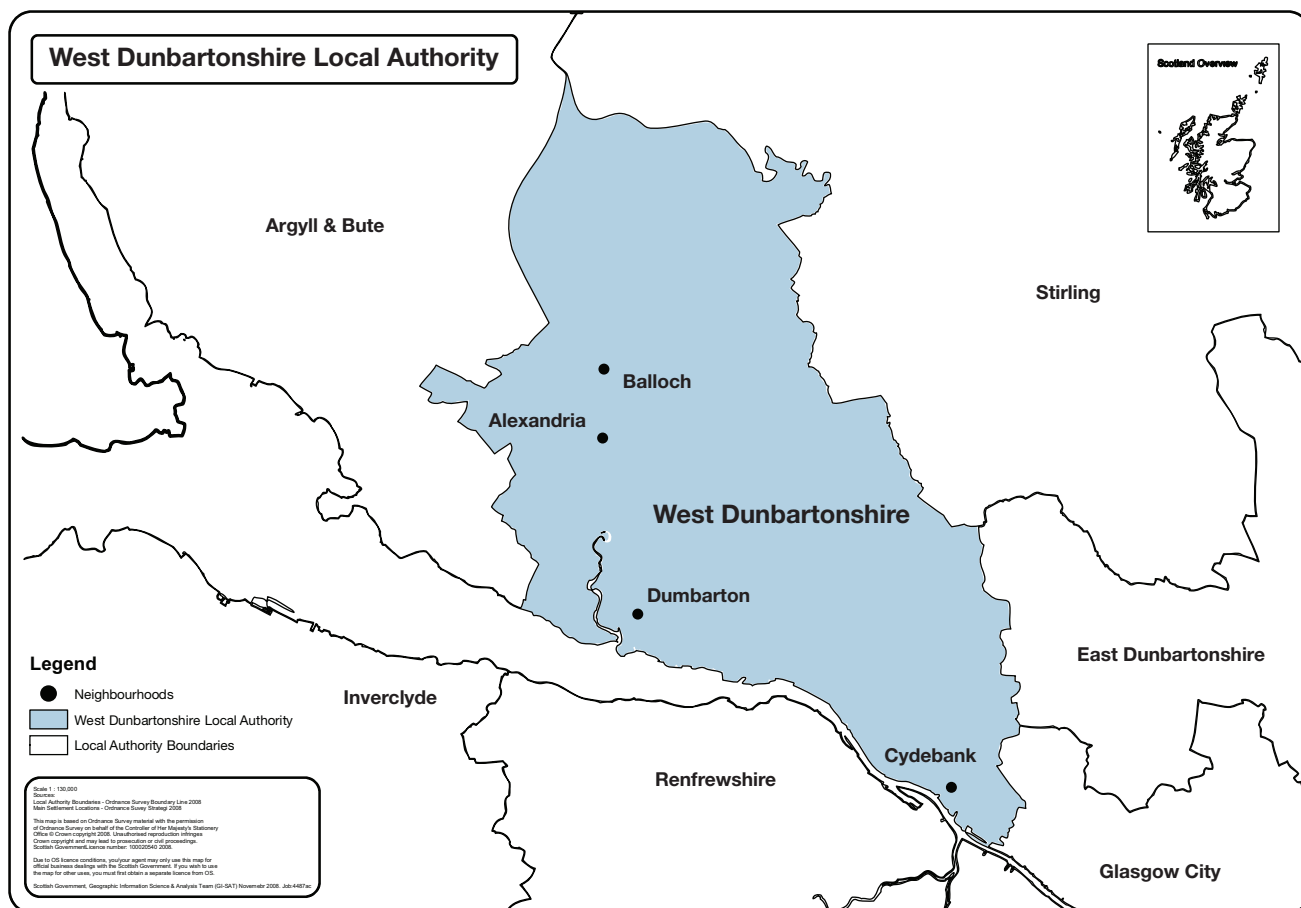
Life (and healthy life) expectancy rates are among the lowest in Scotland. In the 2001 census, around 23% of the population reported having a chronic illness or disability and by the time people pass their mid-fifties they have a 50/50 chance of being in this group. Alcohol and smoking rates are amongst the highest in Scotland, diets are poor and physical activity levels low.

According to the 2001 national census report, those from a minority ethnic background make up 1.5% of West Dunbartonshire's population, less than the Scotland figure of 2.0%.

3 General Register Office for Scotland, 2006-based Population Projections for Scottish Areas

4 Scottish Government, Labour market statistics: Local Economic Profiles, January 2009

Figure 1: Map of West Dunbartonshire



Criminal justice social work services

West Dunbartonshire’s criminal justice services were inspected in 2004. During the performance inspection the team carried out a follow-up inspection of these services. We examined 10 criminal justice case files as part of the file reading exercise and met with criminal justice staff and service users during the two weeks of fieldwork.

A copy of the inspection report of the Argyll, Bute and the Dunbartonshires’ Criminal Justice Social Work Partnership is available on the SWIA website at www.swia.gov.uk

Organisation of social work services

West Dunbartonshire Council provides social work services through the Department of Social Work and Health. The department is led by the executive director of Social Work and Health, who also holds the role of Chief Social Work Officer. The departmental senior management team (SMT) comprises of the executive director and five heads of service. Three of these heads of service are joint management posts who have management roles covering social work services and health services run by the local West Dunbartonshire Community Health Partnership (WDCHP).

West Dunbartonshire Council is linked with the Greater Glasgow and Clyde health board. Prior to this the council was linked to two health boards: Argyll and Clyde, and Greater Glasgow. In 2006, Greater Glasgow merged with part of Argyll and Clyde to become Greater Glasgow and Clyde.

Criminal justice services are delivered through a formal partnership arrangement with Argyll and Bute and East Dunbartonshire Councils, under a single management structure and joint budgetary arrangements. This partnership also forms part of the North Strathclyde Community Justice Authority.

Appendix 4 contains a diagram of the management structure of social work services. This structure is currently subject to review.

Throughout the report we refer to West Dunbartonshire Council's social work services as 'Social Work and Health', 'the service' or 'the department'.

Political structure

The council area is divided into six multi-member wards: Clydebank Central, Clydebank Waterfront, Kilpatrick, Dumbarton, Leven and Lomond. There are a total of 22 members of council. Following the May 2007 local council elections the SNP formed a minority administration. The political make up of the council at the time of the inspection was:

Labour	10
SNP	9
Independent	2
Scottish Socialist Party	1

Inspection methodology and process

The structure of this report is based on the SWIA performance inspection model, which asks the council six key questions.

1. What key outcomes have we achieved?
2. What impact have we had on people who use services and other stakeholders?
3. How good is our delivery of key processes?
4. How good is our management?
5. How good is our leadership?
6. What is our capacity for improvement?

The following chapters address each of these questions in turn.

A more detailed description of the inspection methodology and the way in which we carried out our inspection are included in appendix 3.

Chapter 3

Key outcomes for people who use services

Outcomes for adults, carers, children and families who use services

Social Work and Health performed to a good standard in delivering outcomes, having important strengths with some areas for improvement.

We define outcomes as the direct benefits to people's lives from the services they receive. Service users who we surveyed and who we met were mostly positive about the difference social work services had made to their lives.

A number of carers were noticeably less positive both about the services provided for themselves, and also in some instances, to the person they cared for.

The service collected some outcome information. It had started a process to measure outcomes for all care groups and services, but still had a significant way to go before this was fully in place. It needed to start aggregating existing outcome data for offenders.

The information showed some good outcomes and performance in a number of areas including looked after and accommodated children, adults with learning disabilities and people with acquired brain injuries.

The service generally performed well in terms of the balance of care for older people.

Measuring outcomes

Measuring outcomes is not yet common practice. National and local performance measures and targets are sometimes used as proxy outcome measures in this chapter. We use a consistent set of indicators for all councils, as well as other significant measures and targets.

In common with most local authorities, West Dunbartonshire's Social Work and Health department did not yet routinely measure outcomes for all care groups.

The service said it was developing indicators to measure outcomes for service users and carers and that it had implemented this process in 2007 in line with national policy. We saw some evidence of this, but it was clear from the service's operational plans and its wide range of Local Improvement Targets (LITs) that some parts of the service were further ahead than others in moving from measuring activity levels to meaningful outcomes. We comment later in the report on a number of services which were well regarded and of good quality. It was unfortunate that some of these were not yet able to measure their outcomes.

From the various meetings we had with staff, it was also evident that an understanding of an outcomes focus was not yet embedded throughout the service.

The service had decided to become involved with UDSET (User Defined Service Evaluation Toolkit), a national programme around outcome measures for community care service users. It had also volunteered to be a national demonstrator site for intermediate care for older people. It was using some tools, such as the CHRISTO inventory in substance misuse services and IoRNs (Indicator of Relative Needs) for older people which had an outcome-related focus.

We saw less evidence of action within children and families services to develop outcome measures and performance information beyond statutory performance indicators. Managers we met acknowledged this.

The service's main information system, Carefirst was limited in the outcome performance data it could provide. The council had recently purchased the Covalent performance management system. The intention was to use the system to link performance with national and local objectives and outcomes, including outcome information for social work services.

Recommendation 1

Social Work and Health should move quickly to complete the action it has started to ensure it systematically defines and measures outcomes for all groups of service users and carers.

Views of people who use services and of carers

The findings from our survey of service users showed they were positive about their service outcomes. Most (84%) agreed social work services helped them feel safer and the majority (74%) agreed that social work services have helped them to feel part of the community. Both these findings were comparable with other authorities inspected to date.⁵ Almost all (90%) agreed that social work services helped them to lead more independent lives which was higher than the average in other inspections.

Carers who responded to our carers survey were much less positive about the service outcomes both for themselves and for the person they cared for. For example, whilst a majority (51%) agreed that social work services have resulted in an improved quality of life for the person they cared for, less than half (35%) agreed that these services have helped that person to feel a part of the community. These findings were comparable with other authorities inspected to date.

⁵ This report identifies when survey findings are significantly above or below the average findings in the other local authorities inspected to date. In many instances the findings in West Dunbartonshire were broadly comparable with the other inspections. To avoid constant repetition, the report sometimes but not always specifies this. As such if no comparison is given for an individual survey finding this means it was comparable with the findings for other authorities inspected.

Similarly, less than half agreed they felt valued and supported as a carer and that they are helped to have a say in how things are done (37% and 47% respectively). These findings were below the average from other inspections to date. It was possible that these findings may have been affected by the larger proportion of responses from carers of children with special needs. Based on our inspections to date, there are some shortcomings in services to these children, and their carers tend to respond more negatively than other carers.

We undertook a survey of partners and stakeholders and received 16 responses. Almost all of the respondents agreed that overall the social work service provided good outcomes for people who use services and for their carers.

File reading analysis

Overall, the findings of our analysis of case files in respect of outcomes were positive and were either higher than, or in line with the average to date. In particular:

- most (82%) files had a care plan and in almost all (93%) of these there was evidence that its objectives had been or were in the process of being met;
- in the majority (75%) the individual's circumstances had improved;
- in most (88%) changes in dependency were found to be in-keeping with the needs of the service users; and
- the proportion of files where there had been no improvement in the individual's circumstances was less likely to be attributable in some way to ineffective social work services.

Performance against national and local targets

Services for children and families

Children in need

The service told us it was committed to working to support children and families within their community. It worked with over half of its children and families on a voluntary basis. We comment later on the good quality services in place to support this.

Based on national estimates, there would be some 1,800 young carers in West Dunbartonshire. Line managers told us more needed to be done for young carers.

The Clydebank area was one of four national domestic abuse pathfinder pilot schemes. It aimed to achieve better outcomes for children affected by domestic abuse through earlier intervention and improved joint working by agencies. At the time of our inspection, the pilot had dealt with over 500 referrals. The large majority of these were diverted from being referred to the reporter. Instead the responsibility for responding to the victims and their children was shared across the partner agencies.

Children with disabilities

We saw little outcome-related performance information for children with disabilities.

In terms of respite, West Dunbartonshire Council:

- was ranked 12th out of 31 local authorities on the total overnight respite nights provided for children. The 2007-08 figure was 62.4 nights per 1,000 population; and
- was ranked 5th out of 31 local authorities on the total daytime respite hours provided for children. The 2007-08 figure was 1536 hours per 1,000 population.

We noted how funding from the Community Regeneration Fund was used to enable children with moderate to severe physical and learning disabilities to access a range of leisure and recreational activities, such as creative music and sailing. In 2007-08, 145 children were able to access these activities and the annual report suggested some good outcomes, especially around increased self-confidence.

Later on in the report, we talk about some of the actions taken by the social work department to improve services and outcomes for children with disabilities, such as expanding the children with disabilities team and the development of a locality autism assessment team.

Child protection

In 2008, there were 158 child protection referrals which was equal to 9.6 per 1,000 population and also well below the national average (13.5 per 1,000). Of these referrals, 82 were the subject of case conferences which at 5.0 per 1,000 population was broadly in line with the national average (4.7 per 1,000).

There were 53 child protection registrations in 2008 which, at 3.2 per 1,000 population, was again in line with the national average (3.1 per 1,000). In the same year there were 44 child protection de-registrations which was equal to 2.7 per 1,000 population and below the national average (3.5 per 1,000).

As of March 2008, West Dunbartonshire Council had 27 children on its child protection register which was equal to 1.6 per 1,000 population and was less than the national average of 2.7 per 1,000.

In 2007, HMIE (Her Majesty's Inspectorate of Education) completed a joint inspection of services to protect children in the West Dunbartonshire area. Most of its findings were positive, including those relating to outcomes, such as the response to immediate concerns and meeting children's needs.

The report did however identify the need for increased public awareness of the safety and protection of children as an area for improvement. Historically, the proportion of children in West Dunbartonshire on the child protection register, subject to child protection referrals and to child protection registrations were all below the national average. All of these areas saw an increase in 2008 which suggested that the action taken to increase public awareness in response to the inspection was having an impact.

Looked after children (at home and accommodated)

As at March 2008, West Dunbartonshire looked after 408 children. This was equal to 2.0% of the population aged 0-18 years and was above the national average of 1.3% of the 0-18 population. West Dunbartonshire's figures had been above the national average over the previous five years.

Of the children looked after in 2007-08, 87.5% were looked after at home and 12.5% were looked after away from home. This compared with 89% and 11% nationally.

Although the number of young people in residential schools had remained fairly static, the service had been able to reduce the number of young people in its own residential homes. This had fallen from 36 to 23 over the previous two years and had allowed the service to close one of the homes and to develop an alternative to care service instead.

Of the 107 children looked after away from home on 31 March 2008, 63% had been in placement for one year or more and 13% had three or more placements. For Scotland as a whole the figures were 71% and 31% respectively. Multiple moves within care are not good for children. As such West Dunbartonshire's performance in this regard was encouraging.

Its performance on educational attainment also had a number of strengths. For example in 2006-07:

- overall, 59% of all care leavers in West Dunbartonshire obtained at least one qualification at SCQF level 3 which was greater than Scotland's total of 52%. The figure for care leavers away from home was 70% and for care leavers at home was 50% (compared to 60% and 45% respectively nationally); and
- overall, 29% of all care leavers obtained qualifications in maths and English at SCQF level 3 or above which was less than Scotland's total of 34%. Whilst the figure for care leavers away from home at 48% was just above the national average (45%), the figure for care leavers at home at only 12% was below this (26%).

We held a focus group with young people involved with the throughcare service, a number of whom who were involved in further education. Residential child care staff also spoke about young people who had moved on to attend university.

Adoption and fostering

The Care Commission undertook inspections of the council's fostering and adoption services in October 2007. These inspections resulted in positive reports and found that no children were waiting for a foster placement at that time. However, we found that more recently the service had started to require to make some use of independent sector fostering agencies. With the Care Commission, we jointly held a focus group with foster carers which we refer to in the next chapter.

Throughcare and aftercare services

In 2007-08, there were 63 care leavers in West Dunbartonshire. All of them had a pathway plan and a pathway co-ordinator. Most (84%) were still in touch with the service which was just above the Scotland figure of 81%.

The service was comparatively well resourced for supported lodgings with a number of young people living in supported lodgings before moving on to tenancies of their own. The service had developed an accredited mentoring scheme which used trained volunteers to support young people leaving care. We saw that 15 young people had been supported since the start of the scheme. We also noted that West Dunbartonshire had been identified as a good practice example in 'Sweet 16', the report published in March 2008 by Scotland's Commissioner for Children about the experiences of care leavers.

In 2007-08, 33% of care leavers with known economic activity were in employment, education or training which was lower than the Scotland figure of 42%. The service told us that it usually has 12-16 young people in further education at any one time and that three young people had gone on to university at the time of our inspection.

Youth justice

The number of young people referred to the children's reporter on offence grounds had been consistently above the national average between 2003-04 and 2006-07. For example, whereas 4.2% of children aged 8-16 in West Dunbartonshire were referred in 2006-07, the national figure that year was 3.0%.

There were 42 young people defined as persistent young offenders in 2006-07, equal to 0.41% of the relevant population. This was higher than the overall Scotland figure of 0.26%.

The service had completed a best value review of youth justice to take account of national policy implications and range of different funding arrangements. We say more about this later.

Criminal justice

We found some limited information about outcomes for criminal justice service users. Practitioners were using the LSI-R (Level of Service Inventory – Revised) risk/needs framework as part of their initial assessment and in carrying out reviews. This data can be aggregated to provide evidence of changes in offenders behaviour and circumstances relating to likelihood of their re-offending. However, the service in common with the rest of the criminal justice partnership was not using the data in order to evaluate offender outcomes.

In 2007-08, the service performed above the national average in respect of the proportion of offenders placed on probation seen by the service within one week of their order being made (79.3% compared with 69.3%) and also on the average hours allocated to offenders per week for community service (4.0 compared with 3.3 hours). Performance was just below the national average in respect of the proportion of social enquiry reports delivered to the courts on time (95.5% compared with 97.3%).

Community care services

Older people's service

Overall, West Dunbartonshire performed very well in the balance of care it was achieving for older people between institutional care and care in the community.

In 2007-08, West Dunbartonshire supported 510 older people in care homes. This was equal to 34.9 per 1,000 older people and was less than the Scotland average of 37.2 per 1,000 population. With one relatively minor exception (2005-06), the proportion of older people supported by West Dunbartonshire in care homes had been below the national average for the previous five years.

There were however, some significant challenges in respect of care home provision for the shift in the balance of care to be maintained. These included there being very little spare capacity and the physical condition of the council's care homes. These were being addressed through a best value review.

In 2007, 295 older people attended day care services in West Dunbartonshire. This was equal to 20.2 older people per 1,000 population and greater than the national average of 14.1 per 1,000 population. The service had four day care services for older people with 127 places. This represented 8.7 places per 1,000 population, slightly above the overall Scotland figure of 8.1 places per 1,000 population.

The council's day care services and care homes for older people had all achieved Charter Mark accreditation in recognition of the care they provided.

In terms of respite for older people, West Dunbartonshire was ranked 17th out of 31 local authorities in 2007-08 on the total overnight respite hours provided. It was ranked 4th out of 30 local authorities on the total daytime respite hours provided.

Home care is one of the key services for older people. As of March 2007, the service was providing home care to 1650 older people. This was significantly above the national average (112.9 per 1,000 compared with 67.1 per 1,000 population respectively). Whilst the proportion of older people receiving home care in West Dunbartonshire had increased steadily over the previous five years (from 88.0 to 112.9 per 1,000), the rates for Scotland at a whole had remained consistently between 65-70 per 1,000 population during the same period.

The service also provided comparatively high levels of both intensive and lower level, preventative home care. More specifically in 2006-07:

- 27.4 per 1,000 older people were receiving intensive home care (10+ hours) compared to 17.3 per 1,000 nationally (ranked 3rd out of the 32 local authorities);
- intensive home care represented 43% as a percentage of long term care (ranked 3rd); and
- 85.6 per 1,000 older people were receiving less than 10 hours home care per week compared with 49.8 per 1,000 nationally (ranked 2nd).

We heard a number of positive comments from service users and carers about the home care service, but also some critical ones. These concerned a lack of flexibility in the service with for example 'tuck in' visits taking place earlier than service users would have wished. The service told us it was looking at some reduction in the amount of low level home care as a means of addressing this. It had also identified the need to review its home care service as part of its workforce development strategy.

