Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee

Date:	Wednesday, 25 June 2025
Time:	14:00
Format:	Hybrid Meeting, Civic Space, 16 Church Street, Dumbarton G82 1QL
Contact:	Natalie Roger, Committee Officer natalie.roger@west-dunbarton.gov.uk committee.admin@west-dunbarton.gov.uk

Dear Member

Please attend a meeting of the **West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee** as detailed above.

Members will have the option to attend the meeting in person at the Civic Space, 16 Church Street, Dumbarton G82 1QL or remotely via Zoom Video Conference.

The business is shown on the attached agenda.

Yours faithfully

JULIE SLAVIN

Chief Financial Officer
Health and Social Care Partnership

Distribution:-

Voting Members

Fiona Hennebry (Chair)
Michelle Wailes (Vice Chair)
Libby Cairns
Lesley McDonald
Michelle McGinty
Martin Rooney

Senior Management Team – Health and Social Care Partnership
Chief Executive – West Dunbartonshire Council

Date of Issue: 17 June 2025.

Audio Streaming

Please note the sound from this meeting will be recorded for live and subsequent audio streaming. All of this meeting will be audio streamed and will be published on West Dunbartonshire Council's host's webcast/audio stream platform.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD
AUDIT AND PERFORMANCE COMMITTEE

WEDNESDAY, 25 JUNE 2025

1 STATEMENT BY CHAIR – AUDIO STREAMING

2 APOLOGIES

3 DECLARATIONS OF INTEREST

Members are invited to declare if they have an interest in any of the items of business on this agenda and the reasons for such declarations.

4 RECORDING OF VOTES

The Committee is asked to agree that all votes taken during the meeting be done by roll call vote to ensure an accurate record.

5 (a) MINUTES OF PREVIOUS MEETING 7 - 10

Submit for approval, as a correct record, the Minutes of Meeting of the Health and Social Care Partnership Board Audit and Performance Committee held on 18 February 2025.

(b) ROLLING ACTION LIST 11 - 12

Submit for information, the Rolling Action list for the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee.

6 AUDIT PLAN PROGRESS REPORT 13 - 22

Submit report by Andi Priestman, Chief Internal Auditor, enabling Members to monitor the performance of Internal Audit and gain an overview of the Board's overall control environment.

7/

7 GLOBAL INTERNAL AUDIT STANDARDS 23 - 26

Submit report by Andi Priestman, Chief Internal Auditor, informing the Committee of the new Global Internal Audit Standards (UK public sector) that came into effect from 1 April 2025.

8 ANNUAL REPORT ON THE AUDIT AND PERFORMANCE COMMITTEE FOR THE YEAR ENDED 31 MARCH 2025 27 - 34

Submit report by Andi Priestman, Chief Internal Auditor, providing Members with the Audit and Performance Committee Chair's 2024/25 Annual Report on the Audit and Performance Committee.

9 INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2025 35 - 42

Submit report by Andi Priestman, Lead Internal Auditor, providing information on the internal audit work carried out for the year ended 31 March 2025, which contains an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health & Social Care Partnership Board's internal control environment that can be used to inform its Annual Governance Statement.

10 MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE: MEASURING PROGRESS UNDER INTEGRATION 43 - 64

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an update on the status of the "Progress with Integration of Health and Social Care, West Dunbartonshire Health and Social Care Partnership Action Plan"

11 BEST VALUE STATEMENT 65 - 76

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing a statement in relation to how the HSCP Board has delivered Best Value during the previous financial year.

12 EXTERNAL AUDIT PROGRESS REPORT AND INFORMATION REQUEST TO THOSE CHARGED WITH GOVERNANCE 77 - 102

Submit report by Julie Slavin, Chief Financial Officer, presenting a progress update from Forvis Mazars on their responsibilities as external auditors for the HSCP Board.

13 2024/25 CODE OF GOOD GOVERNANCE AND ANNUAL GOVERNANCE STATEMENT **103 - 122**

Submit report by Julie Slavin, Chief Financial Officer, informing the Audit and Performance Committee about the annual self-evaluation of the Board's compliance with its Code of Good Governance and related improvement actions.

14 ANNUAL PERFORMANCE REPORT (SCRUTINY) **To Follow**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an update on the above.

15 DRAFT UNAUDITED ANNUAL ACCOUNTS **123 - 232**

Submit report by Julie Slavin, Chief Financial Officer, presenting the unaudited Annual Report and Accounts for the HSCP Board covering the period 1 April 2024 to 31 March 2025

16 ANNUAL CLINICAL AND CARE GOVERNANCE REPORT 2024 **233 - 282**

Submit report by Val Tierney, Chief Nurse, describing the clinical and care governance oversight arrangements in West Dunbartonshire HSCP and the progress made in assuring and improving the quality of health and social care.

17 ANNUAL REPORT FOR MUSCULOSKELETAL PHYSIOTHERAPY SERVICE 2024/25 **283 - 342**

Submit report by Helen Little, Musculoskeletal Physiotherapy Manager, presenting the Annual Report for Musculoskeletal (MSK) Physiotherapy Service (Greater Glasgow and Clyde) 2024/25.

18 WEST DUNBARTONSHIRE COLLABORATIVE CARE HOME SUPPORT TEAM ANNUAL REPORT 2024 **343 - 372**

Submit report by Val Tierney, Chief Nurse, providing an update on the work of West Dunbartonshire Collaborative Care Home Support Team [CCHST], and two associated sub groups - The Care Home Practitioners Group & the Care Home Managers Group.

19/

19 REGULATED SERVICES REPORT 373 - 414

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an update on Care Inspectorate inspection reports for externally commissioned registered services located within West Dunbartonshire and internally provided services by West Dunbartonshire Council whose service delivery is caried out by the HSCP

20 STRATEGIC RISK REGISTER SIX MONTH REVIEW 415 - 430

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, presenting the Strategic Risk Register to the West Dunbartonshire Health and Social Care Board Audit and Performance Committee.

21 IMPLEMENTATION OF DIRECTIONS POLICY 431 - 433

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an update on the implementation of the Directions Policy, which was approved by the HSCP Board on the 23 September 2020 and implemented on the 30 September 2020.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD AUDIT AND PERFORMANCE COMMITTEE

At a Hybrid Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee held in the Civic Space, 16 Church Street, Dumbarton on Tuesday, 18 February 2025 at 2.00 p.m.

Present: Michelle Wailes, Lesley MacDonald and Libby Cairns; NHS Greater Glasgow and Clyde; Fiona Hennebry, Clare Steel (deputizing for Michelle McGinty), and Martin Rooney; West Dunbartonshire Council.

Attending: Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Lesley James, Head of Children's Health, Care and Criminal Justice and Chief Social Work Officer; Kim McNab, Service Manager - Carers of West Dunbartonshire; Dr Saied Pourghazi, Clinical Director; David Smith, Unpaid Carers Representative and Val Tierney, Chief Nurse.

Also Attending: Sylvia Chatfield, Head of Mental Health, Addictions and Learning Disabilities; Tom Reid, External Auditors – Forvis Mazars,; Gillian Gall, Head of HR; Andi Priestman, Chief Internal Auditor; Dr Saied Pourghazi, Associate Clinical Director and General Practitioner, Barbara Barnes, Chair of the Locality Engagement Network – Alexandria and Dumbarton Anne McDougall, Chair of the Locality Engagement Network – Clydebank ; Selina Ross, West Dunbartonshire CVS and Lynn Straker and Natalie Roger, Committee Officers.

Apologies: Apologies for absence were intimated on behalf of Michelle McGinty, West Dunbartonshire Council; John Kerr, Housing Development and Homeless Manager and Fiona Taylor, Head of Health and Community Care.

Fiona Hennebry in the Chair

STATEMENT BY CHAIR

Fiona Hennebry, Chair advised that the meeting was being audio streamed and broadcast live to the internet and would be available for playback.

DECLARATIONS OF INTEREST

It was noted that there were no declarations of interest in any of the items of business on the agenda.

RECORDING OF VOTES

The Committee agreed that all votes taken during the meeting would be done by roll call vote to ensure an accurate record.

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee held on 24 September 2024 were submitted and approved as a correct record.

ROLLING ACTION LIST

A Rolling Action List for the Committee was submitted for information and relevant updates were noted and agreed.

Q3 PERFORMANCE

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation, reporting on the delivery of services and on the programme of work as set out in the new West Dunbartonshire HSCP Strategic Plan 2023-2026: Improving Lives Together.

After discussion and having heard Margaret-Jane Cardno, Head of Strategy and Transformation; Lesley James, Head of Children's Health, Care and Criminal Justice and Chief Social Work Officer and Gillian Gall, Head of HRin further explanation and in answer to Members' questions, the Committee agreed:-

(1) to comment on the content of the HSCP Quarterly Performance Report 2024/25 Quarter Two and Three and performance against the Strategic Plan 2023 - 2026 by exception; and

(2) to note that due to timing issues this report presents partial Quarter Three data.

STRATEGIC RISK REGISTER (SCRUTINY)

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation, presenting the Strategic Risk Register to the West Dunbartonshire Health and Social Care Partnership Board Audit and Performance Committee.

After discussion and having heard Margaret-Jane Cardno, Head of Strategy and Transformation and Beth Culshaw, Chief Officer in further explanation and in answer to Members' questions, the Committee agreed to comment on the Strategic Risk Register prior to its submission to the HSCP Board for approval on the 24 March 2025.

AUDIT PLAN PROGRESS REPORT

A report was submitted by Andi Priestman, Lead Internal Auditor, providing information to enable Members to monitor the performance of Internal Audit and gain an overview of the WD HSCP Board's overall control environment.

After discussion and having heard the Chief Internal Auditor, the Head of Strategy and Transformation and Head of HR in further explanation and in answer to Members' questions, the Committee agreed to note the progress made in relation to the Internal Audit Annual Plan for 2024/25.

CIPFA GUIDANCE FOR AUDIT COMMITTEES

A report was submitted by Andi Priestman, Chief Internal Auditor, presenting the output from the development session for Audit & Performance Committee members held on 22 January 2025 including an improvement action plan for members consideration and approval.

After discussion and having heard the Chief Internal Auditor in further explanation and in answer to Members' questions, the Committee reviewed and agreed the current level of compliance against the good practice principles and approved the improvement action plan.

ANNUAL ACCOUNTS AUDIT PROCESS

A report was submitted by Julie Slavin, Chief Financial Officer providing an overview of the process for the preparation of the 2024/25 Annual Accounts of the Integration Joint Board (IJB) identifying legislative requirements and key stages.

After discussion and having heard Julie Slavin, Chief Financial Officer and Tom Reid, External Auditor - Forvis Mazars in further explanation and in answer to Members' questions, the Committee agreed:-

(1) to note the contents of the report;

(2) to note the contents of the draft Forvis Mazars Annual Audit Plan attached at Appendix 1; and

(3) to comment on any aspect of the process requiring further discussion.

QUARTER 3 (Q3) REGULATED SERVICES REPORT

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an update on Care Inspectorate inspection reports for commissioned registered services located within West Dunbartonshire during the period 1 October – 31 December 2024 (Quarter Three).

After discussion and having heard Margaret-Jane Cardno, Head of Strategy and Transformation, Val Tierney, Chief Nurse, Sylvia Chatfield, Head of Mental Health, Chief Officer and Lesley James, Head of Children's Health, Care and Justice and Chief Social Work Officer in further explanation and in answer to Members' questions, the Committee agreed to note the content of this report and its appendices.

The meeting closed at 3.25pm.

WEST DUNBARTONSHIRE HSCP AUDIT AND PERFORMANCE COMMITTEE
ROLLING ACTION LIST

Agenda Item	Decision / Minuted Action	Responsible Officer	Timescale	Progress/ Update/ Outcome	Status
QUARTERLY PERFORMANCE REPORT 2023/24 QUARTER TWO	Equal Communities: Cllr McGinty requested information as to reasons why figures for 'Looked after Children' had increased and plans in place for any sharp increases. Chief Officer to request Briefing Note to be provided to members with this information.	Lesley James	Ongoing ASAP	Update 24/09: Beth Culshaw will provide a Briefing Note on this in the near future.	**Open**
AUDIT PLAN PROGRESS REPORT (JUNE 2024)	Cllr Rooney requested some further information on para 4.5 – 2. Consultant Job Planning, regarding the improvement actions.	Julie Slavin	Ongoing ASAP	Update 24/09: Julie Slavin has emailed NHSGGC to request an update on improvement actions. Still awaiting response 24/09/24	**Open**
STRATEGIC RISK REGISTER (SCRUTINY)	Michelle Wailes requested that the description of the risk for MSK Physio be re-	Margaret-Jane Cardno	25th June		**Open**

	looked at within the Register.				
QUARTER 3 (Q3) REGULATED SERVICES REPORT	Cllr Rooney requested an update from the Chief Officer verbally following the meeting with regards to Hill View and Cornerstone Baxter View care homes.	Beth Culshaw	28th March		**Open**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Andi Priestman, Chief Internal Auditor

25 June 2025

Subject: Audit Plan Progress Report

1. Purpose

1.1 The purpose of this report is to enable WD HSCP Board Audit and Performance Committee members to monitor the performance of Internal Audit and gain an overview of the WD HSCP Board's overall control environment.

1.2 The report also presents an update on the Internal Audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow and Clyde (NHSGGC) since the Audit Committee meeting in February 2025 that may have an impact upon the WD HSCP Board's control environment.

2. Recommendations

2.1 It is recommended that the Audit and Performance Committee note the progress made in relation to the Internal Audit Annual Plan for 2024/25.

3. Background

3.1 In September 2024, the Audit and Performance Committee approved the Internal Audit Annual Plan which detailed the activity to be undertaken during 2024/25.

3.2 This report provides a summary to the Audit and Performance Committee of recent Internal Audit activity against the annual audit plan for 2024/25. A summary is also provided in relation to internal audit work undertaken at West Dunbartonshire Council and NHSGGC which may have an impact upon the WD HSCP Board's control environment.

3.3 This report also details progress in addressing agreed actions plans arising from previous audit work.

4. Main Issues

4.1 The audit plan for 2024/25 is now complete. There was one audit finalised since the last Audit & Performance Committee meeting in February 2025 in relation to Budgetary Control Arrangements.

Budgetary Control Arrangements

4.2 Under the Public Bodies (Joint Working) (Scotland) Act 2014 West Dunbartonshire Council (WDC) and National Health Service Greater Glasgow & Clyde (NHSGGC) are required to formally delegate a defined range of community health and social care services to the West Dunbartonshire Integration Joint Board (WD IJB), known locally as the Health and Social Care Partnership Board (WD HSCP Board). The partnership arrangements for the strategic operation of the HSCP Board as well as the roles and responsibilities of the partner organisations are set out within the Integration Scheme.

4.3 NHS Greater Glasgow and Clyde Health Board and West Dunbartonshire Council agreed to formally delegate all community health and social care services provided to children, adults and older people, criminal justice social work services and some housing functions. WD HSCP Board also hosts the MSK Physiotherapy Service on behalf of all six Glasgow HSCPs and the Diabetic Retinal Screening Service on behalf of NHSGGC. One of the key duties of the WD HSCP Board is to develop a strategic plan for integrated functions and budgets.

4.4 The WD HSCP Board is responsible for the financial governance of the budgets and s.3 of the WD HSCP Board's Financial Regulations details the responsibilities relating to budgetary control and monitoring. The budget available for the WD HSCP Board for the year 2024-25 was £248.244m.

4.5 The objective of this audit was to provide the WD HSCP Board's Audit and Performance Committee with an assessment of the adequacy and effectiveness of the governance, risk management and controls surrounding the key risks faced by the WD HSCP Board in relation to budgetary control.

4.6 The review focused on the high-level processes and procedures in relation to budgetary control arrangements such as budget monitoring, virements and budget reporting to the Board.

4.7 The overall control environment opinion for this audit review was **Satisfactory**. Areas of good practice were identified including:

- Monthly budgetary reports with accompanying analysis are communicated to budget holders to allow for effective monitoring.
- Regular review of budgetary control reports is undertaken with budget holders at which variations are analysed, investigated and acted upon.
- Regular budgetary control and financial reports are produced and reported to the HSCP Board's meetings to aid decision making.

However, two GREEN issues were identified as follows:

- A Budgetary Control and Monitoring Procedures Manual has been developed, however the document is still in draft format and requires to be finalised.

- Finance have drafted training material however a regular programme of training is not yet in place. Survey responses from senior managers confirmed that although training was given at induction, no refresher training has been received which some managers would find beneficial.

4.8 The audit identified 2 GREEN issues which if implemented would enhance the control environment and an action plan is in place to address both issues by 30 September 2025.