We noted that in 2007-08, the service was ranked 22nd out of 31 local authorities on the number of older people home care clients receiving care in the evenings or overnight. It was ranked 26th on home care provided at weekends. The service told us it provided a high level of housing support which impacted on the percentage of overall older people home care service users who received personal care, a service in the evenings or weekends. We saw that taking this into account and based on Audit Scotland reported figures for 2008, West Dunbartonshire ranked 3rd for weekend service, 7th for evenings and weekends and 4th for personal care. We looked at the service's annual performance report for 2007-08 which indicated that the levels of home care provided both at evenings or overnight and at weekends had increased by between three and five percentage points.

In partnership with the senior's forum, the service provided a daily telephone service, 'Good morning West Dunbartonshire' to isolated older people. It was similar to warden call systems in sheltered housing complexes. We thought this was innovative.

Good practice example

'Good morning West Dunbartonshire' was a daily telephone call to older people who are socially isolated to check on their wellbeing.

Also in partnership, but this time with the Macmillan Carers Service and the NHS, the service was able to support cancer sufferers to continue to live at home. Over 70% of those people using the service had been able to die at home which was what they and their families wanted. There was also an important focus on income maximisation aimed at every person in West Dunbartonshire diagnosed with cancer. Over £1 million in benefits and grants was being generated for every 500 cancer patients.

Good practice example

The Macmillan Carers Service, developed in partnership with health and Macmillan Cancer Care provides flexible and responsive support to carers of people with cancer, and people living with cancer, at any stage on the cancer journey. It enabled cancer sufferers to remain living (and to die) at home and generated very significant financial benefits and grants.

We saw that there was a well developed community alarm service and that significant progress had been made in the use of telecare. Some 1,600 people were in receipt of a community alarm service and 400 of these also had the use of telecare. First line managers said these services, and care at home services in general, had played an important part in the reduction achieved in the number of older people moving from sheltered housing to care homes. The telecare service was subject to evaluation by the York Health Economics Consortium. This showed that good progress was being made in West Dunbartonshire in the development of telecare.

We saw little outcome information about older people with dementia. There was a programme of dementia mapping for older people in communal settings, such as day services and care homes. This is an observational tool which allows the quality of care to be examined from the perspective of the person with dementia. The service told us that this helped underpin staff's approach to providing person centred care. The dementia mapping tool is an elaborate and expensive one and it was unclear how the programme was going to be used to inform service planning.

The service was part of a Scottish Government study looking at older people's needs using IoRNs, but some managers told us this was not suitable for people with dementia.

West Dunbartonshire had 34 cases of delayed discharge in April 2007, 21 of which had been delayed for six weeks or more. The service said the number of delayed discharges had been at a similar level for a number of years prior to this. However, it had met the government target of zero delayed discharges over six weeks in April 2008. Furthermore, it told us during our fieldwork that it had been able to maintain this position since then. We thought that this was impressive.

Learning disability services

Most of the outcome data for adults with learning disabilities in West Dunbartonshire was above the national average. For example:

- 49% of adults with learning disabilities had a personal life plan (Scotland 32%);
- 15% used the services of a local area co-ordinator (Scotland 13%);
- 12% had community short breaks (Scotland 8%); and
- 35% lived their own tenancies (Scotland 33%).

Nationally reported data presented a mixed position in respect of day services and opportunities. The estimate of adults with learning disabilities attending a day centre was less than the national average (20% and 28% respectively). However, 33% of those people attending a day centre did so on a full time basis, compared with the overall Scotland figure of 28%. Of the adults with learning disabilities who attended a day centre, 20% also had alternative day opportunities (compared with 27% nationally).

The service told us the number of adults with learning disabilities attending a day centre had dropped from 200 to 85 over the previous five years, with only 28 attending on a full time basis. It also said that over 70 adults with learning disabilities who received a day service did so outwith a day centre.

The percentage of adults with learning disabilities who had employment opportunities was 13% which was around the national average of 16%. The percentage who were in further education, in contrast, was above the average (30% and 20% respectively).

The supported employment service aimed to support adults with learning disabilities (and people with mental ill health) to obtain and maintain paid employment. A proportion of the adults involved with the supported employment service were in full time paid employment. It worked closely with a range of partners, including the council's land services who had employed a number of adults with disabilities.

We met a number of service users involved with the supported employment service who were very positive about how this had increased their confidence about being employed and helped them into paid employment. Over the previous six years, 46 adults with learning disabilities had been supported into paid posts. A number had moved successfully from one paid post into another one. 'Better off in work calculations' were done to ensure potential income was maximised. On average those working 16 or more hours per week were £110 per week better off than before they started work in addition to receiving a £200 back to work payment.

Good practice example

West Dunbartonshire's supported employment service had been successful in supporting its service users into paid employment and increasing their income.

We saw that the service, in partnership with the NHS, was attentive to the health needs and outcomes for adults with learning disabilities. Detailed health checks were being delivered and dementia screening was available for adults with Down's syndrome.

Physical disability services

In 2007, there were 25 people with physical disabilities attending day care services in West Dunbartonshire. This was equal to 0.4 per 1,000 population aged 16-64 which was slightly lower than the Scotland figure of 0.5 per 1,000 population.

We held a focus group with adults with physical disabilities who attended the one day care service in West Dunbartonshire. This was run by the Mungo Foundation. They were generally very positive about the service and we say more about their experiences in the next chapter.

In 2007-08, West Dunbartonshire was ranked 2nd out of 30 local authorities on the total daytime respite hours provided for people aged 18-64 per 1,000 population. It was ranked 10th out of 31 local authorities for total overnight respite nights provided.

Adult protection

An adult protection implementation group had been in existence for some six months prior to our inspection. The first meeting of the Adult Protection Committee was scheduled to take place in December 2008.

At the time of our inspection, the service had 16 vulnerable adults cases, 13 of which had been subject to vulnerable adult's case conferences.

Adults with mental health problems

There was little outcome data for service users with mental health problems. We saw that as with the other community care client groups, LITs were in place, but these were very process based. The service told us it was reviewing the LITs to ensure that they had a more meaningful outcome focus. For example, they wanted to use the level of hospital admissions as a means of seeing if the joint mental health crisis service was impacting on outcomes.

West Dunbartonshire's self evaluation questionnaire (SEQ) said that the service supported over 200 adults with mental health problems and that mental health officers (MHOs) protect around 100 people each year. It commissioned Stepping Stones, a consumer-led organisation which provided support to a further 300 people.

The Acquired Brain Injury (ABI) Team supported over 500 people affected by ABI and their families. We held a focus group with a small number of service users of the ABI Team. This, combined with the relevant files we read as part of our file reading exercise suggested some good outcomes for people with head injuries.

Sensory impairment services

Along with the NHS, the service had agreed a sensory impairment strategy for 2007-10. Whilst this included some prevalence information, it did not contain outcome data.

The LITs identified that in 2007-08, 310 people received an outreach service, 28 people received a service from the rehabilitation team and 73 people received a specialist assessment.

Substance misuse services

Substance misuse services were provided jointly by the service in partnership with health. We saw there had been an emphasis on increasing the number of people using the services and reducing waiting times for accessing them. We saw improved performance in these areas from the annual performance report for 2007-08 compared to the previous year.

The service was also a partner in the multi-agency SNIP service (Special Needs in Pregnancy service). There were specialist addictions posts in the two children and families teams. The service had also recently established a young people's addiction service which had recently set outcome objectives, primarily around harm reduction. We talk about these services in more detail later.

In order to improve its focus on outcomes the service had established a service user group, FAST (Future of Addiction Services Team). It had also implemented the CHRISTO monitoring tool as a means of measuring the progress of individual service users in tackling their substance misuse.

CHAPTER 4

Impact on people who use services and other stakeholders

This chapter looks at three areas for evaluation:

- **impact on people who use services;**
- **impact on staff; and**
- **impact on the community.**

Impact on adults, carers, children and families who use services

Performance in this area was good, having important strengths with some areas for improvement.

People who used services were mainly very positive about their experience. This included young people involved with the throughcare and aftercare service and older people in the service's residential and daycare services. Carers views were more mixed, especially parents of children with disabilities and young carers. The council's partnership venture with Carers of West Dunbartonshire was resulting in the increased identification of and support to carers.

There was some good practice in involving user groups in developing and improving their services. This included people with acquired brain injury and people using substance misuse services. Other user groups were involved only through surveys and representation on planning groups. More needed to be done to extend personalisation across services.

Views of people who use services about their experience

The views of people who received services from Social Work and Health were very largely positive. Staff also reported positive informal feedback from most people they worked with.

Most (86%) of the users of services in our questionnaire agreed they could rely on the services they received and that they had received the help they needed when they needed it. Most (88%) also agreed they were treated with respect and dignity. These findings were comparable with inspections to date. The majority (68%) of carers thought the person they cared for was treated with dignity and respect which was below the average for previous inspections.

During our fieldwork, 16 observed practice sessions were held. Most of the service users and carers we spoke to during these sessions were very positive about the impact that the social work service had had on their lives.

People we met in self help or other groups run or supported by the service were generally very positive about their experience of these groups. They included a number of offenders, people with addiction problems, people with physical disabilities, parents on a parenting course, and children and young people. For example, children in the group work programme told us how it helped them to cope better with their lives at home, at school and in the community. Parents said the eight week parenting programme helped them to deal more positively with the difficulties between them and their teenage children at home.

Service users we met in the council's care services and establishments were also very positive about most of these services. This included the care homes and day care services for older people, and the children's units and foster carers for children and young people. This feedback was consistent with the Charter Mark status acquired by many of these services and with Care Commission reports. For example, we visited Boquhanran care home for older people where a residents survey had recently been completed. This found that 90% of the residents were happy with the care provided.

We held a focus group of young people aged 16-21 who had been looked after and accommodated. Although they had mixed views about their experiences when accommodated, they were largely very positive about the throughcare and aftercare service. They were all settled in accommodation and most were in some form of further education, training or employment.

We heard positive feedback from offenders involved with the Constructs PSSO group work programme.⁶ One, for example, said that it was 'helping him to get himself together'. The criminal justice partnership had established procedures for obtaining feedback from offenders about how useful they found the service in helping them stop offending. The most recent partnership sample included positive comments from offenders who had completed community service orders in West Dunbartonshire. However, there were no comments from offenders who had completed probation or throughcare licences. The partnership was considering ways of improving these procedures to obtain a better picture of service user views.

People with physical disabilities supported by the Mungo Foundation's West End Project were very positive about the support they received in terms of the services provided and about the staff. They said that if it was not for the project they would have had little interaction with the outside world. However, a number said it had been some time since there had been an assessment or review of their needs.

Service users we met who were involved with substance misuse services spoke positively about the help they had received to support them in addressing their substance misuse issues. However, those with children who also had involvement with the service around child care issues were much less positive about that involvement.

⁶ Constructs PSSO – positive steps to stop offending – a nationally accredited group work programme for offenders assessed as at medium to high risk of re-offending

We saw that some exercises had been done to obtain feedback from users of the welfare rights service and were impressed that over £6.5 million had been generated for them in the previous year. Questionnaires had been sent to 180 users of an attendance allowance project operating out of a number of GP practices and supported by the welfare rights service. This found a high rate of satisfaction. So did a survey of 50 users of the Macmillan benefits project where three quarters of respondents said their weekly income had increased as a result of their involvement with the project. One said:

“I didn’t think I would get any help because my wife was working. So when a letter came telling me how much I would get, I can’t tell you how much pressure that takes off you on a financial level.”

Views of carers about their experiences

The views of carers, reported by carers themselves, the people they cared for and staff, were mixed. In terms of the impact of the service on carers themselves, 49% said that the help they received met few or none of their needs. The majority (58%) agreed social work services were reliable and that the help received was given at the time it was most needed. Both these findings were comparable with previous inspections to date. In both the questionnaire and during our fieldwork, some carers expressed the view that help was on a ‘take it or leave it’ basis.

There was some positive feedback in the survey and during fieldwork, especially about the carers centres and their impact on the lives of carers. One said that as a result of contact with the centre ‘my own physical and mental health which had been deteriorating has improved’.

There were two carers centres which since 2007 had been run by Carers of West Dunbartonshire. This operated as a partnership venture with the council and the Princess Royal Trust for Carers. At the time of our inspection over 200 carers were being supported by the carers centres. Amongst other things, it had developed and provided a complementary therapy programme for carers. This was in recognition of the negative impact that caring responsibilities can have on a carer’s health.

The children with disabilities team had worked in partnership with the council’s leisure services and the voluntary sector to develop a range of opportunities for children with disabilities. This included summer activity schemes, sailing and dance. Evaluations of these services completed by parents of children with disabilities had been very positive. It was clear from this and other developments, such as a sibling support programme that the service was committed to the development of services to support children with disabilities and their families.

However, despite this, the parents and carers of children with disabilities we met in a focus group were very critical of Social Work and Health. They described their experience of asking for services as not being needs led and of having to fight constantly for resources. In an effort to facilitate a dialogue, the service was providing community work support to some local groups of parents and carers.

We held a focus group with a small number of young carers. They said their caring role had adversely affected their school and social life and that they had little opportunity to talk to anyone about this.

The foster carers we met at a large focus group were very positive about their link workers. This confirmed previous Care Commission inspection findings. In contrast they felt strongly that their opinions about their foster children were not valued by the children's social workers or by the chairs of reviews. They thought there was a tendency for area team staff to see them as 'glorified babysitters'.

Views on finding out about, obtaining and using services

In our service users survey, the majority (74%) of respondents agreed they found it easy to get clear information about the range of services that might help them. This was higher than the average in other inspections to date. Most (82%) reported that they had a good response when they were first in touch with social work services. Carers were less positive with less than half (39%) and a majority (66%) respectively agreeing with these statements. These findings were broadly comparable with other inspections to date.

The response from the service during the day was rated better than the response received out-of-hours for both users of services and carers. Carers were particularly negative about the out-of-hours service with only a quarter (25%) agreeing they got a good response during evenings and weekends.

Informing and involving people who use services and their carers

In our survey, service users were generally positive about how included they felt they had been in their assessment and care plans. More specifically:

- most (77%) agreed they had seen their written needs assessment;
- most (82%) agreed they had been fully involved in deciding what services they should receive; and
- the majority (74%) agreed they had been given choices about the type of service they receive.

The second of these findings was comparable with previous inspections. The other two findings were above the average.

Again responses in our carers survey were less positive. Whilst the majority (70%) agreed they had been fully involved in deciding what assistance the person they cared for should receive, less than half (42%) felt consulted and listened to. Similarly, only 47% agreed they had a say in how things were done. The last two findings were below the average from previous inspections. The parents of children with disabilities were very critical of consultation in our focus group.

The majority (67%) of partners and stakeholders we surveyed agreed the service paid a lot of attention to the views of service users and carers about how they would like their needs to be met.

Our file reading exercise suggested that services shared key information. In almost all (90%) of the files there was evidence that the services shared key information with the individual or with an appropriate representative. Similarly, in 93% of the files there was evidence that the views of the individuals were taken into account at each key stage. These findings were comparable with previous inspections to date.

A newsletter and quarterly reports were used to try and keep people with learning disabilities informed, a group of who were actively involved in commenting on the Partnership in Practice (PIP) agreement. We saw this was published in a user friendly version. A group of people with learning disabilities were involved in training staff. We concluded that good efforts were being made to inform and involve people with learning disabilities.

People with an acquired brain injury were involved in improving services through the Brain Injury Experience Network as were people with mental health problems. A senior MHO had been allocated responsibility for consulting with service users.

Good practice example

The Brain Injury Experience Network (BIEN) provided mutual support and social events. With staff, service users had published (2008) a pack called 'The Journey' which was a collection of stories and experiences. It included a section on help for the journey.

In 2005, mental health services and the Lomond and Argyll Advocacy Project supported the Mental Health Forum to undertake a small narrative research project: 'What's the Story?' for which volunteers who had themselves experienced mental health services, interviewed 21 people who use or have used mental health services. Most spoke well of the help they had received. They made suggestions about improvements needed.

In substance misuse services, FAST had grown out of service user involvement meetings. Members helped to produce a newsletter with information about services. They also hosted a national service user conference which we attended. We were impressed by the level of service user involvement evident at the conference.

Communication with and involvement of other service user groups was more mixed. Service users groups had members involved in the existing consultation and planning processes. There was a regular newsletter for recipients of home care. Surveys, whether internal or commissioned, are an integral part of service development. We saw that reports of their findings had been done across most service areas and pilot projects.

Older people generally fed into the consultation and planning process through the elderly forums. Evaluation surveys had been completed on home care and other care at home services. We saw that older people, including people with dementia had the opportunity to contribute to these surveys. However, in other regards consultation with older people was largely done through elderly forums, rather than directly with older people who were themselves social work service users. We thought the service needed to take action to address this.

Carers were involved through the carers centres and around specific users/services such as day centres and residential homes. Enhanced support for carers of older people was specifically mentioned in the best value committee report on services for older people. Carers were involved in the ongoing review of the carers strategy.

The HMIE child protection report had evaluated involving children and families in key processes as weak. In particular, it concluded that staff were not consistent in obtaining or recording children's views and that there was no agreed or systematic approach to guide staff in this work. We found that attention had been given to this. Inter-agency guidance was complete and leaflets were in production. Viewpoint technology had been introduced in order to help systematically gather the views of children and families. As far as young people generally were concerned, the council used Dialogue Youth and Y Sort It – the local information service for young people.

Personalisation of services and direct payments

Personalisation aims to give people with social care needs choice and control over the shape of the support they receive.

Apart from learning disability services we heard and read little about personalisation. In its SEQ, the service told us it had a self-directed care strategy group. There was a direct payments policy, dated January 2004 which was in the process of being reviewed at the time of our inspection to take account of the national guidance in relation to 'In Control'. Managers told us that there had been some delay in this due to staff absence.

Evidence gathered during the inspection indicated that although the service had started to move in the right direction around personalisation, it still had along way to go.

Staff had managed to increase funding from the Independent Living Fund (ILF). In September 2008, there were 117 users of ILF in West Dunbartonshire. This was equal to 14.1 per 10,000 population and was almost double the Scotland figure of 7.4 per 10,000 population.

The service's assessment procedures said that everyone should be advised of the availability of direct payments as part of the assessment process. An information worker was attached to the direct payments scheme.

We saw that the number of people in receipt of direct payments in West Dunbartonshire had increased from 31 in 2007 to 41 in 2008. However, at 4.5 per 10,000 population this was still below the Scottish average of 5.1 per 10,000 population. The estimated average value of the direct payments for 2008 at £10,200 was also below the Scottish average of £10,800.

When we met with the local advocacy services they commented that community care staff had recently started to become more knowledgeable about, and pro-active in promoting self-directed care, including direct payments. However, in focus groups with service users, carers, providers and staff we heard a different view. There appeared to be little obvious enthusiasm for direct payments. Some users and carers said that direct payments were discouraged or had not been actively promoted. Staff said there had been 'no rush of people asking for direct payments in West Dunbartonshire'.

Compared with the national average, relatively high numbers of adults with learning disabilities had personal life plans and we saw some good examples of personalised care plans. However, the frustrations expressed by service users about not being able to do some of the things they wanted and a continued reliance on council buses, were examples of how personalisation required further development. The comments we heard around lack of flexibility in aspects of home care provision were a further example.

Recommendation 2

Social Work and Health should complete its strategy for self-directed care as a matter of priority and extend personalisation across its services.

Impact on staff

We rated the performance of Social Work and Health in this area to be good, having important strengths with some areas for improvement.

We found from our survey and our fieldwork that most staff were committed and enjoyed their work. Morale was not good, but many staff identified that this was in large part due to the problems over single status. Staff generally felt valued by management. Senior managers recognised the need to continue to work to improve communication with staff.

Staff were less sure about being valued by the council, and in particular by elected members.

Staff were largely very positive about the training and supervision they received and their relationships with partner agency staff.

Most staff were aware of social work policies, and what standards their team was expected to meet. Almost all were aware of the code of practice for social work and two thirds thought that their employers were fulfilling their responsibilities under the code.

Motivation and satisfaction

We met many enthusiastic, professional and committed staff in our inspection. An important finding from our inspection, especially the fieldwork was the extent to which staff had a different and a much more positive view about their jobs, and being part of the social work service, than they did about being employed by the council. The protracted arrangements around single status and the number of changes made to these had clearly had a major impact on staff morale. Staff were also weary of some of the political difficulties and instability within the council which had attracted adverse media publicity. We were impressed by the extent to which the staff were able to separate out their views about the service from their views on single status and the council's political history.

Most staff who responded to our survey believed they were making a real difference to the lives of people they were helping. Almost all (95%) thought the services their team provided helped people lead as independent a life as possible, and a similar percentage thought their team did everything possible to keep people safe.

Most staff (86%) also agreed that they enjoyed their work. However, the majority (56%) disagreed that staff morale had been good in their team for at least the last six months, with only 29% agreeing that morale had been good. These figures were below the average in the authorities inspected to date. These findings were reflected in the social work staff survey of 2008, in which 29% thought that morale was good, while 61% thought it was poor. Focus groups run by the council suggested that issues such as job evaluation had played a part in this. In our own survey, the effects of the continuing problems over single status were consistently highlighted as having a major contribution to low staff morale. For example, one staff member in talking about single status commented that:

“It has been frustrating and divisive, the recent decision by the local councillors has added to already low morale for these workers losing out because of this implementation and constant change of agreed policy.”

Many staff in our survey and in our focus groups commented that they were happy in West Dunbartonshire because of the close working relationships and the opportunities for career development. However, some were of the view that neighbouring authorities had better pay and conditions which could mean colleagues leaving the authority when single status was concluded.

In our focus groups, most staff indicated they felt valued by social work management. In contrast some comments in the staff survey identified communication between senior management and front line staff as a problem. Most staff we met said they did not feel valued by the council and in our survey only 36% of respondents agreed that social work was highly valued by elected members (comparable with other inspections to date). The service’s own survey found that staff were generally positive in their views about working for Social Work and Health (and more specifically their team) and more so than in respect of working for the council.

Again in focus groups, staff expressed a high degree of motivation and satisfaction with their job. Amongst others, this included a range of fieldwork and administrative staff, residential and day care staff, and budget holders. More specifically:

- administrative staff said their morale was good, their role was respected and they were included in development days;
- welfare rights staff said their service was innovative and they liked the way it targeted areas of special need; and
- children and families practitioners said their staff group had ‘stabilised’ and they felt well supported by all their managers.

Working for each other in a small authority was cited as an important aspect of this satisfaction. Some said it meant communication was easier, as was access to senior management. The flatter organisational structure was also identified as being helpful in promoting better communication in the service. In contrast, one group of staff identified delays in filling first line management vacancies as having a negative impact on morale.

In our survey, less than half (48%) of those who responded felt valued by their managers in carrying out their day-to-day job, below the average of authorities inspected to date. Forty-eight percent agreed that senior managers communicated well with staff, and 35% agreed there was effective leadership of change in social work services, both comparable with other authorities inspected to date.

Fifty-six percent of staff in our survey agreed that West Dunbartonshire offered flexible working practices, and this positive view was confirmed in our focus groups. The majority (70%) of staff in our survey agreed their workload was manageable within normal working hours. Both of these findings were comparable to those found in other authorities. In focus groups, staff were positive about flexible working practices and workloads. We heard a number of examples from staff of how they had been helped and supported by 'family friendly' policies and approaches. Criminal justice practitioners were the exception. They said their workloads were too high, were increasing and impacted on their morale. First line managers said there was a missing tier in the management structure and too much was expected of them as a consequence.

Most of the respondents to our survey agreed that they had received adequate training to fulfil the responsibilities of their job, which was comparable to other authorities inspected. Staff in focus groups were very positive about both training opportunities to help them fulfil their responsibilities and opportunities for training and career development. Front line home care staff were the exception saying they had few career progression possibilities. The council's own staff survey had found increased staff satisfaction around training and career development.

The majority of the staff we met in focus groups agreed they knew about the new supervision policy and that they received regular supervision. In our survey, the majority (65%) of staff agreed that they received an adequate level of supervision. This level of agreement was comparable with other authorities inspected to date. Forty-four percent of staff in our survey agreed that the annual appraisal system helped them to do their job, comparable with other authorities inspected to date.

While staff were positive about the teams they worked in, they were less so about the regularity of team meetings and how purposeful and effective these were. In both of these areas the responses were below the average to date. However, 64% agreed that their team had a plan providing them with clear directions in carrying out their day-to-day jobs, while 89% agreed that their team responded effectively in crisis situations, both comparable with the authorities inspected to date.

Staff ownership of vision, policy and strategy

In our staff survey, 70% of respondents agreed that West Dunbartonshire had a clear set of social work policies which was at the upper end of the levels of agreement of authorities inspected to date. In our focus groups, intermediate managers were very clear about the wider vision and values for their respective services, and said they understood where the department was going. Front line staff interviewed were less clear, but many indicated that they knew about the department's service plan and the plan for their own service. In its SEQ, the service stated it was in the process of ensuring staff were briefed on the new Service Plan, the vision, and what it meant to staff.

In our survey, 48% of respondents agreed that there was a clear vision for social work (comparable with findings from previous inspections), while 15% disagreed. In contrast, the department's own survey found that 82% were aware of the department's aims and objectives, and 74% that they knew how to contribute to them. A new poster had recently been sent out to all offices with the department's vision and values. We saw it in the offices and establishments we visited.

Ninety-one percent of staff in the local survey knew the standards of performance they were expected to achieve, and in the SWIA staff survey, 88% of staff agreed they were aware of the standards their team were expected to follow, and 68% that their team performed well against local service targets. Both figures were comparable with other authorities inspected to date.

Ninety-eight percent of the staff who responded to the council's survey in 2008 agreed that they understood the needs and priorities of their clients.

Ninety percent of respondents to our survey agreed that they were aware of their responsibilities set out in the Code of Practice for Social Service Workers, and 67% agreed that their employer was fulfilling their responsibilities under the Code of Practice for Employers of Social Services. These results were comparable with other authorities inspected to date.

The SEQ recognised that it was important for the senior management of the department to demonstrate that they really valued staff, put over clear information about challenges faced, and about the vision for the future of the department. Given that posts were frozen and the impact of single status, we thought it was important that senior management gave continued priority to improved communication with staff.

Impact on the community

We evaluated performance in this area as good, having important strengths with some areas for improvement.

We found Social Work and Health and the council more widely to be actively involved in efforts to inform, consult and engage the community.

The service made efforts to inform the community about social work services with the welfare rights service being a good example of this. There were high levels of community involvement in social work activities and the community work team fulfilled a positive community development role. The council and the service had faced challenges in balancing and meeting the needs of its various communities.

Community perception, understanding and involvement

In terms of recognising the needs of different communities, West Dunbartonshire comprised of three rather separate communities; Clydebank, Dumbarton and the Vale of Leven. The Community Planning Partnership was in the process of setting up three community forums in order to consult with these areas on council services.

Service users, staff and stakeholder organisations we met often referred to the Clydebank and the Dumbarton (including the Vale) ends of the authority. They said each area has its own identity which needed to be taken into account in allocating resources. We heard that it had been a challenge for the council to balance allocating resources on a needs led basis with giving each of the areas equal opportunities. We also heard that the move from two to a single health board area for the council had been of some assistance in this regard.

The population of West Dunbartonshire included a relatively small number of people from minority ethnic backgrounds. The service told us that it used the council's social and economic profiling data and information produced by health to inform future service planning. The council had an equality and diversity strategy and a Gypsy/Traveller Strategy. Staff from the service supported the Asian Women's Group and chaired the Gypsy Travellers Forum.

Considerable efforts were made by the service and by the council as a whole to inform the public about the range of social work services. This included a bi-monthly newspaper delivered to every home. Every year the council issued an A-Z guide to council services which covered all social work services. The council web site provided area office contacts, links to key services such as addiction, domestic violence and single shared assessment as well as access to more substantial reports and guidance. The council hosted a 'community week' at which Social Work and Health had stalls to present its services and its work.

Chapter 4: Impact on people who use services and other stakeholders

We were impressed by the way the welfare rights service had made itself known in the community, for example by the use of bus advertising for its helpline. We say more about this in the next chapter.

We met many service users and carers during the inspection who were in receipt of services from voluntary organisations funded by the council. We were surprised at their lack of awareness of the funding provided by the council. Many of these services were much appreciated, and it was unfortunate that there was not greater recognition that without the funding by the council, they might not have been provided.

The department as a whole was developing a public information strategy and there was some evidence of wider public recognition of the value of some social work services. For example, we found that the community service team was very well regarded by the agencies and services who benefited from its work. This had attracted some positive media coverage.

There were mixed views amongst staff and elected members about the media more generally with some saying it was often hostile to the social work services. Others pointed to a more positive stance recently, especially towards services such as home care which generally have public support.

We also heard mixed views from staff on the extent to which elected members promoted social work services. A number felt they were not interested, but some said they thought well of social work services and promoted them. Others commented that they were diligent about attending openings, awards ceremonies and other public occasions. The elected members we met spoke positively about social work services.

Impact on other stakeholders

Efforts were made to ensure that other stakeholders were aware of the range of social work services available. The CHP, for example, received relevant committee reports and there were strong strategic and operational links with education and housing. The majority of partners and stakeholders who responded to our questionnaire considered that there was good quality information available about services, although not all of them agreed it was in the right places.

The survey and our fieldwork also identified a number of positives in how the service engaged with local organisations and providers. A number said the service made its training available wherever possible. Its commissioning arrangement with the Lomond and Argyll Advocacy Service had allowed the service to train some 150 local volunteers to provide advocacy alongside its salaried staff. There were a number of positive comments in the survey which included reference to the service's 'responsive and inclusive approach'.

Community capacity

There were high levels of involvement of the community in social work activities. The service had a strategy for volunteers. They played an important role with a number of service user groups and service users. This included acting as mentors for young people leaving care, befrienders of children and in voluntary groups which worked with the department such as the befriending service for older people at Ben View care home. We heard that recruitment of panel members for the Children's Panel and of volunteers for the advocacy service was relatively easy. Similarly, although West Dunbartonshire, as everywhere, faced significant challenges in recruiting foster carers, it had been more successful in this regard than many areas.

The community work team focused on community care activity. Groups of people had been identified who would either benefit from or requested community work support. People with acquired brain injury were an example of this. Meetings were called, groups established and then members supported to become involved in departmental consultations and planning processes. This process and community work involvement with carers was instrumental in the setting up of the carers centres and also in the active carer involvement in the bathing service. There were structures for involvement at the specific user group/carer level and at the more strategic level; the latter including a community care forum and a carers forum feeding into the PIP (Planning and Implementation Partnership).

Good practice example

The community work team worked with service users and with service users groups to help develop services to meet the needs of community care service users and carers. This was an example of good community development practice.

We held a number of meetings and focus groups at Bruce Street resource centre, a former adult training centre. As well as a location for employment initiatives and for use by specific user groups, considerable efforts had been made to make it accessible to the local community. This seemed a good, non-stigmatising way to involve a local community. The extent of its presence in the premises, including its café, indicated that these efforts had been successful.

We were impressed by the community capacity and commitment within West Dunbartonshire and the efforts made by the service to make best use of this.

CHAPTER 5

Delivery of key processes

Social Work and Health performed to an adequate standard, with strengths just outweighing weaknesses.

Multi-agency working was an area of real strength for this authority where there were many good initiatives in place. The service had also taken steps through its community work team to provide support to many hard-to-reach groups. The service's welfare rights team ensured that access to the advice it offered was widely available and well advertised.

The service worked hard to provide assessments of need within timescales and there were very few service users who needed to have an allocated social worker or case manager who did not have one. However, assessment of potential risks in community care and criminal justice cases needed to be improved.

Although we found examples of good care planning and management, there were important aspects of this that needed to be improved. This included improving the way the service reviewed the needs of looked after children, older people in residential care and people with learning disabilities. There were also significant delays for people who were serving community service orders to begin their work placements.

Access to services

Comprehensive information

The service had a range of up-to-date information leaflets and posters about the services it provided and had displayed these prominently in reception areas. Information about some services, including eligibility criteria for community care assessments, was also accessible via the council's website.

The service had adopted some interesting and innovative approaches to providing information. These included:

- care group-specific newsletters, for example for people using addiction or learning disability services, for people living in older people's homes and for those receiving a home care service; and
- welcome packs in children's residential units that gave children and their parents important information about the home, its surroundings and local services and activities.

Good practice example

The welfare rights team issued a calendar (entitled 'It's yours claim it') to every person of pensionable age. Each page of this calendar offered advice on a different benefit each month, provided useful phone numbers and promoted the welfare rights freephone service. In addition to providing an advice service in social work offices the team also provided welfare rights advice in health centres and in some GP surgeries. Its helpline was advertised on local buses.

The service had also developed a potentially useful directory of services for children with disabilities (available in hard copy and online) compiled in partnership with children and their families. Some parents considered the glossary unhelpful, commenting that it highlighted services that they were unable to access. Others were more positive, describing it as a 'well-thumbed' source of information.

Some service users and carers we met said that they were not fully aware of the services the department provided or purchased. The service had received similar feedback from the citizen's panel survey and had since drafted a public information strategy to improve the way it communicated about its services. This draft set out some key principles and objectives but did not yet have an action plan spelling out how it would achieve these. The service had recently completed a comprehensive directory of services.

Referral and out-of-hours arrangements

The service operated a generic duty system to screen new referrals. Operating from each of the service's three main offices, the system was staffed on a rota basis by social workers and senior social workers from all childcare and some community care teams. Information about the location and opening hours of these duty points was set out in information leaflets and posters and on the council website.

Overall, the system appeared to operate efficiently. It offered the option of both appointments and a walk-in service to ensure that all those that needed to speak to a duty worker could do so. A childcare and community care social worker were on duty each day and were able to confer with each other for advice in addition to accessing advice from a duty senior social worker. To ensure that duty workers recorded the right kind of information about initial referrals the service had developed recording guidelines. These emphasised the need for duty workers to make a clear assessment about the referral.

On a daily basis, the duty senior social worker reviewed all referrals that could not be dealt with by duty staff within a day, moving these on to the relevant care team for allocation. Exceptions were child protection referrals that resulted in case conferences. These remained with duty workers who had carried out the investigation until the conference had taken place (normally within a week).

Staff in some specialist community care teams such as the learning disability, sensory impairment, and community mental health teams operated their own duty services for people who were already known to them (the mental health duty service was open to people not known to team, but who required an urgent assessment). They did not participate in the generic duty rota. Although this may have been the best use of such resources, the situation appeared to have developed largely by default as teams moved out of the main offices or as key personnel moved on to other posts. We thought that the service should make the arrangements clearer.

There were additional measures in place to make sure that the duty system operated efficiently. These included provision by the welfare rights team of a parallel duty system to deal with enquiries regarding benefit entitlement, and direct access by health staff to some social work services. The implementation of single shared assessments meant that health staff did not need to route requests for home support or occupational therapy services through the duty system.

Staff that we met were confident that the various arrangements in place to deal with referrals offered the public a good, accessible duty service. They were concerned about proposals to provide a social work duty service through the council's contact centre that dealt with enquiries about all council services. They were not convinced that contact centre staff would have sufficient skills to deal with the sensitive and complex issues social work services had to deal with. The council will need to make sure that any model it adopts can properly meet the needs of vulnerable people.

Out-of-hours services were provided by the West of Scotland Standby service through a service level agreement. Stakeholders we met raised concerns similar to those we have highlighted in previous inspection reports, most notably difficulty in contacting the service. The council provided its own out-of-hours arrangements for home care services. This helped ensure a speedy response out-of-hours to support hospital discharges and prevent admissions, but depended in part on the good will of the home care managers involved. The service told us it was in the process of strengthening the management arrangements to support this.

Access to offices and units

Offices providing a generic duty service were in modern purpose-built buildings which were centrally located and had disability access. Most other offices that we visited were also of reasonable quality. An exception was the premises of the centralised criminal justice team. This building was rambling, not in good condition and there was a lack of suitable interviewing space. Staff commented that they felt vulnerable using certain parts of the building, particularly when working outside office hours.

Day to day planning and resource allocation

Prioritisation and allocation

Community care services

There were clear eligibility criteria in place in community care services for allocating referrals for assessment. First line managers we met told us that they used these to review referrals on a daily basis. At the point of our inspection there were few unallocated referrals for a community care assessment and few cases which needed an allocated case manager that did not have one. There was no waiting list for a home care service.

Staff in joint or co-located teams – the mental health, learning disability and addiction teams – also described routine processes for reviewing and prioritising work. These teams also had no waiting lists for assessments or services.

There were waiting lists for some resources provided or purchased by the authority including certain care homes, short breaks for carers, rehabilitation services for blind people, and occupational therapy services. The service had done well in managing to achieve a marked reduction in its waiting lists for aids and equipment. The maximum waiting time for these resources was 12 weeks. Some equipment such as internal banisters and external stair rails were available on the basis of self-assessment.

The service had recognised it needed to be better at keeping people informed if, following assessment, they were then placed on a waiting list for the service they needed.

Childcare services

Although draft criteria for children's services were still out for consultation, first line managers in these services said that they already shared a common understanding about priorities for allocation. They reviewed referral lists on a daily basis and met on a fortnightly basis to discuss all those that remained unallocated. The area manager for children's services received a weekly report on the number of these cases. At the point of inspection there were no unallocated statutory childcare cases and only a small number of other cases awaiting allocation.

Criminal justice services

National Standards for criminal justice social work services require work placements to start within 21 days of a court making a community service order. West Dunbartonshire was not meeting this standard with some offenders waiting up to 10 weeks before beginning their work placements. Managers said this was due to a shortage of suitable placements in work teams and because the action they had taken to increase the staffing establishment had been offset by long term sickness. However, delays in implementing court orders undermine the intention of sentencers and are therefore a serious matter.

Recommendation 3

The service should take steps to make sure that those offenders placed on community service orders begin work placements within the timescales set out in National Standards.

Effective day-to-day planning and use of resources

Although systems in place for allocating referrals for fuller assessment or care management were largely straightforward, arrangements for accessing resources to establish packages of care were less so. For example, at the time of our inspection, staff were required to take all requests for care home places for older people to a weekly resource group (the ARG) for consideration. When considering these requests the ARG also considered whether the older person's needs could be met by an intensive care at home service as an alternative.

However, staff were not required to get ARG authorisation when they sought complex or expensive packages of care in the community. The decision to do so was optional. This did not seem to us to be a consistent approach to managing limited resources. The head of service with responsibility for care home placements for older people said that consideration was being given to disbanding the ARG. This was because the process involved could build in delays to older people being discharged from hospital.

In the previous chapter we highlighted concerns expressed by some parents about the effectiveness of the group which considered requests for packages of care for children with disabilities. Staff and stakeholders were more positive about the operation of this group.

A multi-agency transitions group considered the resource needs of young people with disabilities making the transition from children to adults services. Staff and stakeholders we met said that this group helped ensure transition arrangements worked well for some young people.

However, they also said these arrangements did not work as well for young people with autism because the specialist learning disabilities teams were resistant to accepting them and there could be a delay in them being allocated a community care worker as an alternative.

The service told us that anyone on the autistic spectrum with a defined learning disability would receive a service. However, the learning disability service did not provide specialist services to adults with autism. Managers said that they would do so in future, following the development of eligibility criteria for learning disability services. There were no timescales for developing and implementing these criteria.

We found that there was no coherent pathway for accessing 'specialist' resources for children in need or at risk of offending or re-offending. Social workers looking for a service from the group work and family support teams, the alternative to care team, the youth justice team or from the purchased service Includem, effectively 'window-shopped' among these resources. Following a best value review the previous year, managers had developed proposals to rationalise the situation. Senior managers had not yet reached a decision on whether to implement these.

Recommendation 4

Social Work and Health should review its mechanisms for approving the more expensive packages of care to ensure decisions are made within appropriate timescales and that there is an effective and consistent approach to resource management.

We found other resources that were not well used. There was low take-up by courts of the DTTO (Drug Testing and Treatment Orders) service, managed by the criminal justice social work service. Numbers were well below the target rate and we concluded that the service could and should do more to highlight the potential benefits of this disposal.

Workload management

There was no formal workload management framework in place. The service depended on first line managers to ensure through individual supervision that staff had reasonable workloads. The majority (71%) of staff who responded to our survey agreed that their workload was manageable within normal working hours. Just under a quarter disagreed. These results were comparable to other authorities inspected to date.

There had been no systematic look at the workload of staff across the teams to ensure that staffing levels in each team were fair and equitable. However, this was now part of the remit of the workforce planning group.

Assessment and case management

Assessment of need

Overall, West Dunbartonshire's results from our file reading exercise for the delivery of key processes, such as assessment and care management were in line with or higher than the average in inspections to date.

We found assessments in most files that we read, most (77%) of which had been completed within the preceding 12 months. Three-quarters of these assessments were good, very good or excellent. One in five were adequate and a small number (2%) were weak. These findings were comparable with other authorities inspected to date.