4.2 In relation to internal audit action plans, the current status report is set out at Appendix 1.

4.3 In relation to external audit action plans, there are no current external audit actions.

4.4 In relation to internal audit work undertaken at West Dunbartonshire Council, since February 2025, there were no Internal Audit reports issued to the Council which are relevant to the WD HSCP Board.

4.5 In relation to internal audit work undertaken at NHSGGC, there were 2 Internal Audit reports issued to the NHSGGC Board which are relevant to the WD HSCP Board as follows:

Audit Title	**Rating**	**Number and Priority of Issues**			
		4	**3**	**2**	**1**
Waiting List Management – Mental Health (1)	Minor Improvement Required	0	1	4	0
eHealth Project and Programme Management	Minor Improvement Required	0	0	5	0
Q4 Action Follow Up	N/A	N/A	N/A	N/A	N/A
Total		**0**	**1**	**9**	**0**

(1) The grade 3 recommendation relates to improvements to the centralised recording or subsequent monitoring of actions taken to address any long waiters or service level concerns directly affecting delivery of services required for those on the waiting lists.

4.6 Internal Audit at West Dunbartonshire Council and NHSGGC undertake follow up work in accordance with agreed processes to confirm the implementation of agreed actions and report on progress to their respective Audit Committees. Any matters of concern will be highlighted to the Committee.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Risk Analysis

7.1 The annual audit plan for 2024/25 was constructed taking cognisance of the risks included in the WD HSCP Board risk register. Consultation with the Chief Officer and the Chief Financial Officer was carried out to ensure that risks associated with delivering the strategic plan were considered.

8. Equalities Impact Assessment (EIA)

8.1 There are no issues.

9. Environmental Impact Assessment

9.1 There are no issues.

10. Consultation

10.1 The Chief Officer and the Chief Financial Officer have been consulted on the content of this report.

11. Strategic Assessment

11.1 The establishment of a robust audit plan will assist in assessing whether the WD HSCP Board and Officers have established proper governance and control arrangements which contribute to the achievement of the strategic priorities of the Strategic Plan.

12. Directions

12.1 This report does not require a Direction.

Author: **Andi Priestman**
Chief Internal Auditor – West Dunbartonshire HSCP Board

Date: **25 June 2025**

Person to Contact: Andi Priestman, Chief Internal Auditor
E-mail – andi.priestman@west-dunbarton.gov.uk

Appendices: Appendix 1 – Status of Internal Audit Action Plans at 31 May 2025

Background Papers: Internal Audit Annual Audit Plan 2024-2025

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF INTERNAL AUDIT ACTION PLAN POINTS
AT 31 MAY 2025

Summary:

Section 1 **Summary of Management Actions due for completion by 31/05/2025**

There were no actions due for completion by 31 May 2025.

Section 2 **Summary of Current Management Actions Plans at 31/05/2025**

At 31 May 2025 there were no audit reports delayed due to management not finalising the action plan within agreed timescales.

Section 3 **Current Management Actions at 31/05/2025**

At 31 May 2025 there were 4 current audit action points.

Section 4 **Analysis of Missed Deadlines**

At 31 May 2025 there were 2 audit action points where the agreed deadline had been missed.

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF INTERNAL AUDIT ACTION PLAN POINTS

SUMMARY OF MANAGEMENT ACTION PLANS DUE FOR COMPLETION BY 31.05.2025

SECTION 1

No. of Actions Due	No. of Actions Completed	Deadline missed Revised date set*	Deadline missed Revised date to be set*
0			

* These actions are included in the Analysis of Missed Deadlines – Section 4

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF INTERNAL AUDIT ACTION PLAN POINTS

SUMMARY OF CURRENT MANAGEMENT ACTIONS AS AT 31.5.2025

SECTION 2

CURRENT ACTIONS

Month	No of actions
Due for completion June 2025	1
Due for completion September 2025	2
Due for completion October 2025	1
Total Actions	4

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON STATUS OF INTERNAL AUDIT ACTION PLAN POINTS

CURRENT MANAGEMENT ACTIONS AS AT 31.5.2025

SECTION 3

Action	Owner	Expected Date
IJB Recovery and Response Arrangements (April 2023)		
Provision of Assurance to the Board on Business Continuity Arrangements (Green) As a control improvement and example of good practice, management to consider presenting members with an annual Business Continuity Assurance Statement.	**Head of Strategy and Transformation**	**30.06.25***
IJB Workforce Planning Arrangements (August 2023)		
Adequacy of Succession Planning Arrangements (Amber) All Heads of Service will work with the Head of HR to embed succession planning through service planning structures and through annual performance reviews. Additionally, the Head of HR will consider any additional leadership resource requirements to enable visibility across services and create the conditions for engagement.	**Head of HR**	**31.10.25***
IJB Budgetary Control Arrangements (April 2025)		
Adequacy of Procedural Documentation (Green) Finalise the Budgetary Control and Monitoring Procedures Manual and ensure all team members refresh their own understanding regularly	**HSCP Finance Manager**	**30.09.25**
Adequacy of Training (Green) Finalise the draft training material already developed and work with HR and OD colleagues on how to roll it out with maximum benefit.	**Chief Financial Officer and Head of HR**	**30.09.25**

* See analysis of missed deadlines – Section 4

WEST DUNBARTONSHIRE PARTNERSHIP BOARD
INTERNAL AUDIT REPORT TO AUDIT AND PERFORMANCE COMMITTEE ON
STATUS OF INTERNAL AUDIT ACTION PLAN POINTS
ANALYSIS OF MISSED DEADLINES

SECTION 4

Report	Action	Original Date	Revised Date	Management Comments
IJB Recovery and Response Arrangements (April 2023)	**Provision of Assurance to the Board on Business Continuity Arrangements (Green)** As a control improvement and example of good practice, management to consider presenting members with an annual Business Continuity Assurance Statement.	**30.09.23** **30.06.24**	**30.06.25**	This will be incorporated within the HSCP Board's Annual Governance Statement for 2024-25.
IJB Workforce Planning Arrangements (August 2023)	**Adequacy of Succession Planning Arrangements (Amber)** All Heads of Service will work with the Head of HR to embed succession planning through service planning structures and through annual performance reviews. Additionally, the Head of HR will consider any additional leadership resource requirements to enable visibility across services and create the conditions for engagement.	**31.03.24**	**31.10.25**	The IJB is required to submit a draft workforce plan to the Scottish Government in June 2025 and the formalised plan will go live in October 2025.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Andi Priestman, Chief Internal Auditor

25 June 2025

Subject: Global Internal Audit Standards

1. Purpose

1.1 The purpose of this report is to inform the Audit and Performance Committee of the new Global Internal Audit Standards (UK public sector) that came into effect from 1 April 2025 and that internal audit teams in the public sector will be working to implement these new internal audit standards by 31 March 2026.

2. Recommendations

2.1 It is recommended that the Audit and Performance Committee considers and notes the contents of this report and that further update reports will be provided during 2025/26 in relation to the new Global Internal Audit Standards (UK public sector).

3. Background

3.1 The Integration Joint Board is required to comply with Article 7 of the Local Authority Accounts (Scotland) Regulations 2014. The regulations require a local authority to operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing.

3.2 From 1 April 2025 Internal Audit teams in the UK will be working to new professional standards. These will be a combination of the Global Internal Audit Standards (GIAS) and the Application Note “Global Internal Audit Standards in the UK Public Sector”.

3.3 Internal Audit teams will not be required to demonstrate full compliance on this date but must work in accordance with the new standards from 1 April in order to transition to the new requirements by 31 March 2026.

3.4 The Standards are arranged into five domains:

I Purpose of Internal Auditing
II Ethics and Professionalism
III Governing the Internal Audit Function
IV Managing the Internal Audit Function
V Performing Internal Audit Services

3.5 Across the domains are 15 Principles and 52 Standards. These include requirements, considerations for implementation, and examples of evidence of conformance.

3.6 CIPFA has developed the Code of Practice for the Governance of Internal Audit in UK Local Government (the Code) to support local authorities in establishing their internal audit arrangements and providing oversight and support for internal audit. The Code is designed to work alongside new internal audit standards and replaces the organisational responsibilities set out in the Statement on the Role of the Head of Internal Audit (CIPFA, 2019).

4. Main Issues

4.1 The Audit and Performance Committee play a vital role in ensuring that the internal audit function adheres to the Standards and fulfils its mandate effectively and efficiently. The Audit and Performance Committee members and senior management should be familiar with the new Standards and their implications.

4.2 The internal audit service for the HSCP Board is provided by West Dunbartonshire Council. Having reviewed the requirements of the new Standards, it is considered that the Council's internal audit service aligns with the intent of the Standards. During 2025/26, processes and templates will be refreshed as part of the ongoing quality assurance and improvement programme to ensure alignment with requirements of the new Global Internal Audit Standards.

4.3 The Chief Internal Auditor will provide further reports in relation to the new Standards during 2025/26 and a transition plan will be developed and implemented to ensure that Internal Audit service's practices and templates are aligned with expectations.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 There are no significant risks arising from the proposed recommendations in this report. The report should provide a key source of assurance over the Council's internal audit arrangements.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 The GIAS will require close engagement with HSCP management. The Chief Internal Auditor will therefore discuss the changes in more detail with the Chief Officer and the Chief Financial Officer.

12. Strategic Assessment

12.1 The reports helps ensure strong governance and will help support delivery of the strategic priorities of the HSCP Strategic Plan.

13. Directions

13.1 This report does not require a Direction.

Author: **Andi Priestman – Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board**

Date: **25 June 2025**

Person to Contact: Andi Priestman, Shared Service Manager – Audit & Fraud
West Dunbartonshire Council
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Appendix: N/A

Background Papers: Institute of Internal Auditors Global Internal Audit Standards; CIPFA Application Note and the Code of Practice on the Governance of Internal Audit.

Wards Affected: All Wards

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Andi Priestman, Chief Internal Auditor

25 June 2025

Subject: Annual Report on the Audit and Performance Committee for the year ended 31 March 2025

1. Purpose

1.1 The purpose of this report is to provide members with the Audit and Performance Committee Chair's 2024/25 Annual Report on the Audit and Performance Committee.

2. Recommendations

2.1 It is recommended that members review and endorse the Chair's Annual Report on the Audit and Performance Committee for 2024/25.

2.2 Agree that the report should be presented to a future meeting of the West Dunbartonshire HSCP Board in line with best practice guidance.

3. Background

3.1 It is important that the Audit and Performance Committee fully complies with best practice guidance on Audit Committees to ensure it can demonstrate its effectiveness as a foundation for sound corporate governance for the West Dunbartonshire HSCP Board (the Partnership Board). The Chartered Institute of Public Finance and Accountancy (CIPFA) issued an updated guidance note Audit Committees Practical Guidance for Local Authorities and Police 2022 Edition which incorporates CIPFA's Position Statement: Audit Committees in Local Authorities and Police. This sets out CIPFA's view of the role and functions of an Audit Committee.

3.2 A development session was held on 22 January 2025 for Members to undertake a self-evaluation against the guidance and an improvement action was developed which included an action to develop an annual report on the Audit and Performance Committee to inform the Partnership Board of how the Audit and Performance Committee has fulfilled its roles and responsibilities in line with CIPFA good practice guidance.

4. Main Issues

4.1 The Audit and Performance Committee Chair's 2024/25 Annual Report is appended with the main issues identified being:

- The Audit and Performance Committee has met three times during the financial year with every meeting being quorate.
- The Audit and Performance Committee sought assurance on the adequacy and effectiveness of the Partnership Board's governance, risk management and system of internal control. This was achieved through reports received from internal audit, other HSCP functions and external audit with particular focus on internal control and governance.
- The Audit Committee has provided assurance to the Partnership Board as detailed in the appendix.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 There is a risk that the Audit and Performance Committee does not comply with best practice guidance in relation to demonstrating its effectiveness in providing a foundation for sound corporate governance. The annual report provides this assurance to the Partnership Board on the activity of the Audit and Performance Committee.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 This report has been agreed with the Chief Officer and the Chief Financial Officer of the West Dunbartonshire Health & Social Care Partnership Board.

12. Strategic Assessment

12.1 The reports helps ensure strong governance and will help support delivery of the strategic priorities of the HSCP Strategic Plan.

13. Directions

13.1 This report does not require a Direction.

Author: **Andi Priestman – Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board**

Date: **25 June 2025**

Person to Contact: Andi Priestman, Shared Service Manager – Audit & Fraud
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Appendix: 1 – Annual Report on the Audit and Performance Committee 2024-2025

Background Papers: CIPFA Guidance for Audit Committees – Report to Audit and Performance Committee 18 February 2025

Localities Affected: All Localities

West Dunbartonshire Health and Social Care Partnership Board
Audit and Performance Committee
2024/25 Annual Report from the Chair

Introduction

This annual report has been prepared to inform West Dunbartonshire Health and Social Care Partnership Board (HSCP Board) of the work carried out by the Audit and Performance Committee during the financial year 2024/25.

Meetings

The Audit and Performance Committee met three times during 2024/25 comprising meetings on 27 June, 24 September and 18 February to consider reports relevant to the Audit cycle and other matters as deemed appropriate. Pre-Agenda meetings were also held ahead of Committee involving the Chair, Vice Chair and appropriate officers.

The purpose and remit of Audit and Performance Committee as detailed in Terms of Reference is to provide an independent and high-level focus on the adequacy of governance, risk and control arrangements through a process of constructive challenge. By ensuring there is sufficient assurance over governance, risk and control this provides the HSCP Board with greater confidence in discharging their responsibilities.

To fulfil this remit, the Audit and Performance Committee sought assurance on the adequacy and effectiveness of both West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board systems of governance, risk management and internal control to ensure efficient operations and the highest standards of probity and accountability. This was achieved through reports received from Internal Audit, other HSCP functions and External Audit with focus in particular on internal control and governance.

At each meeting of the Audit and Performance Committee it considered findings from Internal Audit reports together with monitoring the progress made by management in completing agreed actions to improve both the Council and Health Board control environments. It also considered the external Annual Audit Report for the 2023/24 audit from the external auditors (Mazars).

The Audit and Performance Committee also received reports on:

- Review of HSCP Board Financial Regulations.
- Performance Reports.
- Risk Management.
- Best Value Statement.
- Care Inspectorate Inspection Reports.
- Alcohol and Drug Partnership Annual Update.
- Drug Related Deaths in West Dunbartonshire.
- Review of the Local Code and draft Annual Governance Statement.

The minutes of Audit and Performance Committee meetings are first confirmed as a correct record at the next Audit Committee before being remitted to the HSCP Board for approval.

Membership of the Audit Committee

The Audit and Performance Committee comprises six voting members of the HSCP Board, with equal representation from both West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board, and two co-opted independent members with relevant knowledge, skills and experience. These co-opted members are non-voting members.

Every meeting of the Audit and Performance Committee during 2024/25 was quorate.

Attendance by Officers

All meetings were attended by the Chief Officer and Chief Financial Officer.

Other senior officers also attended meetings as appropriate for items on the Agenda for which their presence was relevant. Representatives from the HSCP Board's external auditors (Mazars) were present at relevant meetings.

Assurance Statement to the HSCP Board
The Audit and Performance Committee provides the following assurance to the HSCP Board:

- The HSCP Board has received the Minutes of the Audit and Performance Committee meetings throughout the year.
- The Audit and Performance Committee has operated in accordance with its agreed terms of reference, and accordingly with the audit committee principles in the CIPFA Position Statement relating to its Audit functions.
- It did this through reports received from Internal Audit, External Audit, and assurances from Management. It focussed on matters of governance, risk management and internal control; giving advice to the HSCP Board on the value of the audit process; on the integrity of financial reporting; and on governance arrangements.
- For all audit reports, the Audit and Performance Committee considered whether it was satisfied that an adequate management response was in place to ensure action would be taken to manage risk and address concerns on governance, risk management and internal control arrangements. The Committee acknowledges that all the audit recommendations are subject to ongoing follow-up by Internal Audit and reporting thereon.
- The Audit and Performance Committee has received and considered material to fulfil its scrutiny role on performance management activity.

Conclusion

Based on the reports received and reviewed by the Audit and Performance Committee, they are in agreement with the Chief Internal Auditor's annual audit report which confirms that reasonable assurance can be placed upon the adequacy and effectiveness of the Partnership Board's internal control system in 2024/25. I am satisfied that active monitoring and follow up is in place in respect of agreed management action.

Councillor Hennebry
Chair of the Audit and Performance Committee
25 June 2025

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Andi Priestman, Chief Internal Auditor

25 June 2025

Subject: Internal Audit Annual Report for the year ended 31 March 2025

1. Purpose

1.1 To submit the Chief Internal Auditor's Annual Report for 2024/25 based on the internal audit work carried out for the year ended 31 March 2025, which contains an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health & Social Care Partnership Board's internal control environment that can be used to inform its Annual Governance Statement.

2. Recommendations

2.1 It is recommended that the West Dunbartonshire Health & Social Care Partnership Board note the contents of this report.