Community care services

Over two-thirds of the community care assessments we read were of a good or very good quality. Around a quarter were adequate and a few (6%) were weak or unsatisfactory. Stakeholders we met broadly reflected this picture, describing the quality of assessments as variable.

Use of the single shared assessment for most community care groups was well embedded with standard assessments supported, where required, by additional addictions, mental health or occupational therapy assessments.

The Carefirst system was accessible to appropriate health staff and to some voluntary sector providers, including its principal addictions provider. Despite this, there were still difficulties around health staff inputting their assessments directly into a common electronic form. To address this arrangements were in place for health staff to dictate assessments by phone to social work administrative staff who entered them on to electronic forms on their behalf.

In order to encourage greater involvement of health colleagues in completing assessments, mental health services had developed a version of the single shared assessment for use when it appeared that only a single service or intervention would be needed. Staff said that this had led to health staff completing increasing numbers of single shared assessments.

Within older people's services, the service and its partners had a target of five days to start assessments and 28 days to complete these. During the period 2007-08 they had managed to begin assessments within an average of 3.65 days and to complete them within an average of 19 days.

Childcare services

Most (82%) assessments in the children and families files that we read were good or very good and a few were excellent. Less than one in five was adequate and none were weak or unsatisfactory. Stakeholders we met were positive about the overall quality of the reports they received commenting that there was much less 'cutting and pasting' from old reports than had been the case in previous years.

Performance in respect of keeping to required timescales for submitting assessment and review reports to the Scottish Children's Reporter's Administration had improved. Against a national target to submit 75% reports on time, the service had submitted 51% of its reports by the due date. This compared favourably with a national average of 39% reports submitted on time and represented an increase of 25 percentage points from the 2006-07 figure.

Children's services were at an early stage of rolling out an integrated assessment framework. Following an initial pilot they had begun to roll this out incrementally from July 2008. Social work, and more recently education staff, had only completed a small number at the time of our inspection. Partner agencies had established a multi-agency monitoring group to oversee implementation of the framework and monitor the quality of reports completed.

Criminal justice services

Criminal justice services were also performing well in submitting assessment reports to courts on time. In the period to March 2008 they had submitted 97.1% of reports on time.

We read a small sample of reports (seven). The overall quality of these reports was not as good as it should have been. Staff said that they were dealing with an increasing volume of reports and thought that this was affecting their quality.

Care management and care plans

There was a care plan or equivalent in most (82%) of the files read, almost all (97%) of which had been completed within the last twelve months. Most plans (82%) addressed the needs and risk identified in the most recent assessment mostly or completely. Most files (78%) also contained evidence of reviews of care plans. These findings were broadly comparable with other authorities inspected to date.

In reading files to come to a judgement about the quality of care planning and management, we found it easy to tell what was happening due to good quality case recording. Entries were legible, dated, signed, and in all cases the purpose of reports was clearly stated.

Community care services

All those receiving a care at home package had a care diary in their homes that contained the assessment, care plan, contact details of all those involved and daily entries from care staff. There was an option for nursing staff and other services to enter information into the diary.

We observed some very good examples of well-managed packages of care. These included comprehensive care packages for service users with complex problems such as those with long-standing addictions and those who had experienced chronic mental ill health.

Since April 2008, the service had been implementing the Liverpool Care Pathway which is a multi-professional document which provides an evidence based framework for end-of-life care. The service said that the use of the Pathway had played an important role in the number of cancer patients enabled to die at home.

We met a number of people with learning disabilities who had good person-centred plans in place. However, we met others who did not know whether they had an allocated worker who would develop a care plan with them. Managers said this was due to the transfer of responsibility for learning disability work from area teams to the integrated learning disability team, that had come together earlier that year. This team had not yet been able to ensure that all service users had an up-to-date care plan in place. We thought that it is important they do so soon, particularly as some people with learning disabilities considered that they had only been afforded a taste of alternative opportunities. After accessing these opportunities on a time-limited basis they had had to return to attending a traditional day centre without a plan in place for sustainable alternatives for them.

We found some care plans for those receiving community care services were not subject to regular and robust review. Our file reading sample found evidence of regular reviews in around seven in 10 files (71%).

We found some particular weaknesses in the review arrangements for older people. Social work staff in care homes, those in care at home services and external providers of care home places commented that care managers rarely continued to be involved with older people's care plans following initial six-week reviews of residential placements or once care at home packages were in place. Care homes, including those run by external providers, carried out internal reviews of care plans with care managers or other representatives from community care teams attending only if requested. This meant that care managers were not always meaningfully involved in care planning in cases where it would have been appropriate for them to have been so. Stakeholders commented that reviews did not follow a consistent format, nor did they always happen when they should.

Recommendation 5

Social Work and Health should ensure that there are regular reviews of the care arrangements which adults using services receive. These should involve a care manager where appropriate and should follow a consistent format.

Childcare services

Here too we observed a number of examples of good case management. These included care packages for children with complex disabilities and for young people heavily involved in offending. For example, a multi-disciplinary locality autism team had been established two years previously to replace the eight autism diagnostic teams in the area. These teams had not included social work or education or any follow-up care plans after diagnosis.

Good practice example

The multi-disciplinary locality autism team consisted of a pool of people from which those who knew the child best carried out the assessment. Working in this way had enabled the team to ensure that there were no waiting lists for autism assessments. Even if the team concluded that a child did not have autism, the team still developed a support plan for them and their family. Feedback from professionals and parents following the initial pilot period had been positive.

Regular reviews of care plans were more common in children and families than in community care files. Reviews were taking place in almost all (91%) of the cases sampled. However, we had some concerns that the service had not routinely built independence into its review process for all looked after and accommodated children. While reviews of children in the service's own residential units were chaired by unit managers from another unit, reviews of children in foster care or in residential schools were chaired by first line managers of the children's own allocated workers.

The need for an element of independence in the reviewing process is set out as best practice in Guidance to the Children (Scotland) Act 1995.⁷

Recommendation 6

The service should follow national guidance and should find ways to introduce more independence in the chairing of reviews of all looked after and accommodated children.

⁷ Children (Scotland) Act 1995 Guidance; Vol. 2; Children looked after by local authorities; para.93 states that those reviewing cases should 'ideally' not have line management responsibility for the case.

Through fortnightly multi-agency case progression meetings convened by the Reporter, partner agencies were also able to track progress on plans for young people who were offending. Representatives from some of these agencies we spoke to were positive about the social work service's commitment to doing what it had said it would do.

Children and young people we met who were accommodated or who had now left care were clear about the plans that were in place for them. Most were satisfied that these plans were being delivered. Most care leavers also considered that their transition from care had been well managed and that they received good support from the throughcare and aftercare team. This team did not normally take over case management responsibility for young people until they were no longer subject to statutory measures of care, although it became increasingly involved in offering them support from around their 15th or 16th birthday onwards.

Some of the children and young people we met who were, or had been accommodated, nevertheless expressed some reservations about the quality of case management. Some told us they had not seen allocated social workers as often as they thought they should, usually having contact with them only at reviews or Children's Hearings.

Foster carers who we met echoed these views. They commented that, while social workers generally maintained at least the minimum level of required contact with children, some workers counted access visits with parents and siblings and attendance at hearings as contacts and made no effort to see children on their own. Foster carers also commented that occasionally social workers expected very young children to travel to access visits in taxis unescorted when there was not a member of staff available to act as escort.

We questioned whether these concerns reflected a tension between the service's desire and capacity to provide preventative services and its capacity to provide consistently high quality services to children subject to statutory care. Some managers we met commented that while the service remained committed to its preventative role, they recognised that more could be done to reinforce capacity to undertake statutory work. The proposal (yet to be agreed) around the function of 'specialist' childcare resources was intended to address this.

Criminal justice services

Our reading of criminal justice files and our observed practice sessions showed that most cases had a plan for supervision which was reviewed at three months. However, second and subsequent reviews were not always carried out at the appropriate intervals. The file reading showed that the levels of contact with offenders during supervision were quite good, but more could have been done to work with offenders on behaviours and attitudes relating to their offending. Staff were aware that some National Standards were not being met.

Practitioners and managers said that heavy workloads were affecting the service's capacity to deliver National Standards and they were aware that they could improve the overall quality of case management. They had good access to services that helped offenders with problems relating to their offending, particularly substance misuse and employability services and were making appropriate referrals.

West Dunbartonshire was one of the authorities introducing the Constructs PSSO group work programme for offenders. Staff said that the programme was demanding on their time but that the rewards so far had been limited. Fewer offenders than expected had been considered suitable for the programme, and only 15 had completed it in the last year, although numbers were now picking up.

An initial formative evaluation of the implementation of this service across Scotland has been carried out by the University of Edinburgh.⁸ The evaluation showed that participating offenders were positive about what it offered. The report commented that West Dunbartonshire had experienced particular difficulties in gathering the necessary data to evaluate the effectiveness of the service because the vacant posts of treatment manager and administrative worker had not been filled.

Carer assessments

The local authority had used the establishment of Carers of West Dunbartonshire in 2007 as the opportunity to improve its performance in providing carers with assessments and support plans. In the period April to December 2007, the service had produced only 26 plans and had been likely to fall short of its annual target of 80. The authority had therefore commissioned the new organisation to undertake assessments and had seconded a worker to assist with this. In the seven month period from April to November 2008, 71 assessments had been completed.

The results of file reading and our survey reflected the journey the service had been on to improve performance. In 39 of the cases in our sample, we would have expected to find a carers assessment or evidence that one had been offered. We found assessments in 10% of these files and evidence that one had been offered in 41%. The majority (63%) of carers who responded to our survey who received help from social work said they had had their needs as carers assessed.

8 Criminal Justice Social Work Development Centre for Scotland (www.cjsw.ac.uk)

Risk management and accountability

Inter-agency safeguarding procedures for individuals

The range of inter-agency procedures we would expect to see in place, were in place. Some were in the process of being updated. These included vulnerable adult's guidelines which were to be updated in light of the recent Adult Support and Protection (Scotland) Act 2007 and child protection procedures. There had been delays in local authorities who were part of the West of Scotland consortium and Strathclyde Police and other partners finalising an agreement on these procedures. The service's agreement with partner agencies on managing high risk offenders had been updated in light of the introduction of national multi-agency public protection arrangements.

Effective assessment and management of risk

In making assessments of risk it is important that staff build up chronologies of key events which help them identify any emerging patterns. There were chronologies in the majority (73%) of childcare files we sampled (a significantly higher percentage than the average of authorities inspected so far) but in less than half (32%) of the community care files. In those cases in our sample where there were issues regarding the protection of the primary service user there was an up-to-date risk assessment in most cases (23 of the 29 sampled).

We found a level of confusion among staff about what assessment tools they should be using and also that training for some staff was not up-to-date.

Some community care staff commented that the single shared assessment did not lend itself to a comprehensive assessment of risk. Staff in mental health services were therefore using the Sainsbury assessment tool to enable them to do a more in-depth assessment. Staff in addiction services had been told to discontinue using this tool, but were not clear why.

The small number of criminal justice social enquiry and home background reports we read did not deal with the risk of harm to others sufficiently well. Particular weaknesses were the assessment of risk of re-offending and the risk of harm. There had been recent training in relation to the assessment of sex offenders, but training in the more general assessment of risk had not been updated or refreshed. Staff did not have any specific guidance about when and how to use the available risk assessment tools.

In childcare services, first line managers said that there was a folder available for staff containing various risk assessment tools. Some childcare social workers we met nevertheless remained confused about what they should use. In those cases where a risk assessment should have led to a risk management plan there was no plan in almost half the relevant cases. Plans were more commonly found in childcare files (seven of eight relevant files) than in community care files (five of fifteen relevant files).

Recommendation 7

Social Work and Health should ensure staff have a proper understanding of risk, are aware of the risk assessment tools they should use and have up-to-date training in using them.

Child protection

The inspection of services that partner agencies provided for protecting children, carried out by HMIE in 2007, had been mostly positive in its conclusions. For example it had found:

- a range of early intervention services and easy access to these by vulnerable families; and
- a high level of commitment to ensure the safety of children by motivated and dedicated staff.

However, it identified that partner agencies needed to make some improvements. These had included:

- improving the processes for the immediate assessment of risk and ensuring that initial assessments were followed up with a more comprehensive assessment of risk and needs; and
- ensuring the full involvement of health practitioners, particularly medical staff, in child protection processes.

Partners had put an action plan in place to address these weaknesses. This had included providing social workers with training in risk assessment. The service told us health staff were now involved in all child protection investigations and case management.

Adult protection

Our file reading sample included 11 case files for people identified as adults at risk of harm. Nine of these files contained evidence that objectives set out in the care plan were being achieved. In six of the cases the person's circumstances had not improved. However, this was judged to be due to a lack of co-operation from the individuals involved in five of these cases. In the remaining case, it was at least partly the result of ineffective social work services.

The service and partner agencies had taken steps to implement the requirements of the adult support and protection act. There had been an adult protection implementation group in place for six months, chaired by an independent chairperson. This was to become the adult protection committee with the independent chairperson remaining in this role for an interim period. Minutes of the implementation group meetings had been turned into newsletters. The committee had yet to appoint a co-ordinator/development officer, a training officer and administrative support and was considering sharing resources with East Dunbartonshire. Partners were planning a three year training programme for staff across the agencies. The local authority had appointed its council officers (16 in total), all qualified social workers.

Partnership with people who use services and their carers

Involvement of people in developing their care packages

The local authority told us they worked hard to ensure that adults and children were involved in care planning. We found mixed evidence that this was the case.

In the sample of files we read, we found evidence in 90% of files that the service shared key information with the individual or with an appropriate representative. In 86% of files there was evidence that the individual was invited to attend decision making meetings or reviews. There was evidence that the views of the individuals were taken into account at each key stage in all of the 40 children and families files we read and in 89% of community care files.

The majority of stakeholders who responded to our survey considered that social work services paid a lot of attention to the views of people who used services and their carers about how they would like their needs to be met. They also said services were provided in a flexible way, in response to the individual circumstances of people who use services and their carers.

Seventy-four percent of service users who responded to our survey agreed they had been given choices about the type of service they received. This level of agreement was more than 10 percentage points above the average to date. Most said that they had been fully involved in deciding what services they would receive. The majority of carers (70%) agreed that they too had been involved in deciding what help or services the person they cared for should receive.

Other views were less positive. Around half (54%) of service users agreed that there was a meeting at least once a year to discuss the services they received. Less than half of carers also agreed that the person they cared for had been given choices about the type of care they received while 40% disagreed (17% strongly).

In its 2007 inspection of adoption and fostering services, the Care Commission highlighted the need for better recording of children's views. HMIE too, in its inspection of services to protect children, had recommended improving the ways in which children and their families were involved in the child protection process. The child protection committee had begun this process by producing information leaflets.

Advocacy

The service commissioned an advocacy service for looked after and accommodated children from the national provider Who Cares? This singleton worker submitted an annual report on work undertaken and issues raised and throughout the year had quarterly meetings with a social work manager to provide updates. All staff, managers, accommodated young people and their parents that we met were highly positive about the quality of the service offered. There was no advocacy provision for children or young people who were not accommodated.

Since 2000, the service and partner agencies had commissioned individual and collective advocacy for adults with mental health problems and those with learning disabilities from a local provider. In 2007-08, 45 older people, including 22 older people with dementia received a service. The provider was of the view that staff and managers in social work services working with these care groups had a good understanding of the role of advocacy. This was evidenced by the high number of referrals they made to the service. As an example, staff in learning disability services routinely made requests to the advocacy provider to prepare person centred plans for adults in situations where there was an element of conflict about what that plan should contain. Gaps in advocacy provision were identified as being for older people resident with independent sector providers and for adult carers.

More recently, partner agencies had commissioned the provider to offer an advocacy service for parents and carers of children with disabilities. Here the experience had not been so positive. While there had been an increasing number of self-referrals to this initiative, there had been very few referrals from childcare social workers.

Inclusion, equality and fairness in service delivery

Ethos and practice of inclusion

The authority had up-to-date equalities and diversity policies in place and we found that the service implemented these in day-to-day practice. Almost all respondents to our stakeholder and service user survey agreed this was the case. It was also reflected in our file reading where there was evidence in most cases (88%) that social work services had taken potential differences or barriers into account when they were delivering a service to those who were from an ethnic minority or who had a disability or sensory impairment. In all the files we read, staff had recorded the service user's ethnicity or recorded that the service user had not disclosed this.

The service had taken steps to make sure that hard-to-reach groups had a voice. Examples included employing community work staff to identify and support groups such as the brain injury experience network, groups of parents/carers of children with disabilities and an Asian women's group that focused on health and other issues. All those we met who were members of groups supported by these staff were extremely positive about the role the staff had played.

In criminal justice services there was no specific provision for women who were placed on community service orders. Women who could not be placed in individual agency placements (and this was the majority) worked in teams alongside male offenders. Managers told us that they had been unable to appoint a female work supervisor. This issue was raised in the inspection of criminal justice social services in West Dunbartonshire in 2004 (part of a national programme of such inspections). We were unconvinced by the view that all women were happy about or were suited to working in predominantly male teams (as managers told us) and concluded this issue needed to be addressed.

Recommendation 8

Social Work and Health should make more strenuous efforts to make suitable working arrangements for women placed on community service orders.

Comprehensive information

Information leaflets and posters were available in other languages or formats as required. The public also had access to 'Language Line' that provided a 24-hour telephone interpreting services.

Overcoming obstacles and barriers

The council had a rolling programme of action to ensure accessibility to its premises and had installed hearing loops in its main offices and care settings. The service had taken steps to overcome barriers by employing a respite and leisure co-ordinator to support access to leisure activities for children with disabilities. The council's website set out the different activities that children could access, such as dance classes, football training and swimming lessons. It had also made efforts to improve its understanding of the issues that faced people who had significant barriers to work. In 2007, it had commissioned a service user consultation on this issue.

Seventy percent of staff who responded to our survey agreed that there was a fair geographic coverage of social work services within West Dunbartonshire. However, staff, service users, carers and stakeholders we met also criticised differences in the availability of services between the Clydebank and Dumbarton/Vale ends of the authority. Most comments related to the health services available in areas that had formerly been part of the two different health boards. However, some comments related to social work services. Examples included differences between learning disability and addiction services in the two parts of the authority.

Multi-disciplinary working

Multi-agency working was an area of particular strength for this service. In our file reading there was evidence of multi-agency working, with clearly stated roles and responsibilities in most cases. However, there were a few areas of tension. For example, some staff we met commented that Glasgow hospitals sometimes provided too little notification of hospital discharges. Others commented on tensions with housing services around the anti-social behaviour agenda. However, the majority of staff who responded to our survey agreed that their team had a good working relationship with partner agencies.⁹ These findings were comparable with other authorities inspected to date. The majority of stakeholders who responded to our survey or who we met agreed. We found a number of very good examples of multi-agency working. In addition to the numerous individual cases we observed where agencies were working well to deliver often very complex packages of care, there were also a number of multi-agency initiatives in place. We highlighted some of these earlier in the report.

Good practice example

The special needs in pregnancy service. This well-established service provided a multi-agency service primarily for women with substance misuse issues, though also accepted referrals for other vulnerable women. Partner agencies held pre-birth case discussions at 32 weeks gestation and thereafter worked with women through and beyond their pregnancy for at least six months.

Other examples included:

- leisure facilities and activities for children and young adults with disabilities. There had been close working between leisure services, parents, service users and social work to find solutions that would enable those with disabilities to enjoy a range of leisure activities. This included installing hoists in leisure facilities, training leisure staff how to best assist people with disabilities, providing free entry to leisure activities for children and young people and a parent or support worker, and providing both taster courses in various activities and running specific activities upon request; and
- there were multi-agency groups in place in schools to consider the needs of young people requiring additional supports. Joint agency teams (JATs) focused on early intervention while multi-agency consultation groups (MACs) considered more complex situations. We were impressed by the JAT meeting that we observed where it was evident that all agencies were working closely together to support young people. Social work managers had recognised nevertheless that more needed to be done with partners in education services to reduce the number of exclusions from schools. We saw that there had been a significant improvement in West Dunbartonshire's performance in this area in 2007-08.

⁹ 62% in respect of the education service, 63% in respect of housing services and 79% in respect of health services.

Management

This chapter looks at three areas for evaluation:

- policy and service development, planning and performance management;
- management and support of staff; and
- resources and capacity building.

Policy and service development, planning and performance management

Overall, we found performance of Social Work and Health in this area to be good, having important strengths with some areas for improvement.