3. Background

3.1 The Public Sector Internal Audit Standards (PSIAS) became effective on 1st April 2013 and require that:

"The chief audit executive [for WDC: Shared Service Manager – Audit & Fraud] *must deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement*

The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The annual report must incorporate:

- *The opinion;*
- *A summary of the work that supports the opinion; and*
- *A statement on conformance with the Public Sector Internal Audit Standards and the results of the quality assurance and improvement programme"*

3.2 For the purposes of providing an annual opinion, reliance will be placed on the work of NHS Greater Glasgow and Clyde internal auditors and West Dunbartonshire Council internal auditors and any other work carried out by other external assessors, for example Audit Scotland and Care Inspectorate.

3.3 In order to ensure proper coverage and avoid duplication of effort, the internal auditors of NHSGGC and all local authorities operating within this Health Board area meet periodically.

4. Main Issues

4.1 The Internal Audit Annual Report for 2024/25 included at Appendix 1 concludes with the Chief Internal Auditor's independent and objective opinion that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2025 that the Health & Social Care Partnership Board requires to rely upon within both the Council and the Health Board.

4.2 The basis of the audit opinion includes taking reliance from:

- The Assurance Statement for the year ended 31 March 2025 from the Shared Service Manager – Audit & Fraud (Chief Internal Auditor) of West Dunbartonshire Council; and
- Information provided by the Internal Auditors of NHS Greater Glasgow and Clyde on audits that they have carried out during 2024/25.

5. People Implications

5.1 There are no personnel issues with this report.

6. Financial Implications

6.1 There are no financial implications with this report.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 There is a risk that failure to deliver the Internal Audit Plan would result in an inability to provide assurances to those charged with governance over which the Health & Social Care Partnership Board is required to rely upon within both the Council's and Health Board's system of internal financial control.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 This report has been agreed with the Chief Officer and the Chief Financial Officer of the West Dunbartonshire Health & Social Care Partnership Board.

12. Strategic Assessment

12.1 The establishment of a robust audit plan will assist in assessing whether the Partnership Board and Officers have established proper governance and control arrangements which contribute to the achievement of the strategic priorities of the HSCP Strategic Plan.

13. Directions

13.1 This report does not require a Direction.

Author: **Andi Priestman – Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board**

Date: **25 June 2025**

Person to Contact: Andi Priestman, Shared Service Manager – Audit & Fraud
West Dunbartonshire Council
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Appendix: 1 - Internal Annual Audit Report for the year ended 31 March 2025

Background Papers: Internal Audit Progress Reports to Audit Committee in September 2024 and February 2025

Wards Affected: All Wards

West Dunbartonshire
Health & Social Care Partnership

Internal Audit Annual Report for the year ended 31 March 2025 from the Chief Internal Auditor

To the Members of West Dunbartonshire Health & Social Care Partnership Board, the Chief Officer and the Section 95 Officer (Chief Financial Officer)

As the appointed Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board, I am pleased to present my annual statement on the adequacy and effectiveness of the internal financial control system of the Health & Social Care Partnership Board for the year ended 31 March 2025.

Respective responsibilities of management and internal auditors in relation to internal control

It is the responsibility of senior management of the Health & Social Care Partnership Board to establish an appropriate and sound system of internal financial control and to monitor the continuing effectiveness of that system. It is the responsibility of the Chief Internal Auditor to provide an annual overall assessment of the robustness of the internal financial control system.

The Health & Social Care Partnership Board's framework of governance, risk management and internal controls

The Health & Social Care Partnership Board has a responsibility to ensure that its business is conducted in accordance with legislation and proper standards.

The governance framework comprises the systems and processes, culture and values by which the Health & Social Care Partnership Board is directed and controlled and how it accounts to communities. It enables the Health & Social Care Partnership Board to monitor the achievement of its strategic priorities and to consider whether those objectives have led to the delivery of appropriate services and value for money.

The system of internal control is a significant element of the governance framework. Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. Accordingly, the Health & Social Care Partnership Board is continually seeking to improve the effectiveness of its systems of internal control in order to identify and prioritise the risks that would prevent the achievement of the Health & Social Care Partnership Board's strategic objectives as set out within its Strategic Plan.

The work of internal audit

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

The operational delivery of services with WDC and NHSGGC on behalf of the WD Health & Social Care Partnership Board is covered by their respective internal audit arrangements.

Both the Council's Internal Audit Section and the Health Board's internal audit function operate in accordance with the *Public Sector Internal Audit Standards* (PSIAS) which have been agreed to be adopted from 1st April 2013 by the relevant public sector Internal Audit Standard setters. PSIAS applies the Institute of Internal Auditors International Standards to the UK Public Sector.

Work Performed in 2024/25

The Internal Audit Plan for 2024/25 was approved by the Health & Social Care Partnership Board Audit and Performance Committee on 24 September 2024.

A budget of 20 days was allocated to undertake the following: service the audit committee; carry out specific assurance work including a review of the recently updated CIPFA Guidance for Audit Committees, a review of budgetary control arrangements and to monitor the progress of the implementation of the agreed internal audit actions plans by management.

Progress reports highlighting internal audit activity were provided to the Health & Social Care Partnership Board Audit and Performance Committee meetings in September 2024 and February 2025. There were no significant matters arising from internal audit activity carried out in relation to the Health & Social Care Partnership Board for the financial year ended 31 March 2025.

Planned work for 2025/26

The Internal Audit Plan for 2025/26 will be reported to the Audit Committee meeting in September 2025, following a risk-based assessment of the activities of Health & Social Care Partnership Board and consultation with the Chief Officer and the Chief Financial Officer.

Basis of Opinion

My evaluation of the control environment is informed by a number of sources:

- The audit work undertaken by Internal Audit within the Council and the Health Board and also for the Partnership Board during the year to 31 March 2025;
- The Assurance Statement for the year ended 31 March 2025 from the Chief Internal Auditor of West Dunbartonshire Council;

- The Assurance Statement for the year ended 31 March 2025 from the Internal Auditors for NHSGG&C is awaited but assurances have been provided by NHSGG&C officers that no significant governance or internal control issues have been highlighted by their internal auditors;
- The review of the Local Code of Governance and the identified improvement actions;
- The assurance statement from the Chief Officer on the operation of the internal financial controls for the services for which she was responsible during the year to 31 March 2025;
- Reports issued by the External Auditors of the Council and the Health Board and other review agencies; and
- My knowledge of the Partnership Board's governance, risk management and performance monitoring arrangements.

Opinion

It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2025 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself.

Signature: **Andi Priestman**

Title: **Chief Internal Auditor for West Dunbartonshire Health & Social Care Partnership Board**

Date: **10 June 2025**

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

25 June 2025

Subject: Ministerial Strategic Group for Health and Community Care: Measuring Progress Under Integration

1. Purpose

1.1 The purpose of this report is to update the HSCP Board Audit and Performance Committee on the status of the "Progress with Integration of Health and Social Care, West Dunbartonshire Health and Social Care Partnership Action Plan" [the Action Plan] (Appendix I).

2. Recommendations

It is recommended that the HSCP Audit and Performance Committee:

2.1 Note the contents of the "Progress with Integration of Health and Social Care, West Dunbartonshire Health and Social Care Partnership Action Plan", September 2023 (Appendix I), and

2.2 Agree that given the advanced nature of this work that no further update reports are required.

3. Background

3.1 At the meeting of the Ministerial Strategic Group for Health and Community Care (MSG) on 29 May 2019, members considered how they would wish the existing MSG measures set to be extended and/or complemented with other information, to allow them to understand better the progress being made towards the health and wellbeing outcomes across the wider health and care system under integration.

3.2 MSG members agreed that they would like to better understand what information / evidence exists on outcomes and sought the support of HSCPs to collectively and iteratively improve awareness, understanding and evidence around the difference that integration is making to people.

3.3 In response to this request West Dunbartonshire HSCP undertook a mapping exercise in order to fully define the extent and types of activities that the partnership were already undertaking in respect of feedback/impact/outcome measures for people supported by, or working within, health and care services.

3.4 Leading on from this mapping work, in September 2019 the HSCP

developed an Action Plan (Appendix I).

3.5 An update on progress was provided to the HSCP Board Audit and Performance Committee on the 19 September 2023.

4. Main Issues

4.1 Of the 62 improvement actions agreed in September 2019, 35 were complete in August 2023. Of the remaining 27, this report shows 22 to be complete in July 2025 with 5 outstanding. This is summarised in table one below:

	Number of Agreed Actions 2019	Number Complete In August 2023	Number Complete in June 2025	Number Outstanding in June 2025
Shared and collaborative leadership must underpin and drive forward integration	7	4	2	1
Relationships and collaborative working between partners must improve	3	3	n/a	n/a
Relationships and partnership working with the third and independent sectors must improve	4	0	4	n/a
Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration	3	2	1	n/a
Delegated budgets for IJBs must be agreed timeously	4	1	3	n/a
Delegated hospital budgets and set aside budget requirements must be fully implemented	4	2	2	n/a
Each IJB must develop a transparent and prudent reserves policy	1	1	n/a	n/a
Statutory partners must ensure appropriate support is provided to IJB S95 Officers	1	1	n/a	n/a
IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations	2	0	1	1
Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB	4	0	3	1
Improved strategic planning and commissioning arrangements must be put in place	2	2	n/a	n/a
Improved capacity for strategic commissioning of delegated hospital services must be in place	3	3	n/a	n/a
The understanding of accountabilities and responsibilities between statutory partners must improve	2	1	0	1
Accountability processes across statutory partners will be streamlined	2	1	1	n/a
IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis	2	2	n/a	n/a
Clear directions must be provided by IJB to Health Boards and Local Authorities	5	5	n/a	n/a
Effective, coherent and joined up clinical and care governance arrangements must be in place	2	1	0	1
IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data	2	0	2	n/a
Identifying and implementing good practice will be systematically undertaken by all partnerships	4	3	1	n/a
Effective approaches for community engagement and participation must be put in place for integration	2	1	1	n/a
Improved understanding of effective working relationships with carers, people using services and local communities is required	2	2	n/a	n/a
We will support carers and representatives of people using services better to enable their full involvement in integration	1	1	n/a	n/a
	62	36	21	5

Table One: Summary of Improvement Actions

4.2 There have been many areas of good integrated practice which have taken place in the period since the development of the Action Plan, with work areas impacted both positively and negatively by the global pandemic. Given there is greater stability across the HSCP, this work has to a large degree become mainstream and has been enhanced by the publication of the HSCP Strategic Plan 2023 – 2026 “Improving Lives Together”.

4.3 The action plan is now in its sixth year with most actions complete or nearing completion. There are a small number of actions which remain incomplete these will in the main be reported to relevant committees via standalone papers. As such it is recommended that no further standalone reports in respect of this plan are required.

5. Options Appraisal

5.1 An options appraisal is not required for this report.

6. People Implications

6.1 There are no people implications arising from the recommendations within this report.

7. Financial and Procurement Implications

7.1 There are no financial or procurement implications arising from the recommendations within this report.

8. Risk Analysis

8.1 There are no risks identified because of the recommendations within this report. This report does however support the mitigation of the following risk as contained within the HSCP Strategic Risk Register:

8.2 Performance Management Information: Failure to review and scrutinise performance management information; creates a risk of the HSCP being unable to manage demand analysis, service planning and budget management across totality of the organisational responsibilities.

9. Equalities Impact Assessment (EIA)

9.1 An equality impact assessment is not required as the HSCP Board is not being asked to take a substantive decision at this time and the report does not have a differential impact on any of the protected characteristics.

10. Environmental Sustainability

10.1 A Strategic Environmental Assessment (SEA) is not required in this instance.

11. Consultation

11.1 The HSCP Senior Management Team, Chief Financial Officer and Monitoring Officer within Regulatory Services have been consulted in the preparation of this report.

12. Strategic Assessment

12.1 This improvement plan predates the current HSCP Board Strategic Plan "Improving Lives Together 2023 – 2026".

13. Directions

13.1 These recommendations do not require a direction to be issued.

Name:	Margaret-Jane Cardno
Designation:	Head of Strategy and Transformation
Date:	13 June 2025

Person to Contact:	Margaret-Jane Cardno Head of Strategy and Transformation West Dunbartonshire Health and Social Care Partnership
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Collaborative Leadership And Building Relationships									
Shared and collaborative leadership must underpin and drive forward integration.									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position in June 2025**	**Evidence in June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	(i) All leadership development will be focused on shared and collaborative practice. An audit of existing national leadership programmes will be undertaken by the Scottish Government and COSLA to identify gaps and areas of synergy to support integration of health and social care. Further work will be delivered on cross-sectoral leadership development and support. Timescale: 6 months	We will make further use of the range of leadership opportunities delivered across the NHS/HSCP/Council, focussing on learning about good practice and assessing opportunities for joint learning across the system.		Development opportunities are presented on a regular basis to appropriate staff.	Complete	Training opportunities are promoted to staff at regular intervals. Proactive work in respect of succession planning has taken place and this is monitored through regular supervision.		Gillian Gall	31-Mar-24
		We will, in the year ahead, be improving strategic commissioning, with partners, and the quality monitoring processes that accompany this.		Quality Assurance Strategy to be considered by the IJB on the 19 September 2023.	Ongoing	Quality Strategy at an advance stage but yet to be implemented.	Further action required to implement the strategy.	MJ Cardno	31 March 2026

		To date, organisational development support has been provided through the NHS, however we are going to commission additional resource from the Council; with the implicit objective of widening understanding of the HSCP across the Council.		Good progress for example work related too hard to fill vacancies and social work career pathways.	Complete	Work related to recruitment and retention is embedded as business as usual.		Gillian Gall	31-Mar-24

Relationships and partnership working with the third and independent sectors must improve									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence in June 2025**	**Improvement Action**	**Responsible Officer**	**Original/Planned Completion Date**
	(iii) Relationships and partnership working with the third and independent sectors must improve. Each partnership will critically evaluate the effectiveness of their working arrangements and relationships with colleagues in the third and independent sectors, and take action to address any issues. Timescale: 12 months	We will work to further develop our Provider Forums, across all care groups, to establish joint attendance from HSCP and third/independent sector providers for shared dialogue and development.		The HSCP are in the process of establishing a range of strategic frameworks which will provide a platform for provider forums to exist. These will go live on the 1 April 2024.	Complete	Provider forums established and bespoke frameworks developed.		MJ Cardno	01-Apr-24
		We will conclude our work on developing and publishing a Commissioning Strategy, informed by close working with our Care Inspectorate Link Inspector		Commissioning Strategy to be considered by IJB on the 19 September 2023.	Complete	Commissioning and procurement strategies are agreed for each piece of work. Approvals are in the main delegated to the Chief Officer.		MJ Cardno	31-Mar-24

		We will review the process for service reviews to ensure early engagement with key stakeholders in the redesign of service delivery models		Quality Improvement and Service Redesign Strategies to be considered by IJB on the 19 September 2023.	Complete	Several major service reviewed are underway. These align with the Scottish Standards for Service Design and adhere to NHS and Council Change Policies.		MJ Cardno	31-Mar-24
		We will involve third sector partners as they provide a valuable contribution to our way forward; there is scope to have partners more involved in some pieces of work including the work developing through the ADP and the procurement Pipeline work already underway		The above evidence contributes to the delivery of this action.	Complete	Third Sector Partners are commissioned to deliver services on behalf of the HSCP. There is active and positive engagement across a number of key multi disciplinary forums for example the Suicide Prevention Steering Group and the SDS Circle.		MJ Cardno	31-Mar-24

Integrated finances and financial planning									
Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence in June 2025**	**Improvement Action**	**Responsible Officer**	**Original/Planned Completion Date**
	2. (i) Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration. In each partnership area the Chief Executive of the Health Board and the Local Authority, and the Chief Officer of the IJB, while considering the service impact of decisions, should together request consolidated advice on the financial position as it applies to their shared interests under integration from, respectively, the NHS Director of Finance, the Local Authority S95 Officer and the IJB S95 Officer. Timescale: By 1st April 2019 and thereafter each year by end March.	We are continuing to work towards whole system financial planning which is at its very early stages.		The board, finance colleagues and the 6 HSCP CFOs have agreed a mechanism for costing the activity aligned to set aside budgets. These are reflected within our annual accounts. However, work continues to move towards release of elements of the set aside budget into community based budgets.	Complete	Regular six weekly finance meeting in place with West Dunbartonshire Council. Finance focused performance reviews are also in place with NHS GGC. A whole system planning group has also been established and this is supported by a chief finance officer.		Julie Slavin	Complete