There was a range of policies and procedures in place, but there were some gaps and some work to review and update strategies to be completed. There was evidence of operational and partnership planning but this still needed to be put in place at unit and team level. The operational planning for criminal justice services in West Dunbartonshire needed to be SMARTER.

We found a good commitment to joint planning and saw some good examples of the involvement of stakeholders in planning and service development. More emphasis had been given in the past to developing joint, rather than fully integrated services. More recently, the service and the NHS had decided on greater integration of community care services. They needed to finalise and formalise these arrangements.

We found there was a good range of services available across the various care groups. This included some very good services for children and young people and in particular to children who had been looked after and accommodated. Services for people with cancer and their carers were a significant strength, as were services for people with acquired brain injuries and for people with substance misuse problems.

Performance management had been given limited effective attention in the past, but significant efforts had, and were continuing to be made, to address this.

Policy review and development

Comprehensive policy frameworks for all services

Social Work and Health had a range of strategies and policy frameworks in place for many of its services. However, there were some important gaps. The carers strategy 2003-06 was out of date and although significant work was being done to update and improve the strategy, this was still to be completed. The service said the best value review of older people's services was its strategy for older people. However, we saw it made very little reference to older people with dementia. The integrated children's services plan 2005-08 was reaching its end date and the work to update it had not been concluded at the time of our inspection (this was done in February 2009). There was no local strategy for mental health services. Managers and staff told us that outstanding work to update and review strategies would be completed within the next 12 months.

The service and the council had equality and diversity strategies and policies for minority groups including the Gypsy/Traveller Strategy 2008-12.

We were impressed with the department's Service Plan 2008-12 which was a well written and thorough document. It covered all aspects of social work services and linked vision and values to national, council and departmental policy initiatives. It had a financial framework and action plans covering the period of the plan. It included arrangements for reporting progress against performance indicators and other measures. It was an ambitious plan which will be challenging for the service to achieve.

The original Integrated Children's Services Plan 2005-08 had clearly set out the priorities for the development of services to children and families. Although it contained few targets, we saw that it had played an important role in the development of both specialist and universal services for children in West Dunbartonshire.

Regular review and updating of policies

The service had reviewed and updated a number of its policies. However, we did not find evidence of an effective strategic approach which allowed a prioritised and systematic approach to policy review.

Much of the information presented as evidence of review activity was in draft. This included guidance on purchasing, the throughcare and aftercare policy, the Partnership in Practice 2007-09 and the inter-agency policy for young carers.

Recommendation 9

Social Work and Health should operate a systematic process to manage policy development and review. This should include an exercise to prioritise policy gaps and policies requiring updating. Timescales should be set to reflect the agreed priorities and monitoring arrangements put in place.

The children and families service had reviewed its approach to public awareness and drafted a communication strategy. The service and its partners were piloting the integrated assessment framework and had drafted eligibility criteria within the timescales they had set.

The council and the service undertook regular and systematic reviews of human resources and staff development policies, a full range of which were in place.

Operational and partnership planning

Links between strategic and operational plans

The service had produced a series of operational plans covering the period for 2007-11 for most services areas. These represented the third tier of planning below the council's corporate plan and the department's service plan. The operational plans linked to the service plan and presented a more detailed priority and performance action plan for the different services. These were substantial documents which were in a standard format and included a financial framework. They provided an effective basis for planning activity. They listed various performance indicators from Audit Scotland, other national performance indicators from the Scottish Government, Local Improvement Targets and new actions for the period covered by the plan.

Operational plans for every team and unit

The operational plans indicated that each team and unit should have its own individual plan as the next tier in the process. For the most part, these plans were still in preparation during the inspection.

The service had piloted the Public Service Improvement Framework (PSIF) in the welfare rights service. PSIF can be used to focus on individual teams or units. Welfare rights staff spoke positively of their involvement in the pilot exercise including the way it had helped them improve how they organised and delivered their service. A decision had been taken to roll out the use of PSIF across all council services.

We looked at the Criminal Justice Authority area plan, the inter-authority Criminal Justice Partnership Strategic Plan and West Dunbartonshire's own Operational Plan for criminal justice services. The area plan set out a vision and a range of strategic priorities which were carried over into the Partnership Strategic Plan, together with some identified actions and outcomes and a timetable for completion. The Operational Plan provided more detail about what was intended in West Dunbartonshire. We thought this Plan should have been clearer and more SMART (Specific, Measurable, Achievable, Realistic and Time bound). The service told us it was taking action to develop the plan including 'lower level actions'. We concluded that this needed to be completed as a matter of priority given some of the issues about the criminal justice service identified earlier in this report.

Recommendation 10

Social Work and Health should develop a more detailed and SMART operational plan for its criminal justice services as a matter of priority.

Commitment to joint planning

The best value audit criticised the council for its process of community planning. We heard that despite this, action to progress community planning had subsequently stalled for a period before being re-invigorated more recently.

In children's services there was a range of joint planning structures. We heard from different services, staff focus groups, stakeholders and from some young people and their families that there was a commitment to joint planning for children.

In community care there was similarly a strong commitment to joint planning, particularly with health services. We saw this happening in learning disability and mental health services. Staff at all levels in both services confirmed their commitment and spoke of the benefits in terms of the organisation and delivery of services. We found the Brain Injury Strategy to be a comprehensive joint strategy between the council and NHS Greater and Clyde.

The criminal justice area plan did not link to the community plan for West Dunbartonshire. The Criminal Justice Authority chief officer had begun discussions with community planning managers about this.

Involvement of stakeholders in planning and service development

Involvement of people who use services in planning and developing services

We found a generally positive picture around the involvement of stakeholders in planning and developing services. As we said in chapter 4, some of the best examples of service user and carer involvement were where the community work team facilitated this, such as in the development of the acquired brain injury service and addiction services. The next stage of the development of mental health services planned to use the community work team in the same way. We also saw good involvement of service users with learning disabilities.

Good practice examples

Initiatives in 2008 that involved people who use services in improving them:

- The Good Life Positive Attitudes Group was a group of people with learning disabilities. One of their activities was to train staff using scenarios from their own experience which generated questions and discussion with participants; and
- The Future of Addiction Services Team (FAST) grew out of user involvement meetings. They saw themselves as helping to develop services. Members helped to produce a newsletter with information about services. They hosted a national service user conference where service users were heavily involved.

In our partner and stakeholder survey, the majority of respondents agreed people who use services and their carers were properly involved in service planning and development.

Joint planning structures

There were well developed joint planning structures for community care and children's services but less so for criminal justice services. The department's service plan renewed its commitment to partnership working. The appendices described the structures for community care, child care and criminal justice services. Both community care and children and families services had a Joint Strategy Group (JSG) to which all the relevant joint planning groups reported. The JSG reported to the relevant council committee and in the case of community care, also to the West Dunbartonshire CHP.

We read that the Integrated Children's Services Plan (ICSP) underpinned joint planning. We saw a partnership approach reflected in the joint planning structures with representation from all the relevant statutory and voluntary sector bodies. The Joint Strategy Group had responsibility for reviewing the partnership's working performance and focusing on potential developments.

The strategic approach to inter-agency planning and integrated working for services for adults and older people was laid out in the Extended Local Partnership Agreement (ELPA). As with children's services, we noted that the joint planning structure supported the ELPA with the JSG as the key driver. The West Dunbartonshire Community Health Partnership Board was part of this structure.

In our partner and stakeholder survey, the majority of respondents agreed there were effective planning structures and processes in place for social work services. In focus groups, most but not all the partner and stakeholder organisations we met were positive about their involvement. Independent sector providers, for example, told us they felt properly engaged in policy/strategy development.

Developing integrated services

Shared planning of joint or integrated services

The service told us on a number of occasions during the inspection that its approach toward the integration of services was a cautious and pragmatic one.

In community care there were more joint services than integrated services. Budgets were aligned, rather than pooled. In line with developments across the greater Glasgow area, substance misuse services and learning disability services had been the first to move towards co-location and greater integration. In some instances, the extent of joint working arrangements within services varied and reflected the approaches previously taken with Greater Glasgow, and Argyll and Clyde Health Boards. For example, in substance misuse services, there was a single manager for the service and the two community addiction teams were co-located. However, in Clydebank, whilst health and social work staff ran joint clinics, there were no joint clinics in the Dumbarton team where the alcohol and drugs services remained separate.

There were two co-located community mental health teams with health and social work staff working alongside each other on a joint working basis. The Clydebank team had been co-located for longer and it was common for there to be a single care manager (either health or social work). In contrast, co-working was the norm in the Dumbarton team.

In common with substance misuse services, there was a single manager for learning disability services at service manager level. He said that so far integration had largely meant co-location and that more needed to be done to develop integrated care management. In care at home, we saw examples of good partnership working with community nursing. The move towards full integration and the possibility of a single service bringing together home care and community nursing was identified as a challenge still to be addressed.

Mental health services were the most advanced in terms of shared planning of integrated services. They had fully worked up proposals for integrated operational management and other aspects of the service.

Sound governance arrangements

We noted that the Framework for Joint Accountabilities and Line Management in Integrated Partnerships had remained in draft form since 2005. Although approved at the Joint Staff Forum in January 2009, it still had to be formally endorsed by the council and the CHP.

Within the joint strategy group structures we found clear evidence of sound governance arrangements. All the forums and joint groups reported to the JSG. Many had developed performance measures and included them in their reporting.

Discussions were ongoing at the time of the inspection in relation to the formal relationship between the council and the West Dunbartonshire Community Health Partnership. Since the creation of a single community health partnership for the council area, there was agreement at senior officer and member level to progress towards a more integrated structure. The service and the NHS in the recent past had jointly appointed a number of heads of service to be single managers for a range of community health and social care services. However, the partners had not concluded their negotiations on the future structural and governance arrangements.

We talk in more detail later in this chapter about the history surrounding the council's formal partnership relationship and arrangements with health and our concerns about the absence of agreed governance and accountability arrangements.

The service was still considering whether further moves should be made to integrate children's services with its education and/or health partners. There were no joint governance arrangements in place or under consideration. The service should give this a high priority ahead of the development of any further integration within children's services.

Clarity about devolved responsibilities and HR arrangements

At the time of our inspection the formal management and accountability arrangements for joint and integrated services had been in draft form from 2005. This was surprising given the number of joint managers appointed since then and the continuing progress in developing joint and integrated services. However, in our fieldwork discussions with managers and staff in joint teams, we found that they understood and applied the principles outlined in the paper. Whilst this was encouraging, it left employing agencies vulnerable to challenge should this position become unstable.

We saw that all the staff in the joint mental health crisis service were NHS employees. Mental health staff we met thought this was as a result of the terms and conditions of the joint service being set solely within an NHS framework and as such, had not attracted local authority applicants. The service told us this was not the case and that the recruitment process had not been confined to health staff. It said it was strongly committed to a model which would involve social care as well as nursing staff. Given this, we thought it was particularly important that the service and NHS partners should give careful consideration in any future moves to integrate services regarding how best to achieve the desired balance of health and social care staff.

Range and quality of services

Broad range of services to meet the needs of people

There was a wide range of services available to meet the needs of vulnerable people in West Dunbartonshire including some innovative services and provision for people with particular needs. These included support to young people who had been looked after and accommodated, its partnership services with Macmillan Cancer Care (we say more about these later in this chapter under partnership arrangements), services for people with acquired brain injury and the locality autism assessment service. We were particularly impressed with the range and quality of services provided by the welfare rights service to all care groups and to the wider population.

A significant number of the department's services had attained Charter Mark status, namely the six care homes and the four day centres for older people, the children's units, the family support and groupwork teams and the children with disabilities team.

In our survey, service users were very positive. The majority (83%) agreed there was a good range of services available to them which was above the average in other inspections to date. Carers were less positive in their response with less than half (41%) in agreement. This was comparable with previous inspections to date.

Services for children and families

As reported in the HMIE inspection of child protection services we also saw that the department had a range of services for early intervention and easy access to these by vulnerable families. The service, along with its partners, had developed an ethos for early intervention and preventative services which included the young families support service, a joint initiative with health. We also found innovative work with young people with addiction problems and were impressed with the proposals for re-designing the services for them.

We heard mixed views from parents of children with disabilities about the range and quality of services available. However, we found that in general West Dunbartonshire made good provision for children with disabilities. This included respite and leisure activities, holiday clubs and play schemes, a group for siblings, a dedicated home care organiser, and a sleep clinic. There was also a positive approach to transition planning for children with disabilities moving to adult services. The service had built funding into future budgets to respond to complex needs based on transition planning.

We were impressed with the high morale, motivation and dedication of the group of residential care staff we met from all the children's care homes. They reported a good quality of accommodation and some interesting approaches to meeting the needs of the young people in their care.

We met a number of young people involved with the throughcare and aftercare service. Based on their views, feedback from the service's stakeholders and the performance data we saw, it was clear that the service was of high quality and offered appropriate and good support to young people.

Good practice example

The throughcare and aftercare service engaged at an early stage with young people to work with them in preparing to leave care. It worked hard and performed well in its efforts to ensure that young people were able to achieve positive outcomes in terms of accommodation, further education, training and employment.

The Care Commission inspection of the fostering service reported that all service users consulted during their inspection described the fostering and adoption team as excellent. As noted earlier, the service had started more recently to need to use independent sector fostering agencies.

Criminal justice services

West Dunbartonshire's criminal justice services had been inspected in 2004 when the findings had been largely positive. Our findings about the range and quality of the services as part of this inspection were less positive.

Whilst community service had achieved a positive public profile, there were insufficient placements available to meet demand without offenders having to wait to start their placements. Drug Testing and Treatment Orders and the Constructs PSSO group work programme which can both impact on offending behaviour were in place. However, as we commented earlier, use of them was more limited than it should have been.

We found some weaknesses in assessment and case management, including in the important area of risk assessment.

The service told us that resourcing pressures, including staff vacancies and absence levels had impacted on some aspects of its performance in criminal justice services. The figures we saw confirmed that the criminal justice service had faced difficulties in these areas. For example, as we identify later in this chapter, the vacancy rate for criminal justice staff in West Dunbartonshire in 2007 had been well above the national average.

Community care services

The service provided a good range of community care services, including some of very good quality. There were some services, such as learning disabilities services and home care where we saw examples of very good practice, but where aspects of the services were in need of further modernisation.

For older people, the council provided the vast majority of care at home services but there was a wide range of services available. These included personal care, domestic care, augmented care for prevention of hospital admission and early supported discharge, community alarms, telecare, an evening service for assisting service users to prepare for bed, a bathing service and a 'good morning' telephone call service.

We saw positive Care Commission reports about the service provided by the council's care home and day care services for older people. This was confirmed in our own contact with service users and carers. We held a number of focus groups in some of these services. Positive comments were made at these meetings about the staff and the care they provided.

Two of the day care services for older people had a particular focus on dementia and the service planned to assess if this approach was more successful than the 'integrated' approach applied in its other day services and in its care homes. The service contracted with Alzheimer Scotland to provide care at home and day opportunities for older people with dementia at the Elm Centre in Dumbarton. We met a group of carers who spoke very positively about the service provided at the centre. However, they also said there was a waiting list and a need for a similar service elsewhere in the authority.

We heard that mental health services were the biggest purchaser of care at home services, as the in-house service did not have sufficient staff with skills and experience of working with this group of service users.

As a result of long waiting lists for equipment the occupational therapy service had undertaken a review of the way it assessed and provided equipment. As a result, the service had virtually eliminated the waiting lists. However, there were still delays in the provision of major adaptations due to the lack of resources for private grants managed by the planning department.

There were some good developments in the range of services available to people with learning disabilities in terms of day opportunities. These included aspects of independent living, shopping, cooking, walking, horse-riding, and training for employment. There were, however, still some limitations around personalisation.

There were some differences in the mental health services provided in the Clydebank and Dumbarton/Vale of Leven area. We were told this was due to the previous division between the two health board areas and more specifically the services provided by the Primary Care mental health team. Psychological services for children were one example of this. The service and the NHS were attempting to rationalise the differences.

The Alternatives (West Dunbartonshire) Community Drugs Service was providing largely complementary services including a range of therapies and activities. It worked in close co-operation with the two drugs teams and criminal justice services.

Quality assurance and continuous improvement

Performance monitoring framework

The council introduced a performance management policy in 2005. The Account's Commission Best Value Audit found the council's performance management arrangements had potential, but were not yet embedded. It also concluded that some of the reporting arrangements required improvement, as they did not provide a robust base for scrutinising performance or informing priority setting and resource allocation.

We saw that performance management had been given significant attention further to this. It was now a high priority for both the service and the council as a whole. The service was gathering the relevant information and in a format which was readily understood by officers and members. Reports went to committee and the traffic light system was used to highlight strengths and weaknesses in areas that required improvement. We saw a range of good quality performance reports.

The council had purchased performance management software, Covalent, and was rolling this out across all departments. Social Work and Health used Carefirst as its client records system and database. In our file reading exercise we saw that considerable data had been input on to the system.

Delays in setting up and using the reporting functions of Covalent meant that the service had not realised its full potential for performance monitoring. The intention was to use Covalent and interface it with Carefirst to produce the required information and reports.

We read the council's policy document on the Performance Management and Public Reporting Framework 2005. It included a strong emphasis on outcomes for service users and provided a comprehensive framework for performance reporting. We saw a number of social work performance reports including the service's 2007-08 Annual Performance Report to the Social Work and Health Improvement Committee. It was a lengthy and very detailed performance report covering a wide range of statutory performance indicators and Local Improvement Targets.

The Criminal Justice Authority had responsibility for performance monitoring but the introduction of a national performance monitoring system had been delayed. Performance reports in relation to criminal justice were submitted to the CJA Partnership Board and also to the service's departmental management team.

Quality assurance and standard setting

In the recent past, the service had made good progress in quality assurance and standard setting. The Carefirst team undertook regular quality assurance of the data entered on the system and reported regularly to operational units with instruction on correcting and updating of data on the system.

There were procedures for supervision, case file audit, allocation and caseload reports, reporting on numbers of service users in key provision such as child protection, accommodated children, delayed discharge, and care home placements etc. A child protection case file audit had been undertaken in 2006, and community care and child care file audits were completed in 2007. We saw the service had an audit schedule covering the next two years.

There were good arrangements in place for assuring the quality of child protection assessments. The child protection co-ordinator audited all child protection reports and related information.

The criminal justice service operated a quality assurance system along with its partners in Argyll and Bute and East Dunbartonshire.

The Care Commission told us it had signed a Memorandum of Understanding with West Dunbartonshire Council at an early stage after the Commission was established. This allowed the two agencies to share information relevant to protecting vulnerable people.

The service's complaints procedure was aligned to the council's corporate procedure. The number of formal complaints involving Social Work and Health at around 28 per year was relatively low. Despite this, we noted with some concern that only 50% of them were responded to within the statutory timescale of 28 days. We also saw no evidence of findings from complaints being used to improve practice.

Recommendation 11

The service should review its reporting and management of complaints to interpret trends and ensure the lessons learned improve practice. It should also ensure that it responds to all social work complaints within the statutory timescale of 28 days.

Best practice and continuous improvement

Best value reviews and service planning days had been the service's main mechanisms for the evaluation of best practice and continuous improvement. There was a best value review process which covered a three year period from 2005. Those service areas selected by the department for Year 1 took far longer than scheduled. This resulted in slippage into Years 2 and 3 and the service had not completed the programme except for older people's services and youth justice services. The service was now developing an action plan based on the older people's review looking at home care, which had already made some service changes, and residential care home provision in particular.

Further to this, the council had agreed to be a pilot area for the Public Service Improvement Framework (PSIF). This had been piloted across a range of council services (including welfare rights) and the council had now decided to adopt and roll out PSIF across the council as its main performance improvement system.

Other services such as occupational therapy, home care, autistic assessment and the brain injury service had undertaken service reviews all of which resulted in service redesign. We saw evidence of improved service delivery as a result.

Management and support of staff

We rated the performance of Social Work and Health in this area to be good, having important strengths and with some areas for improvement.

The service had a workforce development plan, and each service had a specific workforce plan. West Dunbartonshire had experienced difficulties in recruiting staff, but had developed a successful ‘grow your own’ policy. However, there was a recruitment freeze at the time of our inspection because of the financial position. Staff we spoke to were not always clear about its status. The council had safe recruitment policies in place.

The service had a stable workforce, with good family friendly policies. It had a persistent problem with absences, which several initiatives had not greatly improved.

Staff were clear about their roles and responsibilities and most were satisfied about their workloads and the teams they worked in.

The service had clear policies for supervision, training and staff development, and staff were generally positive about the frequency and focus of supervision, access to individual training events and career development opportunities. Criminal justice staff were less positive about these things.

The service had developed a Local Practitioners Forum linked to the Local Learning Network. This allowed staff to share learning opportunities with social care staff from the independent, private and voluntary sectors.

Recruitment and retention

While Audit Scotland’s Best Value Audit progress report of January 2008 criticised the council’s lack of workforce planning and development, it recognised that the social work service had made some progress in this area. The service had a Workforce Development Plan for 2006-10, which attempted to ensure the training and development requirements of appropriate staff were recognised and provision was made for courses, or access made available to courses. It also identified the numbers of staff commencing and completing qualifying and post qualifying courses. Each service had a specific workforce plan. The service had established a workforce planning group in 2007 to look at strategic approaches to recruitment and retention.

Less than half (38%) of staff who responded to our survey agreed that West Dunbartonshire was able to recruit sufficient staff. This was comparable with other authorities inspected to date. Some vacancies were temporary because of people on training or maternity leave, but their posts were not filled with staff having to cover for each other.

The chief executive and the executive director of social work were clear that there had been a recruitment freeze for some time, and that no social work posts were automatically exempt. The filling of any post had to be agreed by the chief executive or executive director. As identified in chapter 4, some front line staff were not clear about this position.

Sound recruitment practices

The council had a corporate recruitment and selection policy, which set out requirements in relation to the Protection of Children (Scotland) Act 2003. This pre-dated 'Better recruitment through safer recruitment', although the service's human resources manager confirmed that this had been put into practice when recruiting staff. The HMIE Child Protection report of June 2007 identified safer recruitment practice in partner agencies as an area of strength. The Care Commission had inspected the service on safer recruitment policies which had implemented the few recommendations made.

The service was part of a council wide safer recruitment group looking at the changes proposed under the Protection of Vulnerable Groups (Scotland) Act 2007. This group was chaired by a member of Social Work and Health's senior management team. All staff involved in selection, interviewing or chairing recruitment panels were required to undertake mandatory training before carrying out these duties, and there was specific training for those chairing recruitment panels.

We saw that there was a comprehensive induction document for new recruits to the department, following the SSSC guidance on 'Preparing for Practice'. It had been updated in 2008. In focus groups, staff indicated that induction varied across the department, with some staff from residential units saying that induction could be limited and that they had to 'hit the ground running'. Fieldwork staff spoke of corporate induction, backed up by some specific areas, depending on their role, while home care staff had their own induction programme. Criminal justice staff spoke about the absence of any meaningful induction.

Supporting and retaining staff

The latest reported national data indicated that West Dunbartonshire had relatively high levels of staff vacancies in the social work service. The vacancy rate of whole time equivalent staff had increased from 5.9% in 2006 to 10.2% in 2007. This was almost two percentage points above the national average. The vacancy level for social workers was 11.8% in 2007, against a Scottish average of 7.4%. In criminal justice the vacancy rate for 2006-07 had been 24.5%, against a national average of 8.1%. The criminal justice service manager told us that while there were still vacancies, the position had improved. The vacancy position for criminal justice staff at the time of our inspection was a total of five vacancies out of 50 staff, a rate of 10%.

The service told us that its overall position in terms of staff vacancies and turnover had improved. This included its children and families services where staff we met confirmed this. Indeed, with the exception of criminal justice, we heard few concerns from staff in focus groups about vacancy levels and their impact on workloads.

West Dunbartonshire had flexible and family-friendly working arrangements. The majority of staff (56%) who responded to our survey agreed these were in place. This agreement was echoed in our focus groups, where staff were positive about helpful working arrangements such as flexible working, family leave, career breaks and home working. In the council's staff survey, 75% thought that the department was a good employer, and 69% said they would recommend the department as a good employer to a friend.

The council also had a range of corporate policies to support staff and ensure their health and well being. These included employee counselling services and health promotion initiatives. The health promotion initiative had experienced problems and a new provider had recently been appointed. Managers hoped this would improve staff confidence in management's intention to provide appropriate support.

The service had a relatively stable workforce, many of whom lived in the council area. However, according to the SEQ, proximity to larger councils able to offer pay incentives had, in the past, created problems in recruiting and retaining qualified social workers. This had been addressed by a 'grow your own' programme. Numbers of qualified staff leaving the department peaked at 19 in 2003 and dropped to five in 2007. Across the service as a whole, the annual turnover rate was 6% in 2006-07, down from 7% in the previous three years.

Staff absence levels were an area for concern for the service. It had the highest absence level in the council. Absence levels for 2006-07 were over 8% against a council average of 6%. More recent figures suggested that the absence rate had decreased slightly. The service had made efforts to reduce absence. A £50 incentive scheme paid to staff with 100% attendance in 2006 had proved unproductive, with a similar percentage of staff having 100% attendance in the year before the scheme. Surveys had been undertaken in service areas which had particularly high absence rates, for example residential care for older people. Home care managers told us that absences in home care had gone down from 10% to 7%.

The service had appointed a maximising attendance officer, who had concentrated on training, absence recording and support to line managers. At the time of the inspection, absence and stress in workplace policies were being reviewed, and consideration was being given to taking a stronger line on disciplinary procedures in absence management. We heard that this was being met with considerable resistance from trade unions.

Staff deployment and teamwork

Clarity about roles

The service's SEQ said that all staff had job profiles outlining the employee's key accountabilities and job competencies within their team or service. These were linked to the departmental service plan and service operational and unit plans.

The authority's own staff survey found that 80% of staff responding thought they had clear roles and responsibilities for their job. Our staff survey specifically asked staff in Social Work and Health if they were aware of their responsibilities in relation to financial matters. Almost all (91%) agreed that they were. Both results were comparable with findings from other authorities inspected to date.

Appropriate staff mix in teams and units

Service and unit plans, and a review of posts in residential care, learning disability, youth justice and welfare rights were designed to ensure the appropriate mix of skills in the department. Staff in focus groups of home care and administrative staff described a stable workforce. In our survey, 75% of staff who responded agreed that they had received adequate training to do their job. Administrative and home care staff and residential care workers were most likely to disagree.

Most residential and day care staff were on 30-hour contracts, and those in our focus groups were concerned about the use of agency workers to cover for sickness, leave, and weekend work. The service had been piloting a senior residential officer grade, which was to be rolled out to all care homes. Home care staff told us that staff deployment varied across their teams, and was dependent on the tasks performed. As we said in chapter 5, consideration was being given by the service at the time of our inspection to changing and rationalising the specialist children and families and youth justice teams.

Sixty-one percent of staff in our survey agreed that there was an adequate level of administrative support available to front line workers, although administrative staff themselves were one of the groups most likely to disagree. This contrasted with our focus groups, where administrative staff said that they felt part of the wider department and that staff 'often went the extra mile'. This view was reflected by other focus groups of staff we interviewed where staff were generally positive about teamwork.

Development of staff

The service's workforce development plan of 2006 aimed to ensure staff and managers prioritised learning in a way that was consistent with personal development plans (PDPs). This approach was supported by other related policies, such as the continuing professional development policy, access to training policy, and the performance development planning policy.

At a corporate level, mandatory equality and diversity training had been introduced for all staff members. As part of their induction all staff had to undertake 'customer first' training. The service told us that in the three years before our inspection over 120 staff had undertaken a two day anti-racist training course.

Staff we interviewed spoke of easy access to training, and the majority (75%) in our survey agreed that they had received adequate access to training to fulfil the responsibilities of their job. This was comparable with previous inspections to date.

Personal development and supervision

The service had a staff supervision policy, produced in June 2008. We saw this was comprehensive, and placed supervision in the wider context of service objectives, personal development plans (PDP) and continuing professional development (CDP). It also distinguished supervision from appraisal, although links were made between the two. Staff we spoke to generally agreed that they knew of the policy, and that they received supervision regularly. This included child care senior social workers, MHOs, addiction staff, learning disability day care staff and administrative staff. Front line staff in criminal justice were an exception, although their managers disagreed.

Personal development planning seemed to be well embedded within the service. Its performance and development planning document set out that it should have been implemented for all social work staff by December 2006. At the time of our inspection between 80% and 85% of all social work staff had a PDP. One large focus group of community care staff told us it was 'well established' and another large focus group of residential and day care staff said that PDPs, including in-year reviews, happened when they should. A group of childcare staff we met were enthusiastic about PDPs and their link with supervision. Trade Union representatives told us that the PDP process did not apply to manual workers, and that home care staff did not have PDPs. The service said this was not the case as manual workers were covered by the corporate PDP policy, a revised version of which was used for home care staff.

The service said it had good working relationships with those who provided training and staff development opportunities. This was confirmed at a focus group of staff from the department's Quality Assurance and Training section and training providers from colleges and universities. Both sides spoke positively about the mutual benefits gained from their relationship.

The local Clydebank College appeared to have a particularly positive relationship with the service. They were the single provider for SVQ training for the department, helping to increase the percentages of social care staff able to meet registration requirements. Some 200 home care staff had already completed an SVQ. However, approximately a further 400 were waiting to go on SVQ2 training, but at a scheduled rate of only some 40 places per year available. This limits the career development prospects for these staff. Staff from learning disability day care centres told us in a focus group that they had good access to training at Clydebank College, and that the service users they worked with also used the college for training purposes.

We saw from the service's SEQ that in children and families all senior social workers either had or were in the process of completing the Dundee University Child Protection Certificate. On average 3-4 social workers undertook the course each year. Middle and senior managers had done relevant management training, such as the 'Leading to Deliver' programme. In adult care services all managers had obtained post graduate qualifications of some description.

There were other initiatives to help staff develop professionally. Many staff had access to CareKnowledge, the internet website providing guidance on best practice. There was a monthly 'Lectures at Lunch' programme. This was a monthly lecture series, open to all staff as well as staff from partner agencies such as health, education and voluntary and private providers. Speakers are drawn from within and outwith the department, from central government, professional organisations, and academia. Some of the 14 sessions which had taken place, attracting audiences of between 60 and 80 people, had been placed on the CareKnowledge site for access by staff unable to attend the lecture. The sessions were evaluated using 'Survey Monkey' and 93% of participants saw them as a valuable learning tool. Staff also used the lectures to evidence ongoing development and PRTL (Post Registration Training and Learning) for the SSSC (Scottish Social Services Council).

The service had also recently established a Local Practitioner's Forum. This had brought together an earlier, but not completely successful local forum and the West Dunbartonshire branch of the SSSC Learning Network West which included staff from the voluntary, independent and private sector providers. The newly established Local Practitioner's Forum aimed to provide shared training and development opportunities. We attended a meeting of the forum and saw that it was well organised and attended. There was a broad range of staff present who were enthusiastic about the work of the forum.

Good practice examples

Lectures at Lunch and The Local Practitioners Forum

Lectures at Lunch is a monthly lecture series, open to all staff as well as staff from partner agencies such as health, education and voluntary and private providers. Staff also use the lectures to evidence ongoing development and PRTL for the SSSC.

The Local Practitioners Forum brought together staff from the social work service and staff from the independent sector in order to share information and learning and development opportunities.

The department's own staff survey found that 75% of those who responded thought that training had made staff more effective.

Resources and capacity planning

We found performance in this area to be good, having important strengths with some areas for improvement.

Much had been done to improve links between financial, strategic and operational plans for the social work service. We found this to be an area of strength. Budgetary control was well managed and budget holders benefited from strong financial support. We concluded that overall, financial management of the service was very good. We found resource management to be good overall, with work in progress to address improvements needed in asset and strategic risk management.

The service had made good progress in embedding the Carefirst information system but improvement was needed in joint information sharing and the system's capacity to generate management reports. There was still work to be done to develop the reporting and use of management information to support performance management and improvement.

We found partnership arrangements to be good overall, although the service needed to give early attention to developing robust and formalised agreements to govern partnership working and jointly managed services. However, partners and stakeholders were generally very positive about their partnership working with the service. There was evidence of how partnership working was having positive results for service users and carers.

There were a number of areas for improvement in commissioning arrangements. Significant shortcomings were the lack of commissioning strategies for the main adult care groups and children's services, lack of a clear rationale for the balance between in-house and commissioned services, and underdeveloped arrangements for procuring external services. More positively, we saw that the service knew what it had to do to address these issues.

Financial management

Financial plans

Budgeted spend for social work services was higher than GAE (Grant Aided Expenditure) for the three financial years to 2007-08 with the variance increasing. Budgeted spend for children and families services was consistently above GAE, and again the variance had been increasing. In 2007-08, the proportion of the council's social work budget for children and families services was above the Scottish average. In contrast, the budgeted spend per looked after child was comparatively low. Managers told us this reflected the relatively high numbers of looked after children in West Dunbartonshire.

The budgeted spend for older people was lower than GAE for the three year period. The service told us this was because older people's services had benefitted from significant other additional sources of funding, most notably resource transfer and supporting people funding which had helped in the development of care at home services. Later we refer to areas of older people's services where resources did not appear sufficient to meet needs.

The Community Plan 2007-17 represented the council's long term vision. The updated corporate plan covered the period 2008-12. We referred earlier in this chapter to Social Work and Health's Service Plan for 2008-12 which we found to be comprehensive. The financial framework laid out in the plan provided a clear breakdown of the department's indicative budget for 2008-12 and attempted to align the budget with how the service aimed to achieve its targets in respect of corporate priorities. Likewise, rolling four year operational/work plans for individual areas of the service contained indicative budgets for the four years. The service was also working on developing longer term financial and service planning arrangements for the department.

We saw that much work had been done in improving the links between plans since the best value review in 2006. Managers said there was now more 'ownership' of plans and that staff had improved their understanding of budget issues. We were satisfied that links between the plans were generally very good and that the budget was properly aligned with service priorities.

Budgetary control

In recent years Social Work and Health had controlled net expenditure at levels very close to the agreed budget. From discussions with a range of staff, and by reviewing council papers, we concluded the budget was well managed and that there were robust budgetary control systems in place. Managers told us they had confidence in the systems now in place.

The service's year end position for 2006-07 showed an underspend of over £500k against budget. The year end position for 2007-08 showed a £25k underspend. As in the previous year, the main area of overspend was in residential accommodation for young people. This was primarily due to fostering costs being higher than the budget because of the increased use of fostering agencies.

Other areas of overspend included residential accommodation for older people, due to the increased staffing ratios to meet Care Commission standards, residential accommodation for learning disabilities and the physical disabilities service.

Again as in the previous year there was a significant underspend in the home care budget in 2007-08. This was said to be due in part to rationalisation of home care provision and also due to income being higher than budget. Whilst recognising the other funding sources which had been used for home care and the service's generally good performance around the balance of care, some first line managers and staff described being unable to meet assessed needs for the service. We thought that the review planned for the home care service should not be restricted by any desire to maintain an underspend in the home care budget to help balance the service's overall budget.

We reviewed budget monitoring reports for the current year, 2008-09. The only material adverse variance reported was in the residential accommodation for young people budget. The projected overspend at the time of the inspection was approximately £250k. This was largely due to a significantly (34%) above inflation price increase, a small but costly increase in the number of secure accommodation placements and the recent reliance on external fostering agencies. It planned to try and address the latter through a review of its fostering service.

There were also some concerns about the projected overspend due to the cost of implementing single status, including the possibility of increased settlement costs. We heard that corporate provision had been made to meet most of the costs of single status.

The council's Corporate Management Team (CMT) met on a two weekly basis where revenue and capital monitoring reports were considered as a standing item. Health and Social Work's SMT and its extended management team both met monthly. The service told us budget monitoring reports were discussed at both forums. We looked at these reports and were satisfied they provided sufficient detail to enable areas of budget pressure to be reviewed and addressed.

We considered that liaison between management and front line budget holders within the service was very good. The involvement by budget holders in the budget setting process ensured budgets were generally properly set, realistic and allowed budgetary control to be well managed.

Capital expenditure/planning

The capital expenditure for the service in 2007-08 was in the region of £1.75m and was, at the end of the financial year, overspent by £25k.

We reviewed the council's capital plans for 2007-08 and 2008-09. Both included several projects for Social Work and Health. The most significant were the costs of improving fire safety in residential homes for older people, purchase of vehicles, and special needs capital adaptations and equipment. The fire safety costs were a considerable financial commitment, in the region of £100k to £150k per home. Work was underway on all of the service's six care homes at the time of the inspection.

Capital expenditure was monitored through corporate reports presented to the council and CMT on a bi-monthly basis. These reports showed the current forecasts for both resources and expenditure. Within the service, monitoring of capital spend was generally dealt with at meetings between finance staff and relevant heads of service. The SMT did not review spend on capital routinely or closely unless a particular issue arose.

The service said that many of its submissions for capital funding were driven by the need to meet Care Commission or health and safety requirements. Managers and staff interviewed thought the council had insufficient capital funding, but that Social Work and Health received a fair share of the total budget. Most were positive about the condition of the properties and the speed of repairs.

Income

The service had no single overarching charging policy, but was developing one which we saw and which complied with CoSLA's guidance. Charges were generally increased in line with inflation. Managers told us they thought West Dunbartonshire Council's charges were low compared to other councils.

At no time had the council charged for food preparation and therefore had not had to make any refunds in terms of free personal care.

Elected members role

Elected members are the ultimate corporate decision makers in local government and so it is important that they base their decisions on clear, complete and unambiguous reports.

The service presented financial position reports to committee on average every eight weeks. We were satisfied that the reports were comprehensive with sufficient detail for members to make informed decisions.

The Accounts Commission found in 2006 that decision making at the highest levels in the council was not as open and transparent as it should be. Senior managers told us members now took an active interest in financial performance reports and vigorously questioned issues where more detail or further explanation was required. Members could request more detail from officers on an informal basis if they wished.

The 2007 best value progress report highlighted the issue of leadership development for elected member and officers. Although managers said there had since been some briefings on financial matters as part of the member induction process, the issue of training for members had to be progressed. The council told us it was progressing a pilot project, along with the Improvement Service and a number of other local authorities, on a continuous professional development framework for elected members. We saw some further briefings for local elected members had recently been completed.

Financial skills within social work services

Budgetary control responsibility within the service was mainly held at service manager or section head level. There had been occasional instances of social workers managing small local activity budgets.

The service had a dedicated finance team which closely supported all budget managers. Financial guidance was issued corporately on an annual basis and was customised by the service. Budgetary control statements were issued electronically to budget holders on a monthly basis who had to account for any variances and confirm the action to address them. This system appeared robust.

The budget holders we met said they had a high level of involvement in the preparation of each year's budget. Regular meetings with the service's finance staff took place. They said the budget setting process took account of operational as well as strategic issues. They said there had not been any formal training but that there were financial elements in the staff induction process. They added that the finance team were very accessible and provided good support which helped them to improve their own financial management skills.

Resource management

Asset management

An asset management plan gives clarity about balancing service needs and available capital resources. It informs a sound capital planning process linking service priorities and objectives.

Effective asset management arrangements did not yet appear to be in place. An asset strategy group was established in 2007 which reported to the CMT. It was responsible for the preparation of the corporate strategy and plan. This had yet to be progressed to any degree. The director of corporate services said asset management had been recognised as an area which needed development.

An asset position was prepared in July 2008 which gave an overview of properties held by Social Work and Health and provided an indication of any problems in relation to the properties. We found that there were several significant asset management issues affecting the service, some of which were of longstanding and had considerable cost implications with very limited funding available to meet them. For example, this included the maintenance of the service's elderly care homes whilst the work on the protracted best value review was progressed.

We noted that property management provided briefing sessions for managers with asset management responsibilities when new systems were put in place or particular issues arose.

The asset management database for the council as a whole was maintained by the property department. There was no database specific to Social Work and Health.

Risk management

The best value report and subsequent progress report contained some criticisms of the council's approach to risk management.

We reviewed a revised corporate risk management strategy together with a policy statement, both dated October 2008. Regular progress reports were submitted to the audit and performance review committee and the CMT was kept informed of progress. Within the service we saw some evidence of risk management discussions at SMT and extended management team meetings, but they were not regular agenda items.

We saw both a corporate risk register and one for the service, dated January 2008. These had been inputted on to the Covalent system. The service had started to review its risk register on an annual basis, and action plans for each risk were documented by the most appropriate manager.

The service told us some training on managing risk had been provided by the council's insurers, but we saw this was less than that proposed within the corporate strategy. We noted the service's health and safety co-ordinator had extended his skills into the area of risk management.

Other than the lack of comprehensive ongoing risk management training to all appropriate staff, we were satisfied that the council and the service were continuing to develop their approach to risk management and to embed risk review procedures.