Delegated budgets for IJBs must be agreed timeously									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence in June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	2. (ii) Delegated budgets for IJBs must be agreed timeously. The recently published financial framework for health and social care sets out an expectation of moving away from annual budget planning processes towards more medium term arrangements. To support this requirement for planning ahead by Integration Authorities, a requirement should be placed upon statutory partners that all delegated budgets should be agreed by the Health Board, Local Authority and IJB by the end of March each year.	We will continue to undertake further work to effectively transition towards medium term financial and scenario planning, in line with Audit Scotland Report recommendations.		Medium term financial plan in place however due to the Covid pandemic the Scottish Government have not published a refreshed financial plan. The move away from single year settlements has therefore not progressed at a national level.	Complete	Medium Term Financial Outlook approved by the HSCP Board in November 2024 and will be updated on a regular basis.		Julie Slavin	Ongoing/Nationally
		We will continue to work with the health board in respect of indicative and formal budget settlements to be made earlier (in time for March IJB meetings) including all aspects of delegated budgets.		Although we work closely with NHS finance colleagues, the NHS budget remains indicative in March each year. This is a systemic issue which can only be addressed by Scottish Government.	Complete	The HSCP Board are provided with formal notification of indicative budgets in line with our budget setting	No further action can be taken at a local level.	Julie Slavin	Ongoing/Nationally

						reporting timetable.			
		We support the move towards medium to long term financial planning across the NHS and the Council which will positively impact on the HSCP financial planning arrangements. We note that as part of the parliamentary review process there is an aspiration for next year's budget process to set out multiyear settlements and the recent change in arrangements for NHS Boards to allow medium term planning and increased flexibility. We welcome these developments.		Medium term financial plan in place however due to the Covid pandemic the Scottish Government have not published a refreshed financial plan. The move away from single year settlements has therefore not progressed at a national level.	Complete	The HSCP Board medium term financial outlook will reflect financial planning assumptions of Scottish Government and our partner organisations.	No further action can be taken at a local level.	Julie Slavin	Ongoing/Nationally

Delegated hospital budgets and set aside budget requirements must be fully implemented									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence in June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	2. (iii) Delegated hospital budgets and set aside requirements must be fully implemented. Each Health Board, in partnership with the Local Authority and IJB, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. These arrangements must be in place in time for Integration Authorities to plan their use of their budgets in 2019/20. The Scottish Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. The set aside arrangements are key to delivering this commitment. Timescale: 6 months	We will develop a Commissioning Plan which will more clearly align finance and planning work streams across all areas including unscheduled hospital bed usage.		Commissioning Strategy to be considered by the IJB on the 19 September 2023.	Complete	Procurement Paper presented to HSCP Board May 2025. Each contract has its own commissioning and procurement strategy. In the main contact acceptance falls within the delegation of the Chief Officer.		MJ Cardno	31-Mar-25

		We will deliver a due diligence exercise, required as part of the overall process of agreeing set aside budgets, which addresses the significant financial gap identified in acute budgets based on figures provided by the health board to date.		The board, finance colleagues and the 6 HSCP CFOs have agreed a mechanism for costing the activity aligned to set aside budgets. These are reflected within our annual accounts. However, work continues to move towards release of elements of the set aside budget into community based budgets.	Complete	The due diligence exercise supported the current mechanism for costing the activity aligned to set aside budgets.		Julie Slavin	Complete

IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence in June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	2. (vi) IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations. Local audits of the Health Board and Local Authority must take account of the expectation that money will be spent differently. We should be focused on outcomes, not which public body put in which pound to the pot. It is key that the resources held by IJBs lose their original identity and become a single budget on an ongoing basis. This does not take away from the need for the	We will work to review the Scheme of Integration to support HSCP officers to manage and deploy the resources in their remit directly and effectively.		This work is well advanced with an initial report due to be considered by West Dunbartonshire Council and NHS GGC Board in October 2023.		A full review of the integration scheme is complete. The schemes will be subject to approval through Council and health board governance routes before being put forward for approval by Scottish Ministers. It is anticipated that this will be complete by 31	Further work required to complete task. This included seeking permission to consult, a period of consultation, approval by NHS Board and WDC and final approval by Ministers.	Beth Culshaw	ongoing

	IJB to be accountable for these resources and their use.					December 2025.			
	Timescale: from 31st March 2019 onwards	We would welcome further national consultation on future funding mechanisms for HSCPs, including pros and cons of direct funding or more medium term funding settlements to health boards and local authorities to allow better medium to longer term financial planning.		The HSCP have contributed positively to work related to the development of a National Care Service for Scotland. The importance of receiving recurring allocations is also highlighted via the national CFO group.	Complete	Representatives from the national CFO section alongside health and care Scotland are represented in appropriate forums.	No further action is required at a local level.	Julie Slavin	Ongoing/Nationally

Effective strategic planning for improvement									
Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence in June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	3. (i) Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB. This will include Health Boards and Local Authorities providing staff and resources to provide such support. The dual role of the Chief Officer makes it both challenging and complex, with competing demands between statutory delivery partners and the business of the IJB. Chief Officers must be recognised as pivotal in providing the leadership needed to make a success of integration and should be recruited, valued and accorded due status by statutory partners in order that they are able to properly fulfil this "mission critical" role. Consideration must be made of the capacity and capability of Chief Officers and their senior teams to support the partnership's range of responsibilities. Timescale: 12 months	We will review the scheme of integration with a view to ensuring the HSCP Chief Officer and HSCP Senior Management Team can act within their appropriate areas of authority.		This work is well advanced with an initial report due to be considered by West Dunbartonshire Council and NHS GGC Board in October 2023.	Ongoing	A full review of the integration scheme is complete. The schemes will be subject to approval through Council and health board governance routes before being put forward for approval by Scottish Ministers. It is anticipated that this will be complete by 31 December 2025.	Further work required to complete task. This included seeking permission to consult, a period of consultation, approval by NHS Board and WDC and final approval by Ministers. A further work stream is required in relation to the Scheme of Officer Delegation	Beth Culshaw	31-Mar-24
		We will review our approach to planning to ensure we are able to identify early the likely support requirements associated with planned changes and the service delivery agenda.			Complete			MJ Cardno	31-Mar-24

		We will refresh the operational approaches across the partnership area relating to transformational change support so we can collectively streamline and align arrangements, operationally and in relation to Strategic Planning and performance.			Complete			MJ Cardno	31-Mar-24
		We will be focusing on delivery of key policies and procedures within operational services areas including Self Directed Support and carers; this aligns to our refreshed approach to commissioning and procurement.		The development of a Policy Register is well advanced.	Complete	Policy register in place and a report will be presented to the HSCP Board with an over view of this work in August 2025.		MJ Cardno	Ongoing

Effective strategic planning for improvement									
The understanding of accountabilities and responsibilities between statutory partners must improve									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence in June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	4. (i) The understanding of accountabilities and responsibilities between statutory partners must improve. The responsibility for decisions about the planning and strategic commissioning of all health and social care functions that have been delegated to the IJB sits wholly with the IJB as a statutory public body. Such decisions do not require ratification by the Health Board or the Local Authority, both of which are represented on the IJB. Statutory partners should ensure duplication is avoided and arrangements previously in place for making decisions are reviewed to ensure there is clarity about the decision making responsibilities of the IJB and that decisions are made where responsibility resides. Existing committees and groups should be refocused to share information and support the IJB. Timescale: 6 months	We will review this to check for clarity of responsibility and accountability as part of the review of the Integration Scheme		This work is well advanced with an initial report due to be considered by West Dunbartonshire Council and NHS GGC Board in October 2023.	Ongoing	A full review of the integration scheme is complete. The schemes will be subject to approval through Council and health board governance routes before being put forward for approval by Scottish Ministers. It is anticipated that this will be complete by 31 December 2025.	Further work required to complete task. This included seeking permission to consult, a period of consultation, approval by NHS Board and WDC and final approval by Ministers. A further work stream is required in relation to the Scheme of Officer Delegation	Beth Culshaw	31-Dec-25

Accountability processes across statutory partners will be streamlined									
	MSG Recommendation	**Agreed Action September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence In June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	4. (ii) Accountability processes across statutory partners will be streamlined. Current arrangements for each statutory partner should be scoped and opportunities identified for better alignment, with a focus on better supporting integration and transparent public reporting. This will also ensure that different rules are not being applied to different parts of the system particularly in circumstances of shared accountability.	We are committed to creating an environment where data and information is reviewed and interpreted by all partners in a similar way		The HSCP developed a Strategic Needs Assessment which served as the basis for the 2023 - 2026 Strategic Plan Improving Lives Together. Six workshops with multiple partners were delivered in order to ensure that the data was understood in a consistent way. The HSCP have established a Programme Management Office as part of the governance framework for all major change projects, this provides further assurance that decisions are data informed. A Multi agency data set has been developed and is used by PPCOG.	Complete	This is now business as usual. Data sets are developed and renewed on a regular basis to ensure the needs of the audience are met. Data is presented to a series of partnership forums including, the Strategic Planning Group; the ADP; and the Suicide Prevention Steering Group.		MJ Cardno	31-Mar-23

Effective, coherent and joined up clinical and care governance arrangements must be in place									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence In June 2025**	**Position In June 2025**	**Evidence In June 2025**	**Improvement Action (June 2025)**
	4. (v) Effective, coherent and joined up clinical and care governance arrangements must be in place. Revised statutory guidance will be developed based on wide ranging consultations with local partnerships, identifying good practice and involving all sectors. The key role of clinical and professional leadership in supporting the IJB to make decisions that are safe and in accordance with required standards and law must be understood, co-ordinated and utilised fully.	We are further developing our quality assurance processes and structures will further develop our quality improvement framework and transformational change approach.		Quality Improvement and Quality Assurance Frameworks will all be considered by the IJB on 19 September 2023.	Ongoing	Quality Framework is well advanced but remains incomplete.	Further work will be required to implement these strategies.	MJ Cardno	31-Mar-24

Ability and willingness to share information									
IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position In June 2025**	**Evidence In June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	5. (i) IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data. Chief Officers will work together to consider, individually and as a group, whether their IJBs' annual reports can be further developed to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure that, as a minimum, all statutorily required information is reported upon.	The national Chief Officers Group have agreed to work collectively to agree a common framework and benchmarking processes.		It appears this has not progressed due to Covid. No further SG updates are available	Complete	No further action can be taken at a local level.	No further action can be taken at a local level.	B Culshaw	Unlikely to progress in the short term.

	Timescale: By publication of next round of annual reports in July 2019	We will continue to work to the challenging timescales of July 2019 round of reports, and will be seeking to work with Scottish Government to address these pressures.		Discussions with Scottish Government via Healthcare Improvement Scotland have reached their conclusion. No improvements which require legislative change will be progressed out with the work related to the National Care Service.	Complete	No further progress at a national level. The HSCP Board continues to develop and publish the annual performance report in line with current legislative deadlines.	No further action can be taken at this stage.	MJ Cardno	Incomplete and unlikely to progress in the short term.

Identifying and implementing good practice will be systematically undertaken by all partnerships

	MSG Recommendation	Agreed Actions September 2019	Position August 2023	Evidence August 2023	Position in June 2025	Evidence In June 2025	Improvement Action (June 2025)	Responsible Officer	Original/Planned Completion Date
	5. (ii) Identifying and implementing good practice will be systematically undertaken by all partnerships. Chief Officers will develop IJBs' annual reports to enable partnerships to identify, share and use examples of good practice, and lessons learned from things that have not worked. Inspection findings and reports from strategic inspections and service inspections should also provide a clear means of	We are committed to working with the national Chief Officers Group to work collectively to agree a common framework and benchmarking processes.		It appears this has not progressed due to Covid. No further SG updates are available	Complete	This work is undertaken at a local level by the Chief Officers. No further action appears to be progressing at a national level.	No further action can be taken at a local level.	B Culshaw	Unlikely to progress in the short term.

	identifying and sharing good practice, based on implementation of the framework outlined below at 5 (iii) and the national health and social care standards. Timescale: 6 - 12 months								

Meaningful and sustained engagement									
Effective approaches for community engagement and participation must be put in place for integration									
	MSG Recommendation	**Agreed Actions September 2019**	**Position August 2023**	**Evidence August 2023**	**Position in June 2025**	**Evidence In June 2025**	**Improvement Action (June 2025)**	**Responsible Officer**	**Original/Planned Completion Date**
	6. (i) Effective approaches for community engagement and participation must be put in place for integration. This is critically important to our shared responsibility for ensuring services are fit for purpose, fit for the future, and support better outcomes for people using services, carers and local communities. Revised statutory guidance will be developed by the Scottish Government and COSLA on local community engagement and participation based on existing good practice, to apply across health and social care bodies. Meaningful engagement is central to achieving the scale of change and reform required, and is an ongoing process that is not undertaken only when service change is proposed. Timescale: 6 months	We will continue to review and revisit our approach to participation and engagement with partners and our citizens and measure against national good practice and standards for community engagement.		The Strategic Plan and associated delivery plan were approved in March 2023. This includes an action to review and update the participation and engagement strategy.	Complete	Participation and Engagement Strategy approved by HSCP Board November 2024. Annual report presented in May 2025.		MJ Cardno	31-Mar-24

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

AUDIT AND PERFORMANCE COMMITTEE

Report by MJ Cardno, Head of Strategy and Transformation

25 June 2025

Subject: West Dunbartonshire HSCP Best Value Statement

1. Purpose

1.1 The purpose of this report is to provide a statement in relation to how the HSCP Board has delivered Best Value during the previous financial year.

2. Recommendations

2.1 It is recommended that the HSCP Audit and Performance Committee approve the Best Value Statement, which can be found in Appendix One of this report.

3. Background

3.1 Integration Joint Boards (IJBs) have a statutory duty to make arrangements to secure Best Value. To achieve this, IJBs are required to have effective arrangements in place for scrutinising performance, monitoring progress towards achieving strategic objectives and holding partners to account.

3.2 Part of evidencing the work that the HSCP Board does in relation to Best Value, the Best Value Statement is reviewed and updated on an annual basis.

3.3 The statement considers West Dunbartonshire's HSCP position in relation to 10 key Audit Scotland Best Value prompts. Based on this statement and placing appropriate reliance on the Best Value arrangements in place through the West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board.

3.4 These 10 questions and last year's response was reviewed by the HSCP Senior Management Team (SMT) on the 3 June 2025. Updated responses were provided and collated, and the draft response can be found in Appendix One of this report.

4. Main Issues

4.1 The 10 Audit Scotland Best Value Prompts are:

1) Who do you consider to be accountable for securing Best Value in the IJB?
2) How do you receive assurance that the services supporting the delivery of the strategic plan are securing Best Value?

3) Do you consider there to be sufficient buy-in to the IJB's longer term vision from partner officers and members?
4) How is value for money demonstrated in the decisions made by the IJB?
5) Do you consider there to be a culture of continuous improvement?
6) Have there been any service reviews undertaken since establishment – have improvements been identified? Is there any evidence of improvements in services and/or reductions in pressures as a result of joint working?
7) Have identified improvement actions been prioritised in terms of those likely to have the greatest impact?
8) What steps are taken to ensure that quality of care and service provided is not compromised as a result of costs saving measures?
9) Is performance information reported to the board of sufficient detail to enable value for money to be assessed?
10) How does the IJB ensure that management of resources (finances, workforce etc.) is effective and sustainable?

4.2 Appendix One highlights opportunities for improvement specifically it is acknowledged there are improvements to be made in linking key performance indicators with budget projections. In the current financial climate it is increasingly important that the HSCP Board can clearly see those outcomes which relate to spending decisions enabling the Board to effectively allocate resources. These linkages can also help forecast the financial impact of performance trends, such as rising demand and improving strategic planning.

5. Options Appraisal

5.1 An options appraisal is not required in relation to the recommendation within this report.

6. People Implications

6.1 There are no people implications arising from the recommendation within this report.

7. Financial and Procurement Implications

7.1 There are no financial and procurement implications arising from the recommendation within this report.

8. Risk Analysis

8.1 The recommendation within this report does not necessitate the development of a risk assessment. Good governance in relation to best value does support the mitigating actions in relation to the HSCP Boards strategic risk "Performance Management".

9. Equalities Impact Assessment (EIA)

9.1 An EIA is not required for the recommendation within this report as the recommendation does not have an impact on those with protected characteristics.

10. Environmental Sustainability

10.1 The recommendation within this report does not require the completion of a Strategic Environmental Assessment (SEA).

11. Consultation

11.1 The HSCP Senior Management Team, the HSCP Chief Finance Officer, the HSCP Board Monitoring Solicitor and the Internal Auditor have been consulted in the production of this report and their comments incorporated accordingly.

12. Strategic Assessment

12.1 On the 15 March 2023 the HSCP Board approved its Strategic Plan 2023 – 2026 "Improving Lives Together". The Plan outlines sustained challenge and change within health and social care, these changes bring with them a host of governance implications: cultural, operational, structural, ethical and clinical.