Health and safety

All health and safety policies were generated corporately. The service had customised the corporate policies to reflect its own requirements. We reviewed the updated policy for Social Work and Health dated August 2008. The detailed procedures which would underpin the implementation and effective application of the policy were being developed on a rolling programme by the health and safety co-ordinator together with short life working groups.

It was managers responsibility to ensure that their staff were made aware of the specific arrangements relevant to them and how they could easily access the service's health and safety policy documentation.

There was a departmental health and safety committee in place which the head of service for children and families and criminal justice chaired. This group had union representation and from personnel.

We noted that the health and safety co-ordinator provided training and briefing for staff. For example, an extensive exercise in training around fire procedures had recently been carried out. There was no formal training programme in place. Instead, relevant information was cascaded down from managers to all employees. We noted that health and safety information as part of the induction process was due for review.

Overall, we were satisfied that the council's arrangements for health and safety were well advanced and embedded in Social Work and Health.

Management information systems

Range of information systems

The service used Carefirst as its principal information system and it was supported by a dedicated team for development, maintenance and training. It was clear that field work practitioners used it operationally on a daily basis to record their work. In some residential and day care settings, only team leaders had access. Middle managers used Carefirst for both caseload and workload management and senior managers used it as the main source of information for reporting to committees on performance, planning and development. Operational and administrative staff reported that it was generally a good system although they raised some issues about duplication of input, speed and reliability. We heard the council was committed to a rolling upgrade programme for Carefirst to address these issues.

The Single Shared Assessment (SSA) tool and electronic assessment module CareAssess were fully compliant with national data standards. SSA administrative staff helped health practitioners to input and access relevant service user information in the absence of any electronic sharing. There was only limited use of the financial and care support Carefirst modules although plans had been made to extend their use. Managers reported that they were working on the specification of outcomes for service users and carers that could be evidenced through Carefirst. The service was actively involved in national forums looking at eCare, outcomes and standards and believed that this participation had helped their development of Carefirst.

The range of information systems in place also included piloting the corporate Covalent performance management software system. This was at a comparatively early stage with coverage limited to home care and addictions.

Carefirst's existing functionality allowed outcomes and progress on individual service users to be recorded. Senior managers acknowledged that there were shortcomings in their management information systems which they planned to address. These included the need for the sharing of information between Carefirst and health's community nursing system; implementation of the Integrated Assessment Framework (IAF) across the partners and the utilisation of Carefirst finance modules across all services. Managers had set target dates for these initiatives with a number due for implementation in 2009. In addition, the service had commissioned an improved report writing system called Actuate.

Use of management information

We refer earlier in this chapter to the Performance Management and Public Reporting Framework. Senior managers told us they used Carefirst as their key tool for monitoring and reporting on service activity to meet the requirements of the Framework.

We were given an example of elected members taking action to allocate additional resources in response to a report about the OT service waiting list.

Partnership arrangements

Strategic approach to partnerships

We refer earlier in this chapter to issues identified by Audit Scotland in relation to the West Dunbartonshire community planning partnership working. We heard during the inspection that the council was giving high priority to addressing these issues and was progressing the appointment of a senior manager for community planning.

Integration of adult community care and health services

We heard from managers and elected members and read reports that set out the background to the development of integration in adult community care and health services. Integrated teams for addictions and learning disability were well established in West Dunbartonshire with single management arrangements. There was also a joint mental health team with a head of service for mental health and partnerships located in the CHP.

In early 2005, the (then) NHS Boards for Greater Glasgow, and Argyll and Clyde agreed to establish a single CHP for West Dunbartonshire. A joint Community Health and Care Partnership was proposed, in line with the model adopted in Glasgow. West Dunbartonshire did not agree with the proposal because of concerns about the operation of a single structure across two health boards, and also because it was not convinced of the case made for an integrated children's service through which its statutory responsibilities for the protection of children could be delivered. Shortly afterwards, a unified NHS Board was established for Greater Glasgow and Clyde, and a 'health only' CHP was created for West Dunbartonshire.

The council and the local NHS had since adopted an incremental approach to further developing joint and integrated working arrangements. In 2007, the decision was taken to establish joint management structures for all adult community care and health services across the NHS CHP and the council, with three heads of service jointly accountable to the director of the CHP and the executive director of Social Work and Health. A programme of activity with agreed milestones was approved, with the intention that, over an 18 month period, the NHS and the council would decide whether or not they both wished to establish an integrated health and care partnership.

We noted that the milestones agreed by the partners had slipped, in significant part because of the absence of a head of service, and the executive director having to cover for the chief executive. Slippage included presenting a review of options for integrated children's services, presenting options for governance of integrated services and deciding on options for the integrated health and care partnership. This was all work in progress. We considered priority needed to be given to ensuring that joint governance and arrangements were fit for purpose. As noted earlier, the framework for joint accountabilities and line management in integrated partnerships was being progressed, but still had to be formally adopted.

As stated earlier in this chapter, we found an absence of adequate formal arrangements for joint working at this strategic level. The timetable for achieving this and other milestones appeared to have slipped.

However, we remained concerned about the length of time being taken to progress the establishment of appropriate governance arrangements, meaning that accountability and reporting arrangements remained unclear. The decision in 2007 to move to joint services under single management increased the necessity of having appropriate governance in place. As noted earlier, the framework for joint accountabilities and line management in integrated partnerships had remained in draft for a very protracted period.

In common with most areas, budgets were aligned rather than pooled and separate cost centres had been set up to capture costs incurred by the council for services provided in conjunction with partners. Joint financial reporting required improvement. There appeared to be no formal funding agreements or joint financial reporting systems in place for jointly managed services. The social work service only reported on its own budgets through the council's revenue budget reporting mechanisms. At the time of the inspection, no joint financial reports had been produced and presented to elected members, nor was there much evidence available of financial or budget issues being discussed jointly at any meetings of officers. We concluded that these were areas for improvement.

Recommendation 12

In advance of decisions about the way forward on integrated structures, partners should ensure that existing partnership governance arrangements are updated to cover all joint services under single management. They should also develop joint financial systems and reporting arrangements.

Partnership working and improved outcomes

We found much evidence of partnership working in what we read and in interviews with staff and other stakeholders. Services that were delivered through a partnership and which were having a positive impact and delivering some good outcomes, included the children with disabilities team, SNIPS (Special Needs In Pregnancy service), the substance misuse teams, the domestic abuse pathfinder project and the community older people's teams. The staff we met in all of these services highlighted the very important role of partnership working in what they were able to achieve.

Reported outcomes for older people from these arrangements included shifting the balance of care, reduction of delayed discharge and the development of carer services. We heard from staff that integrated management arrangements in addiction services were beneficial and from care home providers that their partnership with the department was positive.

We were particularly impressed with the work of the service around the issue of cancer poverty and the partnership it had developed on this with the Macmillan Carers Service and the NHS. This was founded on the recognition of the need for sensitive and effective services to meet the benefits and social care needs of cancer patients and their carers. As part of this, West Dunbartonshire was leading the roll out of the advice and care network attached to the Beatson Oncology Project in Glasgow. At the time of our inspection 26 local authorities had adopted the model. In addition the service had:

- seconded a senior welfare rights officer to resource the national development of the network;
- developed a UK-wide advice toolkit; and
- contributed to the national strategy for cancer care.

Good practice example

Social Work and Health had made a major contribution to the understanding of the relationship between cancer and poverty and to the roll out of a national advice and care network.

The social work staff involved with SNIPs told us that they would not be able to engage anything like as effectively with the pregnant women without the service's partnership approach.

We learned that the department worked closely with the voluntary sector across a wide range of services through many agencies including: Women's Aid, the Citizen's Advice Bureau, Includem childcare, the carers centres and advocacy services.

Comments in our partners and stakeholders survey also pointed to good partnership working. One commented that having worked with a number of local authorities: *"I am strongly of the opinion that West Dunbartonshire's social work service has the most effective partnership approach that I have experienced"*.

Good practice example

The domestic abuse pathfinder project was a partnership project which considered the circumstances of children living in households affected by domestic violence. The partners, including the police, health, education, the Reporter and the social work service shared information to agree the best response. The partnership approach was reducing the need for compulsory measures of care and providing co-ordinated involvement with the children and their families.

Protocols for sharing information and assessments

We read the recently updated Greater Glasgow and Clyde Protocol for Information Sharing between the Health Board and six partner local authorities. It is a very comprehensive guidance document that follows the structure of the Data Sharing Framework issued by the Information Commissioner. There was a Data Sharing Partnership and guidance for staff which required revision in line with the updated protocol. The SSA tool complied with National Data Standards. Joint protocols and procedures were in place to ensure clarity in responsibilities, accountability, referral pathways and care planning.

We read that the JSG for children's services had agreed the assessment of the needs of children and young people should be based on shared information across the partner agencies and that there were protocols in place to achieve this. There was already electronic sharing between social work, education, health and the SCRA and there were plans to extend this to the police and other agencies.

Commissioning arrangements

Strategic commissioning

The service acknowledged that it had not taken a strategic approach to commissioning, although we heard that the development of an overarching commissioning strategy was being given priority at the time of the inspection, and was scheduled to be completed in 2009. The department's service plan identified the development of commissioning strategies as a priority for the service. Work to take this forward, particularly in children's services, was at an early stage.

In adult services, we did not find comprehensive written commissioning strategies for the main care groups. We noted that the best value review of older people's services provided a good foundation for a commissioning strategy as it identified the kinds and levels of service needing to be commissioned until 2025. More detailed planning was underway following committee approval of this approach.

We noted the contents of a very recent draft commissioning strategy for addiction services. This had the aim of providing a service configuration and the means to achieve it. It usefully described how the services should interface to provide a comprehensive care system, but did not indicate resource requirements or how they might be commissioned jointly by Social Work and Health.

Thinking on strategic commissioning of children's services appeared to be very underdeveloped. This required to be addressed not least because, as noted earlier, purchasing activity in relation to residential schools and external foster care placements were the cause of significant budgetary pressures. We read in a recent committee report that a best value review of youth justice services had recommended the redesign and re-commissioning of some services from external providers. Without an overarching strategy, however, the department was not in a strong position to make progress in these areas.

Directly provided and purchased services

Reports indicated that the approximate value of commissioned services for 2008-09 was £29.8 million which was around 46% of the department's total gross expenditure.

There was not an existing document which addressed the issue of the balance to be struck between directly provided and externally purchased services. The service informed us this would be addressed as part of the commissioning strategies. We spoke to elected members who took the view that there should be a mixed economy of care but believed that the council, as the largest employer in the area, should have many in-house services. They also believed it was easier to monitor services provided internally. It appeared from discussions with managers that decisions were made on a service by service basis. Decisions were ad hoc rather than strategic. We found a willingness to support new external services through partnership working, particularly with voluntary sector organisations. Overall, there did not appear to be a clear rationale for what was directly provided and what was commissioned, and it was difficult to see how the council could ensure that it was delivering best value.

Service-wide commissioning

We read that the main areas of commissioned services were: residential schools; foster care; care home services; housing support for older people and those with dementia; specialist residential care and housing support for people with learning disability, physical disability, mental health issues and acquired brain injury; respite services; residential and day addiction services; and domestic abuse related services.

Contracting processes

The current Approved Providers List (APL), which was being updated at the time of the inspection, comprised 87 accredited organisations of which 59 were in the voluntary sector and 28 private companies. It was not a complete list of all the organisations from which services were purchased.

The service used a variety of processes which were intended to comply with the council's standing orders, in particular those governing tendering and contract value. The types of contract used included block, call off, cost and volume, and grant awards. Providers were assessed before being placed on the APL. The service had also implemented the national care home contract. However, we did not find evidence of consistency in approach or a system to ensure effective contracting, monitoring and review of commissioned services.

We met representatives of around a dozen community care providers in the independent sector delivering services to five types of service user. They described a varied picture of contractual arrangements with the majority signed up to service level agreements (SLAs) rather than contracts. They considered the SLAs more meaningful given annual funding was still the norm. Their perception was that contract monitoring was also variable, as was the amount of performance data required. Most reported that the responsibility for arranging service user reviews rested with them rather than departmental staff.

We found that the service was in the course of addressing these weaknesses. We read documents on the provider Accreditation Process, Guidance on Purchasing and Guidance on Service Reviews. They appeared to be at a draft stage but their contents suggested that they would, if implemented, go a long way towards introducing a systematic approach.

Recommendation 13

The service should take a strategic approach to the purchase and direct provision of services. This should include the development of written commissioning strategies, improved purchasing processes and systematic monitoring and review arrangements.

CHAPTER 7

Leadership and direction

We rated performance in this area to be good, having important strengths with some areas for improvement.

At the time of our inspection, the council as a whole was emerging from a difficult period, brought about by a highly critical audit of best value and community planning. The more telling criticisms in the Audit Scotland report had not been directed at the social work service. Across the council, there were signs of improvement at service, corporate and community planning levels, although political tensions, and until recently, a lack of capacity at senior management level both corporately and within the service, had contrived to obstruct recovery. Despite this, signs of greater political stability were beginning to emerge.

Managers and front line staff had worked hard in this difficult and challenging context and had managed to provide good social work services.

We found a coherent set of values and aims and saw that Social Work and Health contributed well to the corporate and community planning agendas. Strategic partnerships were characterised by shared purpose and positive working relationships.

We found evidence of effective political scrutiny, but there was the potential for this to be undermined by a high degree of political conflict.

The role of the Chief Social Work Officer was effectively undertaken by the executive director of Social Work and Health. He intended to make aspects of the role more distinct and visible. He was well supported by senior managers.

Vision, values and aims

Promotion of vision and values

The stated vision of Social Work and Health in West Dunbartonshire reflected those statements made on behalf of the community planning partnership and local authority as a whole. This vision, set out in the social work service plan was 'to support individuals in communities, to be healthier, wealthier, fairer, safer, more tolerant and more inclusive'. Service plans also included a statement of values, derived from that developed by the British Association of Social Workers. These values included human dignity and worth, social justice, service to humanity, integrity and competence.

The single outcome agreement, including both national and local outcomes, reflected a number of key social work priorities and objectives included in the corporate plan – these in turn having been accepted as corporate priorities. These included:

- shifting the balance of care provision for older people towards care at home; and
- improving services to vulnerable children.

To varying degrees, all elected members and senior managers we spoke to were able to articulate and reflect key elements of this vision. In particular, the leader of the council saw people wanting to come and live in West Dunbartonshire as central to this. He regarded it as an important part of his role to improve how others perceived both the area and the council. He was well aware of West Dunbartonshire's poor health and social deprivation indicators and wanted the council to do all that it could, along with community planning partners, to make a real difference to people's quality of life. In that sense, he had a good grasp of delivering outcomes, and the important role and contribution of Social Work and Health in achieving this.

The chief executive expressed satisfaction with the contribution Social Work and Health made in identifying corporate priorities for the local authority. He was particularly positive in relation to the social work contribution to child protection. As chair of the chief officers group in West Dunbartonshire he was appreciative of the help and advice received from the head of children's services and criminal justice, who also chaired the child protection committee.

The establishment of the new corporate management team had signalled a move away from a group of managers primarily focused on their own services, to a team of directors taking on a more corporate level of responsibility within the local authority. This was regarded by a number of senior managers that we spoke to as facilitating an enhanced level of involvement by Social Work and Health across the corporate agenda. For example, we learned about the development of a series of elected member seminars, and were given the example of the executive director providing an input to a recently held seminar on the corporate debt policy. This provided the executive director with an opportunity to highlight the impact and potential consequences of corporate debt policy on vulnerable groups and, by implication, on social work services.

The links between the single outcome agreement and community planning partnership were still to be established. Progress in community planning had been hindered due to difficulties in recruiting a community planning manager (an appointment was subsequently made after the fieldwork stage of the inspection). All partners we spoke to expressed some optimism that previous difficulties were now being overcome.

The council and the service were at an early stage in developing their response to recent national policy on corporate parenting. This was acknowledged by the leader of the council, the chief executive and the executive director. This said, senior social work managers had started introducing the concept across the council, both amongst senior colleagues and elected members. Both elected members and senior managers in other services we spoke to were aware of their responsibilities to looked after children and young people. The council's generally strong performance in relation to the educational attainment of looked after and accommodated young people, and the positive outcomes being achieved by the throughcare and aftercare service with its partners provided evidence of actual good practice consistent with corporate parenting.

Leadership of people

Positive leadership culture

In what had been a very difficult period following the Audit Scotland report, we saw that senior managers, operational managers and front line staff in the social work service had worked hard and managed to maintain a good level of service to the public. The political instability during this period and the uncertainty that came with it had not always been conducive to effective planning and decision making around social work services.

The service's SMT had recently been bolstered and its capacity increased by the establishment of three new posts at head of service level. Prior to this, much of senior management responsibilities for the service rested with the current executive director and head of children and families and criminal justice services who had both worked in the service for a considerable time. We heard numerous positive comments from a range of staff and partners and stakeholder organisations about their key role in promoting, sustaining and supporting the social work services in difficult circumstances. The executive director was described as being very visible and approachable. Other organisations and agencies, and most notably the local ones commented on his commitment to partnership working. We heard nothing but very positive comments about the head of children and families and criminal justice services.

The executive director carried out the role of Chief Social Work Officer in West Dunbartonshire. The chief executive displayed a good understanding of the significance of this position within the council. He considered the fact that the director held the CSWO role helped in maintaining its profile. He had regular meetings with the executive director/Chief Social Work Officer every 4-6 weeks. In the course of the meetings, there was no differentiation between matters relating to the Chief Social Work Officer and those relating to the role of executive director.

At the corporate level it was evident that the two main political groups in the council were continuing to experience some significant difficulties in their working relationships. During the two weeks we spent in the authority, the administration survived a vote of no confidence. Many we spoke to – elected members, senior managers and front line staff – expressed guarded optimism that this vote would lead to a greater degree of stability and co-operation at elected member level for the remainder of the term of this council.

There was agreement that political differences had not normally spilt over into dealings on social work matters. At the meeting of the Social Work and Health committee we attended, we witnessed proper scrutiny, thoughtful debate and a level of agreement and understanding across the political groupings.

Involvement of staff

From staff focus groups, but less so from our survey, we found a largely positive view of senior managers amongst front line staff. The trade union representatives we met were a significant exception.

Staff views of elected members and the council's corporate leadership compared with managers in Social Work and Health were generally not positive. Views of elected members tended to be more positive amongst senior officers. Despite the fact that nearly all the elected members we met were highly complimentary and appreciative of the efforts of social work staff, most front line staff did not feel valued.

We also came across a perception from a number of sources that elected members continued to exercise undue interference in operational matters – resulting in some professional decisions being overturned. For example, one group of staff spoke of intervention by elected members leading to alterations to care packages, which did not match the assessment of need. This was considered by them to be unfair. Another group of front line staff gave examples of elected members overriding management decisions. They found this demoralising and added that the new administration was no improvement on the previous one.

Senior managers we spoke to, both within the service and corporately, told us that they were not aware of this as an issue. It was accepted practice that elected members could contact front line managers in the event of concerns they had on behalf of a constituent. However, both senior managers and elected members considered that the majority of elected member enquiries were made via the executive director or head of service. Indeed a number of elected members said they preferred this arrangement because they were concerned that contacting operational services direct might be misinterpreted by staff as an attempt at elected member interference.

Representing their constituent's is an essential part of the role of elected members. However, we were concerned to note that a number of staff voiced feelings of vulnerability to what they perceived as undue or inappropriate interference in operational matters. Senior managers should address this apparent discrepancy and, if necessary, consider the introduction of more formal arrangements in dealing with officer – elected member dealings.

Leadership of change and improvement

Political leadership and capacity

In order to carry out scrutiny and political decision making in Social Work and Health matters, responsibilities were split between the Education and Lifelong Learning and Social Work and Health committees. This was generally regarded as a satisfactory arrangement, although we heard some elected member comment that social work items rarely featured near the top of the Education and Lifelong Learning agenda.

The respective convenors of the two committees had been in office for less than two years and were candid in acknowledging that in the early stages, their relative inexperience meant that they had tended to follow the lead provided by officers. However, they both expressed confidence that their respective committees were less affected by political differences, and had developed in providing appropriate levels of scrutiny and confidence in making policy decisions. Most elected members we met stated that the standard of Social Work and Health reports, both in terms of detail and balance, were generally better than those submitted from some other council services. The ability of senior social work managers to explain complex issues in person to committee members was positively commented on.