12.2 Good governance, which includes best value, is essential to ensure the actions within the Strategic Plan are implemented effectively and efficiently in a way which promotes safe and effective care whilst achieving best value.

13. Directions

13.1 The recommendation within this report does not require the production of a Direction.

Name: Margaret-Jane Cardno
Designation: Head of Strategy and Transformation
West Dunbartonshire Health and Social Care Partnership
Date: 30 May 2025

Person to Contact: Margaret-Jane Cardno
Head of Strategy and Transformation
West Dunbartonshire Health and Social Care Partnership

Appendices: Appendix I: Best Value Statement

Number	Audit Scotland Prompts	West Dunbartonshire Response
1	Who do you consider to be accountable for securing Best Value in the IJB?	All those within the Integration Joint Board (IJB), known locally as the HSCP Board, and the HSCP itself have a duty to secure Best Value. Arrangements are in place to secure continuous improvements in performance, while maintaining an appropriate balance between the quality and cost of health and social care services. The HSCP Board is supported by the Chief Financial Officer (CFO) who has the responsibility for the administration of the partnership's financial affairs (s95 of the Local Government (Scotland) Act 1973). The IJB is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively, i.e. demonstrate Best Value. The IJB is the key decision-making body, comprising of six voting members, with one from each partner organisation assuming the role of Chair and Vice Chair. West Dunbartonshire Council nominates three elected members and NHSGGC Health Board nominates three non-executive members. There are also several non-voting professional and stakeholder members on the HSCP Board. Stakeholder members currently include third sector, Carer and staff-side representatives; professional members include the Chief Officer, Chief Financial Officer, Clinical Director, Chief Nurse and Lead EHP. In 2024/25 the HSCP Board made a proactive effort to recruit further stakeholder members to ensure the voice of lived experience on the Board was enhanced. This has resulted in the appointment of one new stakeholder member. The IJB is supported by the Chief Officer, Chief Finance Officer, West Dunbartonshire Senior Management team and partner organisations. Responsibility for best value sits at all levels within the HSCP. In addition to the above all commissioning of services from external agencies should be evaluated with Best Value principles as part of the corporate procurement processes for both WDC and NHSGG&C. Greater transparency in relation to commissioned services has been a focus in 2024/25 with the HSCP Board Audit and Performance Committee receiving quarterly reports on the quality of registered services.

2	How do you receive assurance that the services supporting the delivery of the strategic plan are securing Best Value?	The HSCP Board is scheduled to meet six times per year and all agendas and meeting papers are available on the HSCP Board website. While regular financial and performance reporting provides evidence of this, to fully meet this responsibility the HSCP Board continues to have in place robust arrangements for the governance of its affairs and the effectiveness of its functions, including the identification, prioritisation and the management of risk. The IJB has established an Audit and Performance Committee to support the Board in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge and promoting a culture of continuous improvement in performance. In discharging this responsibility, the Chief Officer has put in place arrangements for governance which includes a system of internal control. The system is intended to manage risk to a reasonable level and to support the delivery of the HSCP Board's policies, aims and objectives. The Chief Internal Auditor reports directly to the HSCP Board's Audit and Performance Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Audit and Performance Committee on any matter. The Audit and performance Committee considers care inspectorate reports on services provided by both internal services and external providers and internal audit reports which provides recommendations on improvements. All Audit and performance committee members have been asked to participate in the CIPFA Audit Committee Self-Assessment of Good Practice which will provide examples of how members are demonstrating Best Value. The HSCP Board approved a Strategic plan for 2023/2026. The Strategy details how Best Value is at the core to any new policy or improvement project. The HSCP Strategic Delivery plan aligns with the financial strategy, and the Audit and Performance committee provides assurance around this delivery plan by tracking actions via the Councils performance and risk management system, Pentana. The Audit and Performance Committee share updates of the actions via Pentana at the meetings. Several other governance systems are in place in order that assurance can be provided at all levels for example: HSCP Project Management Office (which has oversight of all major change projects). Clinical & Care Governance Group (ensures the quality, safety, and accountability of integrated health and social care services. Strategic Planning Group (statutory body established under the Public Bodies (Joint Working) (Scotland) Act 2014. Its main purpose is to support the development, review, and monitoring of the Strategic Commissioning Plan for each Integration Authority). HSCP Senior Management Team. Corporate Management Teams of the Health Board and Council. The performance of the HSCP is scrutinised in the public forum, via the HSCP Board and the HSCP Board Audit and Performance Committee. Quarterly in year reports are published alongside the statutory Annual Performance Report and various other annual reports for example the Chief Social Work Officer Annual Report.

		Actual performance is compared to targets and (where appropriate) previous year results, a suitable narrative is provided to address causal factors and outline improvement actions. These reports are published on the HSCP web pages. It is acknowledged there is improvement to be made in linking key performance indicators with budget projections. The reporting is via the HSCP annual performance reports and the medium term financial plan. The IJB also receives reports on the number and nature of complaints received by the HSCP. Service users are made aware of the Complaints process when they are provided a care package by HSCP, details are also available on the HSCP website. Work is ongoing to roll out Care Opinion within the HSCP in order that feedback can be more effectively used to shape service delivery.
3	Do you consider there to be sufficient buy-in to the IJB's longer term vision from partner officers and members?	The IJB members work together to ensure the agreed HSCP strategic plan meets its objectives and to meet the long term vision. This is evidenced through voting and non voting members attending IJB, providing comments on new policies and papers on the IJB agenda. The health board and local authority delegate significant budget resources to deliver the integration of health and social care services, which have themselves been delegated to the IJB. A strategic plan 2023/2026 was created in joint venture with local partners and internal council and NHS services. The partners were involved in providing comment and the key drivers within the strategic plan by attending workshops, strategic needs assessment workshops and completing surveys. The Strategic Plan demonstrates the responsibilities of both partners. In relation to financial planning there are challenges setting the budget, planning and delivering the cost savings required. The current financial position presents a risk, against the longer term strategic planning. This poses a risk that contrary decisions are being made by IJB which will affect previous strategies. Long term ambitions of prevention, versus short comings of current financial pressures is causing complexity within IJB decision making.

4	How is value for money demonstrated in the decisions made by the IJB?	The IJB can demonstrate value for money in their decision-making by ensuring that resources are used efficiently, effectively, and sustainably to improve health and social care outcomes In West Dunbartonshire this can be evidenced through: The IJB has approved it strategic commissioning plan “Improving Lives Together 2023 – 2026”. This plan is based on a strategic population needs assessment, it is supported by a delivery plan which includes evidence based interventions and is supported by stakeholder engagement which includes service users and carers. Regular performance monitoring and reporting, including service performance against national health and wellbeing outcomes; financial performance, including budget adherence and cost-effectiveness and the impact of services on reducing hospital admissions and improving community care. External and internal audit teams assess IJBs’ financial management and service delivery. Any findings are used to improve governance, transparency, and accountability. Collaborative procurement and commissioning working closely with NHSGGC, the local authority and third sector providers. Risk and financial planning, using tools like Pentana and Datix to manage financial and operational risks, ensuring that decisions are sustainable in the long term and responsible to changing demand. All IJB papers carry a section that clearly outlines the financial implications of each proposal as well as other implications in terms of legal, HR, equality, risk analysis, consultation, strategic assessments, diversity and linkage to the IJBs strategic objectives. IJB engages in debate and discussions around the application of new funding and savings proposals, many of which are supported by additional IJB members development sessions on budget position and savings options. For example, any change is trialled and tested, before any lasting change is implemented. All changes are measurable via quality indicators. Various governance routes are required within a project before any final decisions are made, this ranges from strategic IJB approval, through to tactical oversight and PMO and operational engagement via project teams and working groups. The performance and financial reports detail if targets are being met and shows if Best Value has been achieved.

5	Do you consider there to be a culture of continuous improvement?	This is an area which could be strengthened. There is an appetite within the IJB to use data to inform decisions and use measures to drive improvement plans, re-designs of services and digital transformations. Regular audits also provide valuable feedback on what areas need improved. Continuous improvement is a topic which needs to be embedded at every level, and through training, the Service Improvement Lead within the Strategy and Transformational team, processes and change methodology will be provided to all employees. The council and NHSGGG&C provide training on continuous improvement and change management to help managers start improvement plans and projects within their remit. Improvement projects are discussed regularly at IJB and any output from audit recommendations are fed back to services to implement. Through the implementation of Excellence in Care the aim is that all NHS boards and integrated joint boards will have consistent and robust processes and systems for measuring, assuring and reporting on the quality of nursing and midwifery care and practice. The systems will inform quality of care reviews at national and local level and drive continuous improvements in nursing and midwifery care quality. There are multiple change projects ongoing within the HSCP these are delivered in line with key NHS or local authority HR policies and are monitored via the HSCP PMO. Work is ongoing to develop and implement a Quality Framework for internal and commissioned services.

6	Have there been any service reviews undertaken since establishment – have improvements been identified? Is there any evidence of improvements in services and/or reductions in pressures as a result of joint working?	There are multiple service reviews underway across the HSCP. All are undertaken in the spirit of improvement and seek to drive efficiencies within services whilst maintaining quality. These workstreams are approved by the IJB and monitored via the HSCP PMO.
7	Have identified improvement actions been prioritised in terms of those likely to have the greatest impact?	The impact of any proposed change is assessed at an early stage and all major change projects require a Project Initiation Document which highlights impact and outcomes. These are approved and monitored via the PMO and decision based on benefits anticipated, alignment with the strategic priorities and quality care governance and professional standards. The pressure on budgets is a significant driver with improvement projects seeking to achieve financial efficiencies. External factors such as reduction in expenditure can play a factor in prioritising these projects. The outcomes of inspections undertaken by regulatory bodies also play a significant factor in terms of how projects are prioritised.

8	What steps are taken to ensure that quality of care and service provided is not compromised as a result of costs saving measures?	All savings proposals are subject to a full assessment which includes: alignment to strategic plan, alignment to quality care governance, professional standards including risk assessment by professional leads, equalities impact assessment, risk assessment by responsible heads of service, mitigating actions and stakeholder engagement, as appropriate. Where possible the HSCP take an evidence based approached or tests of change to ensure anticipated benefits are realised and there is no compromise to care. It is recognised that care standards are audited against national frameworks. Reserves and additional government funding are used to minimise the reduction of quality of care, however this position is not tenable going forward. The challenging financial position within the IJB is not projected to improve, which means further cuts to service spend is required. The risks are highlighted for each saving proposal for consideration by the IJB. All decisions made are based on risk. Assurance can be found in the measures for quality control. It is key that all services have measures to ensure quality is not degraded by financial changes. Clinical and Care Governance is the process by which accountability for the quality of health and social care is monitored and assured, while supporting staff in continuously improving services using recognised quality improvement methodologies, and ensuring that poor performance is identified and addressed.
9	Is performance information reported to the board of sufficient detail to enable value for money to be assessed?	Quarterly and annual performance reports are submitted to the IJB for scrutiny covering a wide range of indicators. The quarterly public performance report focuses on those key strategic performance indicators for the partnership where performance data is available for the specific time period reported and in addition is augmented with data on key aspects of workforce and financial performance. The preparation and presentation of the annual performance report is produced in line with national guidance. There continues to be an increasing focus on demonstrating the best use of public money. Openness and transparency in how the IJB operates and makes decisions is key to supporting understanding and scrutiny. Transparency means that the public has access to understandable, relevant, and timely information about how the body is taking decisions and using resources. The IJB has its own website which includes the schedule of meetings and the agenda, reports, and minutes for each meeting of the Integration Joint Board and Audit and Performance Committee. Agenda and papers are posted in advance of meetings to allow members of the public access.The IJB have improved the openness and transparency of its activities and decision making. All Board and Audit and Performance Committee meetings are audio streamed, with recordings available on the West Dunbartonshire Council website. Informal HSCP sessions have also been arranged to provide regular updates on projects, key emerging issues and performance reports.

10	How does the IJB ensure that management of resources (finances, workforce etc.) is effective and sustainable?	Workforce and organisational development plans are linked to the strategic plan. The audit committee receives absence monitoring updates and the actions being taken across the HSCP and partner bodies. This is also supported by internal audit reports presented to IJB by the chief internal auditor. Regular budget and performance monitoring reports to the IJB give a detailed review of the management of resources and any required mitigating actions. These reports are firstly scrutinised at SMT and clinical and care governance groups. All IJB reports contain a section outlining the financial implications of each paper. The IJB board includes third sector partners, trade unions, GP locality representatives, carers, and local community representatives. They are involved in board development sessions and the strategic planning group where they can challenge in forums which allow for more informal detailed discussions and lower level management input. The Strategic risk register documents any risks to resources and these risks are reported twice a year to IJB. These strategic risks are escalated risks from the services operational risk register which are reviewed every quarter.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by the Chief Financial Officer

25 June 2025

Subject: External Audit Progress Report and Information Request to Those Charged With Governance

1. Purpose

1.1 The purpose of this report is to:

- Present a progress update from Forvis Mazars on their responsibilities as external auditors for the HSCP Board;
- Consult with members of the Audit and Performance Committee regarding our external auditor's request for information on the HSCP Board's approach to fraud, litigation, laws, and regulations as part of their 2024/25 audit; and
- Review and approve the draft response to our external auditor's information request on compliance with International Standards for Auditing (ISAs).

2. Recommendations

2.1 Members of the Audit and Performance Committee are asked to:

- **Approve** the response to our external auditors on compliance with International Standards for Auditing (ISAs) in relation to fraud, litigation, laws and regulations by the 18 July 2025 deadline.

3. Background

3.1 Forvis Mazars, our external auditors, presented their Annual Audit Plan to the Audit and Performance Committee on 18 February 2025. The plan detailed the scope of the 2024/25 audit, including significant risks and key judgement areas such as Management override of controls.

3.6 As part of their annual review, Forvis Mazars wrote to the HSCP Senior Management Team and the Audit and Performance Committee to seek responses on reporting arrangements for key areas like fraud, litigation, laws, and regulations under International Standards for Auditing (ISAs).

4. Main Issues

4.1 In advance of the submission of the 2024/25 unaudited annual accounts, our external auditor has prepared a short progress report (see Appendix 1) on their responsibilities and activity since the presentation of their Annual Audit Plan.

4.2 They have completed work on planning and risk assessment to enhance their *"understanding of the IJB and its business environment, assessment of the IJB's internal control and risk framework, understanding of fraud and the IJB's risk factors, and set our initial materiality levels".*

4.3 The report also provides details on areas of work in progress, including wider scope work on the IJB's arrangements for financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes during the fieldwork phase of the audit. The audit will also report on how the IJB demonstrates and reports that it has Best Value arrangements in place to secure continuous improvement.

4.4 The HSCP Board's Audit and Performance Committee oversees risk, control, governance, and the governance statement. Appendix 2 includes a letter from the external auditor requesting assurance on how those charged with governance fulfil their responsibilities.

4.5 The request consists of 14 questions, each with sub-sections explaining the relevant ISAs, with a response due by 18 July 2025. A draft response has been prepared by the Chair and Vice Chair of the committee, along with support from the CFO and the Chief Internal Auditor, and is included in Appendix 3.

4.6 The response summarises the assurance work done this year, as described in the review of the Local Code, the Annual Governance Statement, and CIPFA's Financial Management Code. It highlights our partner organisations' lead role in ensuring effective internal control systems.

5. Options Appraisal

5.1 There is no requirement for an option appraisal for the content of this report.

6. People Implications

6.1 The HSCP Finance Team is responsible for preparing the annual accounts and providing all necessary supporting documentation and explanations to external auditors.

7. Financial and Procurement Implications

7.1 There are no financial implications specific to this report.

8. Risk Analysis

8.1 There is a risk that the audit of the 2024/25 annual accounts could be delayed if members of the Audit and Performance Committee do not provide a timely response to our external auditor's information request.

9. Equalities Impact Assessment (EIA)

9.1 There is no requirement for an EIA for the content of this report.

10. Environmental Sustainability

10.1 There is no environmental sustainability impact for the content of this report.

11. Consultation

11.1 This report was prepared in consultation with the Chair of the Audit and Performance Committee, HSCP Board's Chief Internal Auditor and the HSCP Senior Management Team.

12. Strategic Assessment

12.1 The preparation and audit of the HSCP Board's Annual Accounts is a statutory requirement.

13. Directions

13.1 There is no direction required for the content of this report.

Julie Slavin
Chief Financial Officer
10 June 2025

Person to Contact: Julie Slavin – Chief Financial Officer,
Church Street, Dumbarton G82 1QL
Telephone: 07773 934377
e-mail: julie.slavin@nhs.scot

Appendices:
Appendix 1: Forvis Mazars Progress Report
Appendix 2: Letter from Forvis Mazars to the members of the Audit and Performance Committee
Appendix 3: Draft Response by the Audit and Performance Committee as Those Charged With Governance

Background Papers: document-pack-hscp-audit-and-performance-committee-18-february-2025.pdf

Audit Progress Report

West Dunbartonshire Integration Joint Board

June 2025

Contents

01

Audit progress

Audit progress

Purpose of this report

This report provides the Audit and Performance Committee with information about progress in delivering our responsibilities as external auditors for the West Dunbartonshire Integration Joint Board (IJB).

We are committed to the delivery of high-quality audits. In this context, we plan to complete the 2024/25 audit by September 2025 and present our draft Annual Audit Report to the Audit and Performance Committee on 30 September 2025.

We have completed the planning and risk assessment phase of the 2024/25 audit. We have not identified any changes to our audit approach including the significant risks which we presented to you in the Annual Audit Plan.

We have met regularly with the finance team as the audit progresses, and we will continue to do so. We remain on target to carry out our final fieldwork in July and August 2025.

Summary of work and status to date:

Areas	Description	Status
Planning and risk assessment	We have completed our detailed understanding of the IJB and its business environment, assessment of the IJB's internal control and risk framework, understanding of fraud and the IJB's risk factors, and set our initial materiality levels.	Completed
Understanding of key business processes and walkthroughs	We have the remaining procedures to perform at the final fieldwork phase: • Provision for un-recovered charges - Business process understanding and walkthrough • Year-end financial statements close process – Business process understanding and walkthrough	To be completed
Wider scope	We will complete our review of the adequacy of the IJB's arrangements for financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes during the fieldwork phase of the audit. We will also report on how the IJB demonstrates and reports that it has Best Value arrangements in place to secure continuous improvement.	To be completed

02

National publications

National publications

Audit Scotland

1. Publication: Integration Joint Boards finances continue to be precarious

There is a concerning picture of continued overspending, depletion of reserves and savings being met through one-off rather than recurring savings.

Link: https://audit.scot/publications/integration-joint-boards-finances-continue-to-be-precarious

2. Local government budgets 2025/26

Mounting pressures from inflation, increasing costs and demand are exceeding the Scottish Government's additional investment in Scotland's councils. In 2025/26 councils received over £15 billion in government funding, with more money set to be raised from council tax and charges for some services. With communities paying more for services, their expectations are increasing.

Link: Local government budgets 2025/26 | Audit Scotland

National publications

Forvis Mazars

3. Annual Local Government Risk Report

This publication deep dives into the known and emerging risks for Local Authorities in 2025/26, as well as what local authorities should consider including in their internal audit plans.

Link: Annual Local Government Risk Report for 2025/26 - Forvis Mazars - United Kingdom

4. Public sector in focus: Charting the road ahead

This report addresses the significant challenges faced by the public and social sectors, including economic pressures, workforce shortages, and rising demand for services. It emphasises the need for innovative strategies and effective partnerships to navigate these complexities and highlights the importance of operational and technological innovation to improve service delivery and build resilience in public sector organisations.

Link: Public sector in focus: Charting the road ahead - Forvis Mazars - United Kingdom

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Date: 28 May 2025

Dear Audit and Perfromance Committee Members,

West Dunbartonshire Integration Joint Board (the IJB) – 2024/25 : Audit and Performance Committee briefing note – ISA 240 (Fraud), ISA 250 (laws and regulations), ISA 501 (litigation and claims) & ISA 570 (going concern)

Introduction

This letter aims to summarise for the Audit and Performance Committee (the Committee) the requirements under International Auditing Standards, in respect of preventing fraud in the annual accounts, compliance with laws and regulations, litigation and claims, and going concern. This letter requests an update from the Committee in order to inform our continuous audit planning as we move into the final stage of our audit of the IJB's 2024/25 accounts.

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

Background

Under the ISA, the primary responsibility for preventing and detecting fraud rests with both management and 'those charged with governance', which for the IJB is the Audit and Performance Committee. This includes fraud that could impact on the accuracy of the annual accounts.
The ISA requires us, as external auditors, to obtain an understanding of how the Committee exercises oversight of management's processes for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

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

The ISA views fraud as either:

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

What are auditors required to do?

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

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

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

2) How does the Committee oversee management processes to identify and respond to the risk of fraud and possible breaches of internal control? Is the Committee aware of any breaches of internal control during 2024/25? Please provide details.

3) Has the Committee knowledge of any actual, suspected or alleged fraud during the period 1 April 2024 – 31 March 2025? Where appropriate please provide details.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Background

Under the ISA, in the UK and Ireland, the primary responsibility for ensuring that the entity's operations are conducted in accordance with laws and regulations and the responsibility for the prevention and detection of non-compliance rests with management and 'those charged with governance', which for the IJB is the Audit and Performance Committee. The ISA

requires us, as external auditors, to obtain an understanding of how the IJB gains assurance that all relevant laws and regulations have been complied with.

What are auditors required to do?

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

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

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

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

Background

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

What are auditors required to do?

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

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

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

Background

Financial statements are generally prepared on the basis of the going concern assumption. Under the going concern assumption, an audited body is ordinarily viewed as continuing in operation for the foreseeable future. Accordingly, assets and liabilities are recorded in financial statements on the basis that the audited body will be able to realise its assets and discharge its liabilities in the normal course of its operations.

What are auditors required to do?

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

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

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

The way forward

The information you provide will help inform our understanding of the IJB and its business processes, prior to the start of the final stage of the audit of the 2024/25 financial statements.

I would be grateful for your responses, which should be formally considered and communicated to us on the Committee's behalf to cover the year to 31 March 2025, by 18 July 2025. In the meantime, if you have any queries, please do not hesitate to contact me.

Yours sincerely,

T. Reid

Tom Reid
Audit Director
Forvis Mazars LLP

MAZARS LETTER TO THOSE CHARGED WITH GOVERNANCE

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

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

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

HSCP Board Audit and Performance Committee Response

The HSCP Board's financial statements are prepared by experienced and professionally qualified accountants who are regulated by the standards of their respective institutes. The financial statements reflect the transactions which have been processed by both partners' West Dunbartonshire Council (WDC) and NHS Greater Glasgow and Clyde (NHSGGC) financial systems. These systems are protected by internal controls and procedures which are regularly reviewed and tested by both partners' internal audit teams, and our external auditors. Consequently although the material misstatement cannot be ruled out, its likelihood is low.

The HSCP Board Audit and Performance Committee provides oversight and challenge in relation to the financial statements and seeks assurances from the Chief Financial Officer (s95) that the accounts are not materially misstated. Updates are regularly provided to both the HSCP Board and Audit and Performance Committee in key areas of the statement, any changes in accounting policies and their impact on the statements.

The HSCP Board Audit and Performance Committee is provided regular updates on internal audit activity, including anti-fraud activities, across both partner bodies and takes assurance from the partners' internal controls in relation to fraud and error identification.

The HSCP Board is not an employing organisation. All employees engaged to deliver HSCP services will follow the employing partners' code of conduct which describes the standards of conduct and practice which all employees should follow.

As stated above, the HSCP Board is not an employing organisation, therefore takes assurance on the partners' policies and processes for identifying and responding to fraud and error e.g. Whistleblowing Policies which enables any individual to register, in confidence, any concerns regarding alleged misconduct and fraudulent or corrupt activity. These policies can be found on the individual partners' website and intranet.

2) How does the Committee oversee management processes to identify and respond to the risk of fraud and possible breaches of internal control? Is the Committee aware of any breaches of internal control during 2024/25? Please provide details.

HSCP Board Audit and Performance Committee Response

It is the responsibility of the individual partners' management teams, of which HSCP senior managers are members of, to develop and maintain sound systems of risk management, governance and internal control. This includes the requirement to identify and respond to any identified breaches of internal control.

The Annual Governance Statement, approved by the Audit and Performance Committee as a standalone document together with the annual review of the Board's Local Code sets out the assurance taken from the partners' individual internal control systems. It is also acknowledged that internal control systems, no matter how well designed and operated, are affected by inherent limitations that require to be mitigated and minimised. This is supported by key policies including Financial Regulations/Standing Financial Instructions.

In terms of oversight, both WDC and NHSGGC Internal Audit functions plays key roles in this regard. While Internal Audit work is not a substitute for management's responsibilities for the design and operation of these systems, and is not responsible for identifying all significant control failure, the audit teams have an important role in providing assurance on WDC and NHSGGC control environment and in providing a view on the partners' processes for identifying control failures, and endeavours to plan its work so that work is focused on those areas where there is higher risk. The Audit and Performance Committee receives regular updates on the outcome of the work undertaken within the partner organisations.

Both WDC and NHSGGC have risk-based audit plan which are produced annually based on best practice, taking cognisance of the strategic and operational risk registers and engagement with senior managers, including those within the HSCP. The HSCP Board also has its own risk-based audit plan developed in the same way as above.

The methodology for prioritising HSCP Board audit work is set out in the audit strategy and plan. Findings are reported as Red, Amber or Green which aligns with the HSCP Board's risk management strategy. Red and Amber findings are reported to Audit Committee together with management's agreed actions to address these issues.

The Audit and Performance Committee receive a range of assurances/reports during the year which touch upon aspects of internal control. Reports in 2024/25 have included:

- Annual Audit Plans from internal and external audit
- Annual Internal Audit Report and Assurance Statement
- Internal Audit progress reports
- Annual Governance Statement
- Risk management update on Strategic Risk register
- Annual Clinical and Care Governance Report

All HSCP Heads of Service, Chief Officer and Chief Financial Officer attend every meeting of the Audit and Performance Committee to respond to questions.

3) Has the Committee knowledge of any actual, suspected or alleged fraud during the period 1 April 2024 – 31 March 2025? Where appropriate please provide details.

HSCP Board Audit and Performance Committee Response

As the HSCP Board are not an employing body and do not hold a bank account any suspected/alleged instances of fraud that may have occurred during 2024/25 would be detailed within the regular reports to the Council and Health Board Audit Committees.

There were no significant incidents relating to any HSCP service activity.

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

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

HSCP Board Audit and Performance Committee Response

See responses above regarding assurance taken from WDC and NHSGGC internal control systems, role of internal audit teams and reporting to the Committee.

It is recognised by the Committee that as with any large and complex organisation there are a range of fraud risks and emphasis on reducing fraud risk is continuous. The results of the National Fraud Initiative (NFI), WDC and NHSGGC internal audit work and reported fraud show some low value frauds.

WDC, NHSGGC and HSCP Management and respective Audit Committees are kept up to date with fraud risks through updates on counter fraud arrangements, Internal Audit and other ad hoc reports.

Fraud risks are acknowledged in key areas. Members and officers are aware of these and the risks are managed through established risk management processes.

The Committee receives regular reports on Care Inspectorate activity, including concerns and associated improvement actions. The financial viability of externally commissioned services has been added to the Strategic Risk Register.

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

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

HSCP Board Audit and Performance Committee Response

See responses above on HSCP staff being employed by either WDC or NHSGGC and therefore adhere to core policies and processes of the employing organisation. With regards to delivering HSCP services financial transactions are processed through both WDC and NHSGGC financial systems depending on the service being delivered.

Key controls such as the segregation of duties, management review and supervision and authorisation and approval are evident in each of the Council and Health Board's core systems. It is acknowledged that maintaining an effective control environment is challenging in a time of reducing resources and a changing operating environment. For this reason, internal audit teams will have a continued role in supporting the Council and Health Board in ensuring that adequate but appropriate control environments are in place.

The HSCP Chief Officer, Chief Financial Officer and SMT as members of our partners' corporate management teams complete annual returns on the internal control environment and identify areas for improvement. In overall terms, WDC Chief Internal Auditor has concluded that reasonable assurance can be provided on the Council's system of internal control for 2024/25. It is anticipated that NHSGGC's Internal Auditors will provide similar assurance.

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

HSCP Board Audit and Performance Committee Response

See responses above on HSCP staff being employed by either WDC or NHSGGC and therefore adhere to core policies and processes of the employing organisation. All policies including fraud and whistleblowing are available on partners' respective websites and intranet.

Both WDC and NHSGGC promotes a zero tolerance toward fraud and promotes cultures that enables individuals to identify potential fraud and empowers them to report their concerns in a safe and secure manner to the appropriate people at the right time. The Extended Management Team have received Fraud Prevention and Detection sessions in June 2024.

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

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

HSCP Board Audit and Performance Committee

Fraud and corruption, and associated risks, come in many forms and, consequently, it is not easy to specifically identify specific posts where there are greater risks than others. However there is a general recognition that there is an inherent risk of fraud within an organisation like the HSCP and partner organisations and the risk of fraud is managed through existing controls and procedures which are in place across these organisations.

As stated above the Audit and Performance Committee takes assurance from the work of internal audit, the established fraud policies in place and ongoing embedding of a culture of fraud awareness through a programme of anti-fraud training and the work of the Council and Health Board's fraud teams.

This helps ensure that issues identified as a result of Internal Audit work or fraud investigations, result in recommendations to management to address gaps in control to ensure that risks are properly mitigated to acceptable levels.

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

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

HSCP Board Audit and Performance Committee Response

The Audit and Performance Committee are not aware of any related party relationships or transactions that could give rise to instances of fraud. The committee will considered and sign off the annual governance statement, local code and draft annual accounts in June for external audit to commence their audit. Disclosure of significant related party relationships is required for both members and officers in positions of influence.

Both WDC and NHSGGC will provide letters of assurance for 2024/25 year which should confirm that the charges for the services commissioned by West Dunbartonshire IJB reflect the income and expenditure recorded in both Council and Health ledgers and are complete and accurate.

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

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

HSCP Board Audit and Performance Committee Response

See Response above.

The Audit and Performance Committee are not aware of any accounting entries which are suspected to be false or intentionally misleading. Should management become aware of any suspect accounting entries, these would be subject to immediate investigation through Internal Audit.

We are not aware of any assets, liabilities or transactions that have been improperly included or omitted from the HSCP Board's annual accounts.

The HSCP operates within a complex environment with reliance on WDC and NHSGGC internal control systems and processes with all transactions recorded on partners' financial systems. There is always a risk that the committee is unaware that there is some potential false accounting occurring however this is unlikely given the controls in place for processing transactions. An added control in this area is the review by the external audit team who provide added assurance for transactions which are in excess of the materiality value.

Through the partner organisations, current and emerging risks are identified from a number of sources including the National Anti-Fraud Network (NAFN) and other law enforcement agencies.

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

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

HSCP Board Audit and Performance Committee Response

The Audit and Performance Committee and the HSCP Board are well sighted on the financial challenges and risks facing the HSCP and the partner organisations through regular reporting by the CFO and informal member's sessions to support annual budget setting.

By ensuring that both partners adhere to the provisions laid out within the Integration Scheme the HSCP Board have challenged partner decisions to accept additional cost pressures unless they come with additional budget resource.

The HSCP Finance Team support monthly budget monitoring with all levels of budget holder and significant variances are investigated. There is regular reporting on both financial and service performance to both Board and Committee.

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

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

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

HSCP Board Audit and Performance Committee Response

While IJBs are legal bodies in their own right, they do not hold assets, employ staff or hold a bank account. Through the Integration Scheme both WDC and NHSGGC have delegated the strategic delivery of services to the HSCP Board and the HSCP is the delivery vehicle. The majority of laws and regulation apply to the partner bodies and any direct impact on the HSCP are communicated via our partners.

As such the HSCP Board are subject to a range of legal and regulatory frameworks and are supported by a variety of statutory posts. The HSCP Board has its own Local Code of Good Governance and takes assurance from the Chief Officer, the s95 Chief Financial Officer, Chief Social Work Officer, Lead Health Professionals and Legal advisors. All board and committee reports are subject to legal review and comment to ensure key issues are identified.

Through the partner organisations, training is provided (as required) to officers on particular legal issues, some of it being mandatory, for example around data protection and equalities.

Accepting that there will be minor operational instances of non-compliance, we are not aware of any instances of significant non-compliance during the financial year. This is supported by the annual review of the Local Code of Good Governance.

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

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

HSCP Board Audit and Performance Committee Response

The HSCP Board's financial statements disclose contingent liabilities and any provisions for legal claims. The HSCP Board's CFO (s95 Officer) engages with members of the HSCP Senior Management Team, as well as the partner organisations' senior managers as part of the annual accounts preparation process to identify any ongoing or potential cases which require disclosure in the financial statements.

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

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

HSCP Board Audit and Performance Committee Response

The concept of a going concern assumes that an authority's functions and services (in this case the HSCP Board) will continue in operational existence for the foreseeable future. In accordance with the CIPFA Code of Local Government Accounting, the HSCP Board is required to prepare its financial statements on a going concern basis unless informed by the relevant national body of the intention for dissolution without transfer of services or function to another entity. The accounts are prepared on the assumption that the services of the HSCP Board will continue in operational existence for the foreseeable future.