Opposition members complained about a lack of transparency and willingness on the part of the administration to share information in the run up to formal council meetings. They considered this to have a detrimental effect on their ability to scrutinise council decisions and performance. For their part, members of the administration, considering the current political climate, held that providing this information at an early stage might compromise their ability to carry out the business of the council effectively, due to the possibility of unconstructive use of information provided in advance of meetings.

However, from our direct observation of the Social Work and Health committee, as well as our meetings with the leader of the council and committee convenors, we were satisfied that senior elected members were committed to the improvement in Social Work and Health, and that the means for political scrutiny were in place. However, we considered that more constructive engagement with opposition members would both strengthen the levels of scrutiny and lead to greater efficiency in conducting the business of the council.

Leadership of change

As stated above, we found evidence of improvement across social work services. This was supported by the views of some stakeholders. We were particularly encouraged, especially given the previous history, by the positive comments from West Dunbartonshire CHP and NHS Greater Glasgow and Clyde, both of whom now accepted and shared the council's desire to move towards more integrated services in an incremental way.

Significant increases in management capacity at both corporate and service levels had, in our view, led to some improvement in the ability of managers to lead the necessary changes in West Dunbartonshire. In Social Work and Health, this had allowed the establishment of three additional senior management posts and increased the senior management team from three to six people. As stated earlier in this report, there had been concerns in the past that the pace of change had not always been sustained, leading to delays in improvement. There was evidence that this desired increase in momentum was yet to be fully achieved. For example, we looked at the minutes of the social work departmental management team for the period January to May 2008. These were characterised by some reports and papers not being brought to future meetings within the timescales set out in the minutes. This had sometimes been down to lack of capacity; other times due to political instability (for example, delays in introducing single status). We considered it important that the recent improvements shown in both these areas are built on and sustained.

Generally, local authority leadership in a number of partnership arrangements, including child protection, was held in high regard. These views were expressed by a range of stakeholders, from large organisations such as the NHS, police and Reporter's Administration, through to smaller voluntary organisations, and independent providers of services. There was recognition that that the service had largely been able to sustain, and in some instances improve, its performance against statutory performance indicators in difficult circumstances within the council.

However, we had concerns about partnership working in criminal justice. There was no clear link between the Community Justice Authority area plan and the community plan for West Dunbartonshire. The operational plan for criminal justice services in West Dunbartonshire lacked sufficient detail. We concluded that operational planning of criminal justice services in West Dunbartonshire needed significant attention.

In addition, although there was a positive relationship and shared purpose in relation to the partnership with the NHS, we had some significant concerns regarding the establishment of suitable governance and joint financial systems in support of integrated working arrangements, as covered in chapter 6.

The role of the Chief Social Work Officer (CSWO)

The executive director had recently given thought to making the lines of accountability and certain other aspects of the CSWO role clearer and more explicit, and had prepared a committee report, based on the council's response to a recent consultation exercise undertaken by the Scottish Government. The report contained details of the consultation response, as well as a draft framework aimed at defining and delivering accountability on the part of the CSWO. This envisaged a number of reporting mechanisms, including an annual CSWO report to the council. We considered this to be a positive development.

Capacity for improvement

We found West Dunbartonshire's capacity for improvement to be good, having important strengths with some areas for improvement.

We have based our evaluation of capacity for improvement on three key factors:

- **improved outcomes for people who use services;**
- **effective leadership and management; and**
- **quality improvement and performance management.**

Social Work and Health delivered some good services and outcomes for a wide range of service users. It needed to improve outcomes for carers and to press ahead with its work to measure outcomes for all service areas.

We found some good evidence of effective leadership and management. This was likely to be enhanced by a recent increase in senior management capacity. It was supported by some good partnership working, but sometimes had not been helped by political instability within the council.

During the period under inspection the focus on performance management and quality improvement in the service had increased significantly.

Improved outcomes for people who use services

We found Social Work and Health delivered some good outcomes for many service users. In our survey of service users and file reading exercise, the findings about service outcomes were generally positive. For example, almost all service users agreed that social work services had helped them to lead more independent lives and in the majority of case files, the individual's circumstances had improved. More did however need to be done to improve outcomes for carers and around dementia.

Within children and families services, some very good outcomes were being achieved for looked after accommodated children and young people, both in their educational attainment, and also in terms of the throughcare and aftercare support provided to them. The service had an impressive commitment to working with children and families on a preventative basis, as evidenced for example, by the family support and groupwork teams. This said, comments we heard about levels of contact with children by their social workers means the service needs to ensure this is not at the expense of its statutory obligations.

The inspection found that some aspects of the criminal justice service in West Dunbartonshire needed attention and improvement. The senior managers in Social Work and Health accepted this and suggested that some of their attention to their wider partnership working may have been at the expense of action locally. They also questioned whether the lack of a service manager with a dedicated responsibility for the service in West Dunbartonshire (rather than with partnership wide responsibilities as well) was also a factor.

Most of the performance figures for adults with learning disabilities were above the national average and this was the only service area where we heard much about personalisation. The service faced a challenge in sustaining some existing care packages. There was more limited performance data for some other adult care services, including mental health and substance misuse. However, we saw examples of good outcomes in these areas and services, which in the form of the Acquired Brain Injury Team and Community Addictions Teams appeared well positioned to deliver good outcomes.

For the most part, West Dunbartonshire performed strongly in supporting older people to live at home in the community. It had taken demonstrable action to improve outcomes around shifting the balance of care, for example by its investment in SMART technology and around delayed discharge. Some aspects of its home care service were not sufficiently flexible and, as with other service areas, work on commissioning needed to be advanced if improved outcomes were to be delivered in the longer term.

Whilst a focus on and understanding of meaningful outcomes for service users and carers was not yet fully embedded across the service, we saw evidence this was being encouraged and was developing. It had taken some specific steps to measure outcomes, but still had much to do before this was in place across the board.

We concluded that the service's capacity to deliver improving outcomes was underpinned by a committed and competent workforce. Despite major disquiet about single status and some below average findings in our staff survey, this did show that most staff (86%) enjoyed their job. This was reflected in focus groups where staff we met were generally well motivated. Comments they made about working for the social work service were usually positive, compared to those about working for the council which tended to be more critical. We heard from senior managers in the council that the protracted single status considerations were near conclusion.

The workforce was a stable one with relatively low levels of staff turnover. Supervision arrangements were well embedded and there was a good range of personal development opportunities.

Effective leadership and management

We found effective leadership and management throughout much of Social Work and Health. It had a fairly comprehensive service improvement plan. We saw from this and from its own self evaluation that it had a good understanding of which parts of its service provision were most in need of improvement. There were detailed operational plans for the individual service areas, but plans at individual team and unit levels were still the exception rather than the norm. In our survey, the majority of staff (70%) agreed that there was a clear set of social work priorities. Fewer (48%) agreed there was a clear vision for social work.

We met with a wide range of partner and stakeholder organisations during the inspection. They were nearly always very positive both about the service's commitment to partnership working and also about the senior managers they dealt with. They described them as being visible, accessible and good to do business with. Most staff we met expressed similar views with some commenting that the relatively small size of the authority and short lines of communication facilitated this.

The social work service does not operate in a vacuum. Within the council, we heard that it made a good corporate contribution. The position about how social work was supported by others was generally positive. West Dunbartonshire has relatively high levels of social deprivation. Elected members and senior managers from other departments linked this to the important place and role of the social work service in the authority. We saw some good evidence of joint working with the education and housing services to support vulnerable children and young people. The service had been funded for several years at a level above GAE.

Partnership working with health had been complicated and affected to a degree by the service's and council's relationship with Greater Glasgow NHS, the establishment of CHPs and by the disbanding of Argyll and Clyde Health Board. This appeared to be more settled by the time of our inspection. The progress being made around the future of the Vale of Leven Hospital provided some evidence of this. So did the general agreement about the approach towards future service integration, notwithstanding the need for proper governance arrangements to be established.

We have commented in the report on the ways in which the best value audit and the political instability within the council had, and had not, impacted on the delivery, planning and development of social work services. In terms of capacity for improvement, the increase in Social Work and Health's senior management capacity was a welcome development.

Quality improvement and performance management

The service had completed best value reviews of older people's services and youth justice as part of a best value programme. There had been some significant delays in completing the two reviews and in the programme as a whole. The Accounts Commission's Best Value Audit had been instrumental in concentrating council attention on developing a performance management framework. It was implementing the Public Service Improvement Framework (PSIF). In Social Work and Health this had been piloted in the welfare rights service. As part of the corporate continuous improvement strategy, PSIF was going to be rolled out across the service in conjunction with SWIA's performance inspection model 'to ensure a social work context is considered'.

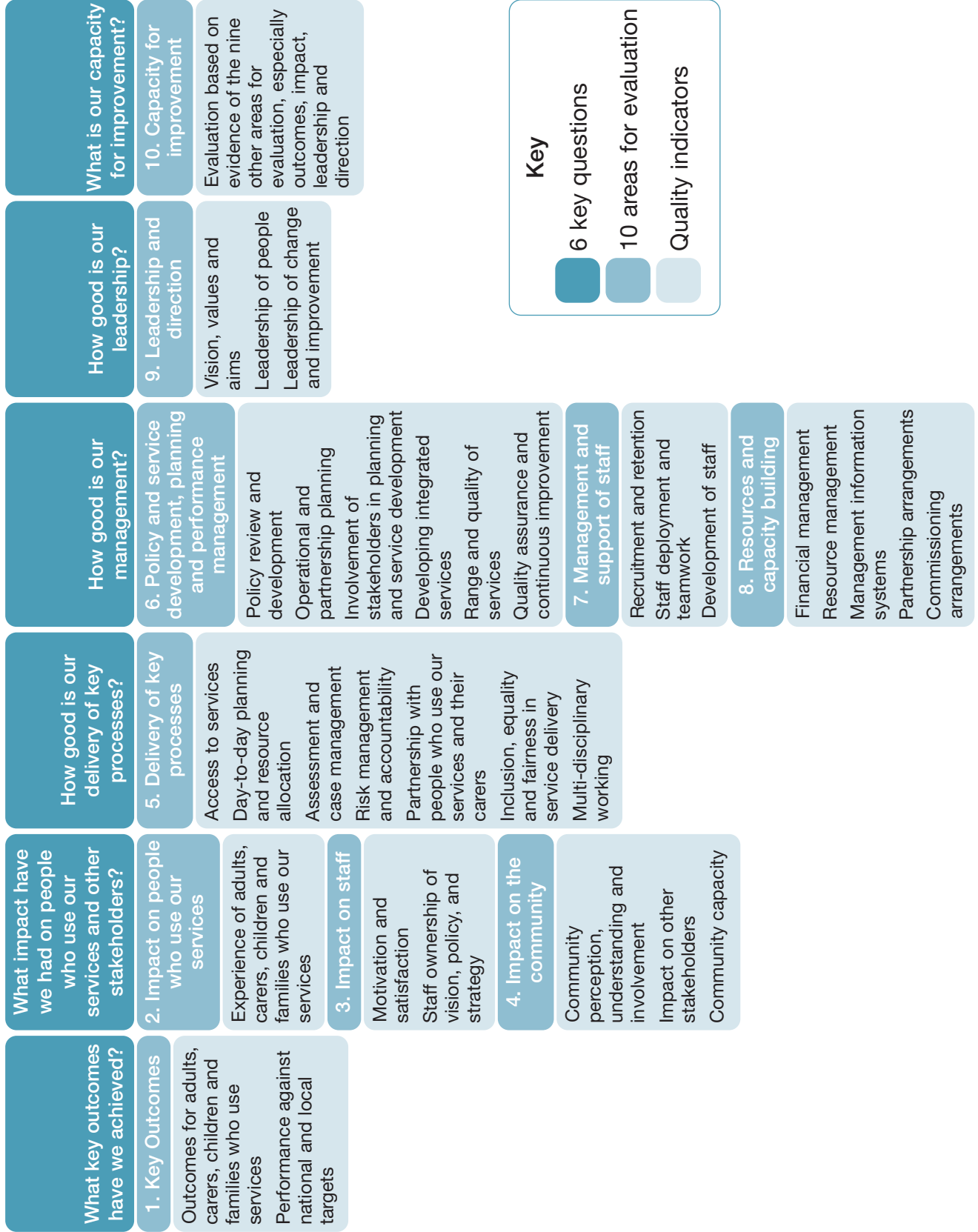
There were procedures in place for case recording, supervision and case file audits. Our file reading showed above average evidence of the impact of worker supervision sessions, although there was still a need for improvement in this and also in the extent of scrutiny of files by managers. A number of case file audits had been done, and an audit programme until 2010 was in place.

The council had moved to establish a performance monitoring and reporting framework and had recently purchased the Covalent system to support this. There was still work to be done to link this with the service's Carefirst system. However, we saw that a wide range of social work performance data was now being reported within the service, the council and publicly.

Conclusion

Social Work and Health had worked hard in an effort to deliver good quality social work services. Sometimes this had been in the context of significant political instability within the council. We concluded that whilst the capacity of the service to deliver improving outcomes for service users was not necessarily dependent on a period of political stability, it would certainly be of benefit.

Performance Inspection Model (PIM)



Key

- 6 key questions
- 10 areas for evaluation
- Quality indicators

APPENDIX 2

SWIA performance inspection methodology

The team conducted this inspection using the SWIA's performance inspection model (PIM). Senior social work managers in the council were asked to consider the following six key questions and develop a self evaluation of their performance. The same six key questions were used to structure the fieldwork in the council. This report reflects the PIM, with a chapter addressing each of these questions.

1. What key outcomes have we achieved?

Here the inspection team gathered evidence on the actual difference that social work services have made, and are making, to the lives of individuals, families and communities. SWIA defines outcomes as the improvements in peoples lives directly resulting from the social work services they receive.

2. What impact have we had on people who use our services and other stakeholders?

The inspection team looked at the direct experience and perceptions of the people who use social work services as well as those of employees and other stakeholders.

3. How good is the delivery of our key processes?

Here the inspection team looked at the day-to-day planning, management and delivery of services from initial contact with the person using the service through assessment and care planning.

4. How good is our management?

This involved examining managers and staff's understanding and implementation of broad national and local strategic plans and objectives, their dissemination, monitoring and review of organisational strategy, along with performance management, integrated working, staffing and financial responsibilities.

5. How good is our leadership?

Here the inspection team looked at corporate vision, values and aims, the ability to work together across council departments, organisational culture and the leadership and management of change at all levels.

6. What is our capacity for improvement?

Here the inspection team brought together all the evidence and reached an overall evaluation about the capacity for improvement, taking into account both strengths and areas of weakness.

The inspection team reached evaluations based on the 10 areas for evaluation in the Performance Inspection Model. The full PIM is set out in appendix 1.

SWIA performance inspection process

The lead inspector for this performance inspection was Richard Fowles (telephone 0141 249 6862).

Along with the completion of a self evaluation questionnaire, we began the inspection process by asking West Dunbartonshire Council to provide background information including strategic plans, policies, guidance, procedures, commissioning arrangements and information relating to performance, finance and quality assurance. We also read the reports relating to the council from other regulatory bodies and inspectorates including Audit Scotland, the Scottish Commission for the Regulation of Care (Care Commission) and Her Majesty's Inspectorate of Education (HMIE).

Questionnaire and file reading statistics

Questionnaires	Number issued	Number returned	Response rate
Service users	500	110	22%
Carers	500	108	22%
Staff	500	174	35%
Partners and stakeholders	50	16	32%

File reading		Number
Total files read		106
of which	Children and families	40
	Community care	66

Fieldwork

Together with six staff from West Dunbartonshire Council, we spent four days reading case files from a cross section of care groups.

We then spent 10 days in West Dunbartonshire looking at services for children, young people and their families, services to adults (physical disability, learning disability, mental health and substance misuse), and services to older people. We also examined strategic planning and support services.

Appendix 3

We examined services in a number of ways:

- meeting people who use social work services and carers;
- interviewing staff at all levels of the organisation, both individually and by bringing them together in focus groups;
- meetings and interviews with councillors and with staff from other parts of the council;
- meetings with partner organisations providing services;
- observation of relevant meetings and visits to a range of services; and
- direct observations of social work practice – some examples taken from the case file reading exercise.

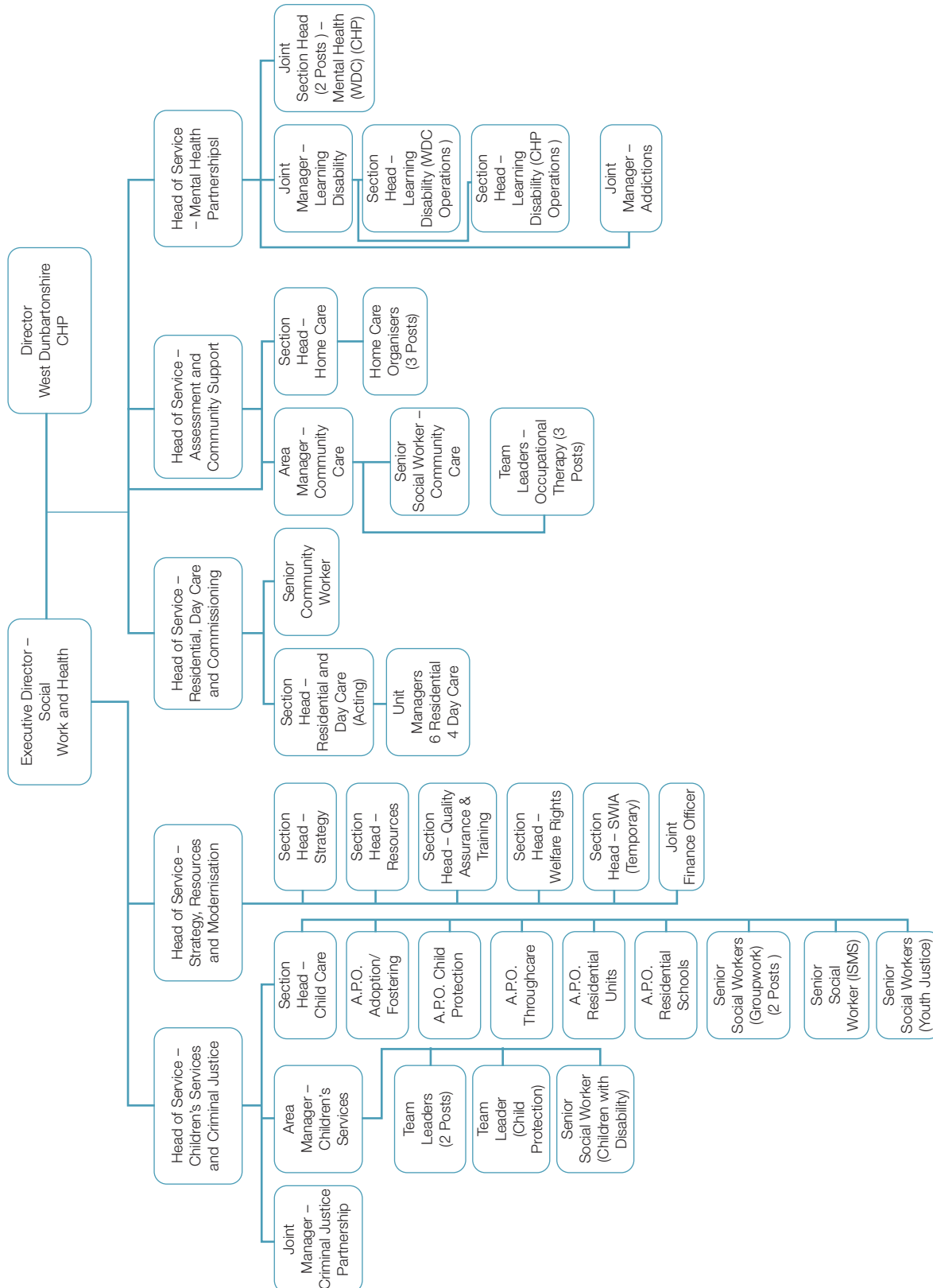
The table below sets out the number of sessions we undertook.

Inspection activity	Number undertaken
Visits to centres and offices	1
Meetings with people who use services	12
Meetings with carers	5
Meeting with front line staff, first line managers and middle managers	35
Meetings with senior social work managers, council officials and elected members	13
Meetings with partner and provider organisations	16
Observation of meetings	6
Observed practice, case file and good practice follow up	16
Total sessions	104

After the inspection

Following the inspection, the council will be asked to develop an action plan to take forward the recommendations in the performance inspection report. SWIA will monitor the improvements taking place over the next year and will undertake a follow up inspection one year after the publication of the performance inspection report.

West Dunbartonshire Council social work services structure chart



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