Going concern is assessed regularly both as part of HSCP's annual budget setting process and throughout the year with the preparation and presentation of regular financial performance reports and refresh of the Medium Term Financial Outlook. The budget setting process also requires the HSCP's CFO (s95 Officer) to provide a view on the robustness of estimates and the adequacy of reserves.

The Integration Scheme requires the Chief Officer and CFO to engage with partners and present to them an annual budget plan which takes account of changes in service delivery, demographics, activity changes, legislative requirements etc. Partners must accept the risk to delivery of delegated services if not appropriately funded. The scheme sets out the arrangements of how to address any budget variance and the responsibility of the partners to provide additional funding if any recovery plan is unsuccessful.

The Audit and Performance Committee are satisfied that the financial information provided, the robust reserves policy and regular review of strategic risks at both board and committee allows them to conclude there are no issues in relation to going concern basis in the preparation of the 2024/25 financial statements.

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

HSCP Board Audit and Performance Committee Response

The HSCP Board agreed a balanced 2025/26 budget on 24 March 2025 and that report presented future budget gaps that will need to be closed in subsequent years taking into account a range of factors influencing a best, likely and worst case position.

This is consistent with all HSCPs, Local Government and Health Boards and reflects the financial climate public bodies are operating in with ongoing real terms funding reductions. Since the establishment of the HSCP Board there have been financial challenges that required the approval of savings programmes to reduce expenditure and/or increase income. The Medium Term Financial Outlook sets out the broad themes of how the HSCP will transform services, make better use of technology and support the robust application of eligibility criteria to support financial sustainability.

There is no doubt that the Covid-19 pandemic response and recovery impacted on the progress of some service redesign programmes, however the HSCP Board have protected a range of funds through earmarking reserves to support the transition and delivery of service change. Therefore, whilst the HSCP Board does have future budget gaps, savings options will continue to be developed to close the gap supporting the HSCP's financial sustainability and to continue as a going concern.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Julie Slavin, Chief Financial Officer

25 June 2025

Subject: 2024/25 Code of Good Governance and Annual Governance Statement

1. Purpose

1.1 The purpose of this report is to:

- Inform the Audit and Performance Committee about the annual self-evaluation of the HSCP Board's compliance with its Code of Good Governance and related improvement actions; and
- Obtain approval for the draft Annual Governance Statement to be included in the HSCP Board's 2024/25 Unaudited Annual Accounts.

2. Recommendations

2.1 The members of the Audit and Performance Committee are asked to:

- **Note** the outcome of the annual self-evaluation and the update of the improvement actions; and
- **Consider** the detail of the Annual Governance Statement and **approve** its inclusion in the 2024/25 Unaudited Annual Accounts.

3. Background

3.1 *Delivering Good Governance in Local Government: Framework,* published by the Chartered Institute of Public Finance and Accountancy (CIPFA) in association with Solace in 2007, set the standard for local authority governance in the UK. CIPFA and Solace reviewed the Framework in 2015 to ensure it remained 'fit for purpose' and published a revised edition in spring 2016. Delivering Good Governance in Local Government: Framework (CIPFA/Solace, 2016) has applied to annual governance statements prepared for the financial year 2016/17 onwards.

3.2 The concept underpinning the Framework is that it assists local government bodies in taking responsibility for developing and shaping an informed approach to governance, aimed at achieving the highest standards in a measured and proportionate way. The Framework is intended to assist organisations individually in reviewing and accounting for their own unique approach. The overall aim is to ensure that:

- resources are directed in accordance with agreed policy and according to priorities;
- there is sound and inclusive decision making; and
- there is clear accountability for the use of those resources in order to achieve desired outcomes for service users and communities.

3.3 The HSCP Board approved the Local Code of Good Governance in May 2017 and updated it in June 2021. Since June 2018, the Audit and Performance Committee has annually reviewed the self-evaluation results and improvement actions to strengthen compliance with the Governance Framework principles.

3.4 The Annual Governance Statement (AGS) is a formal statement within the HSCP Board's annual accounts which recognises, records, assesses and publishes the governance arrangements as defined in the CIPFA/Solace Framework. The statement requires to be signed off by the Chair of the HSCP Board and the Chief Officer when the final audited accounts are presented later in the year.

3.5 It is recognised as good practice to consider the AGS as a standalone document by a board or committee charged with the responsibility for the oversight of the strategic processes for risk and the effectiveness of the internal control environment, as is set out in the Terms of Reference for this committee.

4. Main Issues

4.1 The annual self-evaluation review for 2024/25 has been carried out by the Chief Financial Officer and considered by the Senior Management Team.

4.2 The Annual Governance Statement reflects the annual self-evaluation of the HSCP Board's compliance against the Code of Good Governance as well as details on the internal control environment in which the HSCP operates and relies upon.

4.3 The self-evaluation review (as referred to above in sect 3.1) has identified that current practice is mainly compliant against our Code of Governance, with no areas identified as non-compliant and no significant governance issues identified.

4.4. The review has identified some areas for improvement and these are contained within Appendix 1, which also updates members on the progress of improvement actions identified in prior years. Seven of the eight current actions are now considered complete with work continuing on the one remaining actions.

4.5 This year's review has identified three new actions which align to the key aims of the good governance framework set out in above in section 3.2. The

actions will benefit all stakeholders by enhancing business continuity processes, demonstrating delivery of improvement actions from external inspections and developing a more structured approach to self-evaluation.

4.6 The Governance Statement, attached at Appendix 2 sets out the HSCP Board's governance arrangements as they meet the requirements of the "Code of Practice for Local Authority Accounting in the UK" (the Code) and reports on the effectiveness of the HSCP Board's system of internal control, including the reliance placed on the governance frameworks of our partners.

4.7 The work of internal audit, external audit and external inspection agencies is also reflected in the statement as well as the reliance of the HSCP Board on WDC and NHSGGC systems of internal control. This includes the Chief Internal Auditor's opinion:

"*It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2025 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself."*

4.8 This Annual Governance Statement will be published within the unaudited Annual Accounts for the year ended 31 March 2025 and will be examined by external audit.

5. Options Appraisal

5.1 There is no requirement for an option appraisal for the content of this report.

6. People Implications

6.1 The preparation of the annual accounts and the requirement to produce all required supporting documentation and explanation to external audit is a core function of the HSCP Finance Team.

7. Financial and Procurement Implications

7.1 There are no financial implications specific to this report.

8. Risk Analysis

8.1 There is a risk that a failure to maintain a local code and develop a framework to support the gathering and updating of the necessary evidence will leave the HSCP Board unable to produce a Governance Statement. The current approach to ongoing annual assessment of compliance and reporting to this Committee ensures that the Board can produce a meaningful Governance Statement.

9. Equalities Impact Assessment (EIA)

9.1 There is no requirement for an EIA for the content of this report.

10. Environmental Sustainability

10.1 There is no environmental sustainability impact for the content of this report.

11. Consultation

11.1 This report was prepared in consultation with the Chair of the Audit and Performance Committee, HSCP Board's Chief Internal Auditor and the HSCP Senior Management Team.

12. Strategic Assessment

12.1 The preparation and audit of the HSCP Board's Annual Accounts is a statutory requirement. This report links to the strategic financial governance arrangements of the HSCP Board and both partner organisations of West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board.

13. Directions

13.1 There is no direction required for the content of this report.

Julie Slavin
Chief Financial Officer
10 June 2025

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Appendices: Appendix 1: Update on Local Code Improvement Plan
Appendix 2: 2024/25 Draft Governance Statement

Background Papers: Local Code of Good Governance (wdhscp.org.uk)

West Dunbartonshire

Health & Social Care Partnership

Annual Review of Code of Good Governance Improvement Action Plan 2025

OUTSTANDING ACTIONS FROM PREVIOUS YEARS

Improvement Action	Lead Officer	Due Date	Review June 2025
Ministerial Strategic Group Review on the Progress of Integration Action Plan – from May 2019 Self-Evaluation	Chief Officer	Multiple actions on going since 2019. Revised Date: March 2024 Further Revised Date: December 2024	**COMPLETE as at 25 June 2025** The 19 September 2023 Audit and Performance Committee received a comprehensive update of progress against all MSG actions with a recommendation that no further updates were required. The Committee agreed that a further update report would be required at a future meeting (with no date set). A final update report has been presented to the 25 June 2025 Audit and Performance Committee with the recommendation to accept that the majority of the actions have been embedded as business as usual, no further update would be required.
Scheme of Delegation – the HSCP Board should consider drafting its own Scheme of Delegation which draws on our partners (WDC and NHSGGC) own schemes, to support statutory officers and other key post holders and members to fulfil their responsibilities in accordance with legislative and regulatory requirements.	Chief Financial Officer and Head of Strategy and Transformation	Initial Due Date: March 2024 Revised Date: December 2024	**COMPLETE** The position of the Council's Monitoring Officer is that a separate Scheme of Delegation for the IJB is not required, as roles and responsibilities were covered sufficiently within Council's Scheme. It is recommended the Audit and Performance Committee close this action as it is unlikely to progress.
Align more clearly the Strategic Plan to the Integrated Workforce Plan (IWP) to support the delivery of the approved strategic outcomes.	Head of Strategy and Transformation and Head of Human Resources	Initial Due Date: August 2024 Revised Date:	**ONGOING** The 20 February 2024 HSCP Board received an update report on completed actions and planned progress of outstanding actions.

The current IWP covers a 3 year period and this work will be undertaken in Year 2.		December 2024 Further Revised Date: 31 March 2026	The Integrated Workforce Plan will be reviewed and aligned to the 2026-2029 Strategic Commissioning Plan.
Refresh the Medium Term Financial Plan – the current plan covers the 5 year period 2022/23 – 2026/27 and was refreshed at a high level as part of the 2023/24 budget setting exercise, but the challenging fiscal outlook requires the sensitivity analysis to be reviewed and the projection of funding gaps.	Chief Financial Officer	Initial Due Date: March 2024 Revised Due Date: August 2024	**COMPLETE** The HSCP Board approved the refreshed Medium Term Financial Outlook (MTFO) 2024/25 to 2027/28. Ongoing review of the MTFO will be aligned to the refresh of the Strategic Plan if appropriate.
Undertaken CIPFA Self-Assessment of Good Practice for Audit Committees – recommendation would be to hold a facilitated HSCP Board Member Session to complete this action.	Chief Internal Auditor and Chief Financial Officer	December 2024	**COMPLETE** Self-assessment exercise undertaken by all HSCP Board members on 22 January 2025. The Audit and Performance Committee approved an improvement plan to support delivery of Good Practice. Progress will be reported to a future HSCP Board.
Deliver further training in relation to Complaints Handling Procedure.	Head of Strategy and Transformation	December 2024	**COMPLETE** Training session undertaken with Extended Management Team on 22 March 2024. This has resulted in a slight increase in Stage 1 complaints as confidence increases across teams to recognise and record complaints more effectively. Q4 23/24 – 57, Q1 24/25 – 73; and Q2 24/25 – 83.
Comprehensive refresh of Participation and Engagement Strategy, the implementation of which will complemented by a programme of staff training.	Head of Strategy and Transformation	December 2024	**COMPLETE** Participation and Engagement Strategy reviewed and approved by HSCP Board 19 November 2024. This has resulted in an increase in service user and citizen participation which was reported to the HSCP Board on 27 May 2025.

Establishment of Local Provider Forums to support the delivery of robust local commissioning frameworks	Head of Strategy and Transformation	March 2025	**COMPLETE** Provider Forums have been established across a range of commissioned services. This has resulted in a more collaborative approach to commissioning and the creation of more effective local frameworks. Ultimately this will lead to better outcomes for our service users and support Best Value principles.

NEW ACTIONS (June 2025)

Improvement Action	Lead Officer(s)	Due Date
Development of Business Impact Analysis documentation across the HSCP to support key Business Continuity Plans	Head of Strategy and Transformation	March 2026
Enhance current monitoring of improvement actions arising from external inspections to provide assurance to the HSCP Board that actions are robust and can be embedded	Heads of Service supported by Head of Strategy and Transformation	June 2026
Develop a more structured approach to self-evaluation.	Head of Strategy and Transformation	June 2026

ANNUAL GOVERNANCE STATEMENT

Introduction

The Annual Governance Statement outlines the governance arrangements of the HSCP Board (Integration Joint Board) in accordance with the "Code of Practice for Local Authority Accounting in the UK" (the Code). It also evaluates the effectiveness of the HSCP Board's internal control system, including the reliance on the governance frameworks of its partners.

Scope of Responsibility

The HSCP Board is committed to conducting its business in compliance with legal requirements and appropriate standards, ensuring that public funds are safeguarded, accurately accounted for, and utilised in an economical, efficient, and effective manner. The Board aims to foster a culture of continuous improvement in its operations and strives to ensure best value is achieved.

To fulfil these responsibilities, the HSCP Board has implemented robust governance arrangements to oversee its activities and their effectiveness, including the identification, prioritisation, and management of risk. An established Audit and Performance Committee supports the Board by addressing issues related to risk, control, performance, and governance, providing assurance through constructive challenge and ongoing enhancement across the partnership.

The Chief Internal Auditor reports directly to the HSCP Board's Audit and Performance Committee on all audit matters, with access rights to the Chief Officer, Chief Financial Officer, and Chair of the Audit and Performance Committee, as necessary.

The Chief Officer, with the Senior Management Team has established governance arrangements incorporating a system of internal control. This system is designed to manage risk at an acceptable level and support the achievement of the HSCP Board's policies, goals, and objectives. Additionally, the Board relies on the internal control systems of both Greater Glasgow and Clyde Health Board (NHSGGC) and West Dunbartonshire Council (WDC), which promotes compliance with their respective policies and facilitate the attainment of their organisational goals as well as those of the HSCP Board.

The HSCP Board has adopted governance practices consistent with the Chartered Institute of Public Finance and Accounting (CIPFA) and the Society of Local Authority Chief Executives (SOLACE) framework titled "Delivering Good Governance in Local Government." Based on the framework's seven core principles, a Local Code of Good Governance has been established, is reviewed annually, and demonstrates the HSCP Board's dedication to good governance. A copy of the code is available here (Appendix 1, tbc) on the HSCP website.

Purpose of the Governance Framework

The governance framework is comprised of systems and processes and cultures and values by which the HSCP is directed and controlled. It is not static and is updated to reflect new legislative requirements and best practice.

The system of internal control is a significant element of the governance framework. Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. The system is maintained on an ongoing basis to identify, prioritise and manage the risks facing the organisation. It enables the HSCP Board to monitor and evaluate the achievements of the strategic outcomes laid out within its Strategic Plan and consider whether these have been delivered in an appropriate and cost-effective manner.

Governance Framework and Internal Control System

The HSCP Board serves as the principal decision-making entity, consisting of six voting members. Each partner organisation nominates one member to assume the roles of Chair and Vice Chair. West Dunbartonshire Council appoints three elected members, while NHSGGC Health Board designates three non-executive members. The HSCP Board also includes several non-voting professional and stakeholder members. Current stakeholder members represent the third sector, carers, and staff-side representatives, whereas professional members comprise the Chief Officer, Chief Financial Officer, Chief Nurse, General Practitioner (joint Clinical Director), and Chief Social Work Officer.

Chair

Michelle Wailes
Non-Executive Member

Vice Chair

Fiona Hennebry
Councillor

Voting Member

Lesley MacDonald
Non-Executive Member

Voting Member

Michelle McGinty
Councillor

Voting Member

Libby Cairns
Non-Executive Member

Voting Member

Martin Rooney
Councillor

The HSCP Board convenes six times annually, and all agendas, meeting documents, and minutes are accessible on the HSCP Board website. Audio recordings of each meeting are available for public download.

The governance framework operates within a system of internal financial controls, encompassing management and financial data, financial regulations, administrative procedures (including segregation of duties), management oversight, and a delegation and accountability structure. The development and maintenance of these systems are carried out by the Council and the Health Board as part of the operational delivery arrangements of the HSCP.

The key features of the HSCP Board's governance framework are summarised below:

Feature	Description	Summary
HSCP Board Constitution	Formally constituted by the Integration Scheme approved by Scottish Ministers under the Public Bodies (Joint Working) (Scotland) Act 2014, West Dunbartonshire Council and NHSGGC Health Board established local governance arrangements covering roles, workforce, finance, risk management, information sharing, and complaints. Integration Schemes must be reviewed every five years or upon request by the Council or Health Board. This review was jointly conducted by all six HSCPs in Greater Glasgow and Clyde, resulting in updated Schemes reflecting changes since the initial publication. Approval will proceed through local governance structures by Autumn 2025.	Governance framework established by Integration Scheme.
HSCP Board Members	HSCP Board members observe and comply with the Nolan Seven Principles of Public Life. Arrangements are in place to ensure Board members and officers are supported by appropriate training and development.	The Seven Principles of Public Life (also known as the Nolan Principles) apply to anyone who works as a public office holder.
Strategic Plan 2023 – 2026	The HSCP Board's Strategic Plan 2023 – 2026, "Improving Lives Together," outlines its vision, priorities, and goals. Developed by the Strategic Planning Group, it includes input from local partners and stakeholders.	Strategic vision and priorities for 2023-2026.
Audit and Performance Committee	The committee is a key part of the governance framework and meets publicly four times a year to ensure effective corporate governance.	Ensures sound governance, meets four times a year.

Feature	Description	Summary
Constitutional Documents	Terms of Reference, Code of Conduct, Standing Orders and Financial Regulations, Directions Policy, Records Management and Complaints Handling Policy	Key constitutional documents that set out the scope, authority, governance and strategic decision making of the HSCP Board and Audit and Performance Committee.
HSCP Resilience Group	Integration Joint Boards are classed as Category One responders. The Chief Officer established this group with responsibility for reviewing business continuity plans and pandemic flu plans.	Reviews business continuity and pandemic plans.
Performance Management Framework	Provides regular performance and financial reports to the Senior Management Team, HSCP Board, and Audit and Performance Committee, assessing integrated arrangements, strategic priorities, and financial management.	Regular performance and financial reporting.
Medium-Term Financial Outlook	The Medium-Term Financial Outlook 2024/25 – 2027/28 identifies financial challenges and opportunities for the next three years and offers a framework for sustainability.	Financial planning and sustainability framework.
Programme Management Office (PMO)	Ensures the coordination of efforts across multiple programmes and projects aimed at achieving sustainable transformational change that maximises value delivery.	Coordinates transformational programmes and projects.
Clinical and Care Governance Group	The group oversees and scrutinises clinical and care risk, quality, and effectiveness to ensure safety and person-centred care. It produces an annual report detailing its activities and findings.	Oversight of clinical and care risk and quality.
Risk Management Strategy	The Audit and Performance Committee reviews the strategic risk register twice a year. They approve the level of risk, its potential impact, and mitigation actions before referring them to the HSCP Board. The HSCP Board has evaluated the strategic risk levels and the suitability of mitigation actions according to its Risk Appetite Statement and Risk Management Policy.	Bi-annual scrutiny of risk management.

Feature	Description	Summary
Reserves Policy	Reviewed annually during the budget setting process to determine a suitable amount of general and earmarked reserves.	Annual review of reserves policy.
CIPFA Financial Management Code	Self-assessment of compliance with the CIPFA Financial Management Code.	Compliance with financial management standards.
Performance Appraisal Process	All employees are required to undertake annual training, encompassing statutory and mandatory courses. This training aims to reinforce their obligations to protect service users, including maintaining information security and diversity and equality.	Employee appraisals and mandatory training.
Policy Register	Maintained to support regular reviews.	Supports regular policy reviews.
Participation and Engagement Strategy	The Participation and Engagement Strategy 2024-2027 aims to build active, inclusive, and strong community relationships between the Health and Social Care Partnership (HSCP) and the residents of West Dunbartonshire. This ensures our local communities can help shape and influence decision making to create services and policies that put the community at the heart of the HSCP's work.	This strategy outlines how all HSCP staff will engage with our residents and cements our goals for what we want to achieve over the next three years.

In addition to the HCSP Board Financial Regulations the HSCP complies with the financial regulations of its partner bodies both of which contain details on their approaches to managing the risk of fraud and corruption.

- West Dunbartonshire Council has adopted a response that is appropriate for its fraud and corruption risks and commits to maintain its vigilance to tackle fraud in accordance with the Code of Practice on Managing the Risk of Fraud and Corruption.

- NHSGCC has a formal partnership with NHS Counter Fraud Service, which details the action to be taken when fraud, theft, corruption, or other financial irregularities are suspected. This requires NHSGCC to adopt the Counter Fraud Standard and have a formal Fraud Policy and a Fraud Response Plan, which sets out the Board's policy and individual responsibilities.

Compliance with Best Practice

The HSCP Board's financial management arrangements conform to the CIPFA Financial Management Code, a series of financial management standards designed to support local authority bodies meet their fiduciary duties.

The HSCP Board's financial management arrangements conform to the governance requirements of the CIPFA statement *"The Role of the Chief Financial Officer in Local Government (2016)"*. To deliver these responsibilities the Chief Financial Officer (Section 95 Officer) must be professionally qualified and suitably experienced and lead and direct a finance function that is resourced and fit for purpose.

The HSCP Board complies with the requirements of the CIPFA Statement on *"The Role of the Head of Internal Audit in Public Organisations 2019"*. The HSCP Board's appointed Chief Internal Auditor has responsibility for the internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The Internal Audit service operates in accordance with CIPFA *"Public Sector Internal Audit Standards 2017".* From 1 April 2025 the new Global Internal Audit Standards came into effect for the UK Public Sector and a transition plan is in place to ensure the Internal Audit service is compliant with the requirements by 31 March 2026.

The HSCP Board's Audit and Performance Committee operates in accordance with CIPFA's *"Audit Committee Principles in Local Authorities in Scotland"* and *"Audit Committees: Practical Guidance for Local Authorities and Police (2022)"*. A self-assessment of compliance with the main elements of the CIPFA Audit Committee guidance was undertaken in January 2024 which concluded that the HSCP Board's Audit and Performance Committee complies with most of the main elements, and the opportunities to enhance current arrangements including production of an annual report, facilitation of a private meeting with Committee members and internal and external audit and a further review of membership, were approved by the Committee in February 2025 for implementation in 2025/26.

Review of Adequacy and Effectiveness

The HSCP Board is dedicated to continuous improvement and is responsible for conducting an annual review of its governance framework, including the system of internal control. The effectiveness of this framework is evaluated based on inputs from the Chief Officer and the Senior Management Team, who oversee the governance environment, as well as from internal and external audits and other review agencies such as the Care Inspectorate.

This review is further supported by processes within West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board. Within the Council, all Senior Officers annually complete a self-assessment governance questionnaire and certificate of assurance. The responses are

incorporated into the review of West Dunbartonshire Council's governance framework. Similarly, within the Health Board, Service Managers complete and return a "Self-Assessment Checklist" to provide evidence of their review of key areas of the internal control framework. The Senior Management Team then evaluates these submissions and issues a Certificate of Assurance for their respective services.

HSCP Board Members can face conflicts between their responsibilities to the Board and other duties. To manage these, the HSCP Board requires members to declare potential conflicts of interest. The Chair must ensure these declarations are addressed according to the HSCP Board's Code of Conduct, which follows the Scottish Government's Model Code of Conduct on the Standards Commission website.

HSCP Board's Local Code of Good Governance Review

This is reviewed annually by the Chief Financial Officer and the Senior Management Team as part of the year end assurance processes for both partner organisations and the HSCP Board. For the 2024/25 review the Audit and Performance Committee, which met on 25 June 2025 noted that the self-evaluation review identified that current practices were mostly compliant, with no areas assessed to be non-compliant. A copy of the 2024/25 report is available here (See Appendix 1, tbc)

Three new improvement actions have been identified, which are detailed below. An update of previously agreed improvement actions is also provided. This includes the proposed closure of some completed actions and the addition of new actions to enhance the internal control environment. The priority for 2025/26 will be to advance the remaining ongoing actions to further strengthen the governance framework.

New June 2025 Actions

Improvement Action	Lead Officer(s)	Target Date
Development of Business Impact Analysis documentation across the HSCP to support key Business Continuity Plans	Head of Strategy and Transformation	March 2026
Enhance current monitoring of improvement actions arising from external inspections to provide assurance to the HSCP Board that actions are robust and can be embedded	Heads of Service supported by Head of Strategy and Transformation	June 2026
Develop a more structured approach to self-evaluation.	Head of Strategy and Transformation	June 2026

Update on Previously Agreed Actions

Improvement Action	Lead Officer(s)	Target Date	June 2025 Review
Ministerial Strategic Group Review on the Progress of Integration Action Plan	Chief Officer	Revised Date: December 2024	**COMPLETE as at 25 June 2025** On 19 September 2023, the Audit and Performance Committee was advised that no further MSG action updates were necessary. The Committee decided to require one more update at an unspecified future meeting. On 25 June 2025, the final update report recommended accepting that most actions had become standard practice, making further updates unnecessary.
Scheme of Delegation The HSCP Board should consider drafting its own Scheme of Delegation	Chief Financial Officer and Head of Strategy and Transformation	Revised Date: December 2024	**COMPLETE** The Council's Monitoring Officer believes a separate Scheme of Delegation for the IJB is unnecessary, as responsibilities are adequately covered by the Council's Scheme. The Audit and Performance Committee should close this action since further progress is unlikely.
Align more clearly the Strategic Plan to the Integrated Workforce Plan (IWP) to support the delivery of the approved strategic outcomes	Head of Strategy and Transformation and Head of Human Resources	Revised Date: December 2024 Further Revised Date: 31 March 2026	**ONGOING** The 20 February 2024 HSCP Board received an update report on completed actions and planned progress of outstanding actions. The Integrated Workforce Plan will be reviewed and aligned to the 2026-2029 Strategic Commissioning Plan.
Refresh the Medium-Term Financial Plan: 2022/23 – 2026/27	Chief Financial Officer	Revised Date: August 2024	**COMPLETE** The HSCP Board approved the refreshed Medium Term Financial Outlook (MTFO) 2024/25 to 2027/28 in November 2024. Ongoing review of the MTFO will be aligned to the refresh of the Strategic Plan if appropriate.
Undertaken CIPFA Self-Assessment of Good Practice for Audit Committees	Chief Internal Auditor and Chief Financial Officer	December 2024	**COMPLETE** HSCP Board members completed a self-assessment on 22 January 2025. The Audit and Performance Committee approved an improvement plan for Good Practice, with progress to be reported at a future HSCP Board meeting.

Improvement Action	Lead Officer(s)	Target Date	June 2025 Review
Further training in Complaints Handling Procedure	Head of Strategy and Transformation	December 2024	**COMPLETE** Training session undertaken with Extended Management Team on 22 March 2024. This has resulted in a slight increase in Stage 1 complaints as confidence increases across teams to recognise and record complaints more effectively. Q4 23/24 – 57, Q1 24/25 – 73; and Q2 24/25 – 83.
Refresh of Participation and Engagement Strategy	Head of Strategy and Transformation	December 2024	**COMPLETE** Participation and Engagement Strategy reviewed and approved by HSCP Board 19 November 2024. This has resulted in an increase in service user and citizen participation which was reported to the HSCP Board on 27 May 2025.
Establishment of Local Provider Forums to support the delivery of robust local commissioning frameworks	Head of Strategy and Transformation	March 2025	**COMPLETE** Provider Forums have been established across a variety of commissioned services. This initiative has fostered a more collaborative approach to commissioning and the development of more efficient local frameworks. Ultimately, this will result in improved outcomes for our service users and uphold Best Value principles.

HSCP Board's 2024/25 Audit Plan Progress

The HSCP Board's Annual Audit Plans ensure the Governance Framework is sound. Twenty days are allocated for these audits, which supplement the Council and Health Board's internal audit activities.

The Chief Internal Auditor of the HSCP Board presented the "Internal Audit Annual Strategy and Plan" for 2024/25 to the Audit and Performance Committee on 24 September 2024. This strategy and plan were formulated through a risk-based approach, concentrating audit efforts on areas of higher risk. These considerations included management's risk assessments, previous audit findings, and other relevant internal or external factors affecting the HSCP Board.

In addition to fulfilling annual reporting requirements and following up on action plans by the internal audit team, two significant undertakings were completed: the CIPFA Self-Assessment of Good Practice for Audit Committees (refer to the table above) and an audit of the HSCP Board's Budgetary Control Arrangements. The results of this audit were reported at the 25 June Audit and Performance Committee meeting and can be accessed here (Appendix 1, tbc). The audit concluded that the overall control environment was **satisfactory**, with two "green" (low risk) issues identified:

1. Finalisation of the Budgetary Control and Monitoring Procedures Manual; and
2. Finalisation of Budgetary Control and Finance Training Manual and roll-out to budget holders.

Update on Previous Governance Issues

The 2023/24 Annual Governance Statement did not identify any significant control issues for the HSCP Board. Updates of previous HSCP Board governance issues are covered under the "Review of Adequacy and Effectiveness" section above. Regular updates to the HSCP Board's Strategic Risk Register and assessment of the success of mitigating actions ensure that members are well sighted on current and emerging risks that could impact on the governance framework.

Our external auditor's 2023/24 Annual Audit Report did not raise any deficiencies or general observations in our internal control environment. Their commentary on the wider scope responsibilities, as set out in the Code of Audit Practice 2021 and sits alongside Best Value requirements detailed in the Local Government (Scotland) Act 1973, did identify a significant risk with regards to financial sustainability. The Code's wider scope framework is categorised into four areas:

1. financial management;
2. financial sustainability;
3. vision, leadership and governance; and
4. use of resources to improve outcomes.

Financial management arrangements and culture were deemed robust and well established. Vision, leadership, and governance identified the Strategic Plan priorities, supported by a delivery plan and arrangements that permit scrutiny and challenge. The use of resources to improve outcomes acknowledged financial and workforce challenges but concluded that the performance management framework offered visibility through regular reporting.

Financial sustainability in the medium to long term has been identified as a significant risk, with projected budget deficits in future years. Financial challenges such as inflation, pay awards, demographic pressures, and prescribing costs, coupled with either "flat-cash" settlements or funding increases below the rate of inflation, intensify the ongoing difficulty of identifying and implementing savings without negatively impacting service delivery.

The budget gaps are outlined in the HSCP Board's Medium Term Financial Outlook for 2024/25 to 2027/28, as well as in the 2025/26 Annual Budget Setting Report. Under the direction of the Chief Officer, service reviews within Learning Disability Services, Children and Families, and Care at Home, improved commissioning and procurement processes, and better alignment of resources to strategic outcomes will help the HSCP Board remain financially sustainable.

Governance Issues 2024/25

The 2024/25 Internal Audit Annual Report for the HSCP Board identifies no significant control issues.

As stated above the HSCP Board must also place reliance on the Council and Health Board's internal control framework. Both partner bodies Internal Audit Annual Reports have concluded their reviews of control procedures in key areas with the overall opinions being satisfactory with some improvement needed.

As stated above under "Review of Adequacy and Effectiveness" the Chief Officer of the HSCP completes a self-assessment of the HSCP's operational performance against West Dunbartonshire Council's local code. The Council's Chief Internal Auditor has considered this and has identified some areas for improvement which form part of the Council's Annual Governance Statement and progress will be monitored through the Performance Management Review Group (PMRG) and the Council's Audit Committee.

The Health Board's Internal Auditor's Annual Report was received on 18 June 2025, and the opinion is one that reasonable assurance can be placed on the adequacy and effectiveness of the current governance and control systems and processes.

Conclusion and Opinion on Assurance

Overall, the Chief Internal Auditor's evaluation of the control environment concluded that; based on the audit work undertaken, the assurances provided by the Chief Officers of the HSCP Board, West Dunbartonshire Council and Greater Glasgow and Clyde Health Board, the review of the local code and knowledge of the HSCP Board's governance, risk management and performance monitoring arrangements:

"It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2025 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself."

Assurance and Certification

Whilst recognising that improvements are required, as detailed above, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP Board's governance arrangements.

We consider the internal control environment provides reasonable and objective assurance that any significant risks impacting on our principal objectives will be identified and actions taken to mitigate their impact and deliver improvement.

Systems are in place to regularly review and improve the internal control environment and the implementation of the action plan will be monitored by the HSCP Senior Management Team throughout the year.

Michelle Wailes **Date: 25 June 2025**
HSCP Board Chair

Beth Culshaw **Date: 25 June 2025**
Chief Officer

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Julie Slavin, Chief Financial Officer

25 June 2025

Subject: Unaudited Annual Report and Accounts 2024/25

1. Purpose

1.1 To request that the HSCP Board's Audit and Performance Committee consider the unaudited Annual Report and Accounts for the HSCP Board covering the period 1 April 2024 to 31 March 2025; and

1.2 Approve the unaudited accounts and associated working papers to be passed to our external auditors for their review. Their report on the Accounts will be submitted to a future meeting of the Audit and Performance committee for consideration prior to being presented to the HSCP Board for final approval.

2. Recommendations

2.1 HSCP Board members are asked to:

- **Consider** the 2024/25 unaudited Annual Report and Accounts;
- **Approve** their submission to the HSCP Board's external auditors for review by 30 June; and
- **Note** that the audited Accounts are anticipated to be presented for final approval to the HSCP Board by the 30 September statutory deadline, prior to submission to the Accounts Commission.

3. Background

3.1 The Integrated Joint Board is a legal entity and must prepare its Accounts on an annual basis to 31 March and is required, by the Local Authority Accounts (Scotland) Regulations 2014, to submit these Accounts to the appointed auditor by 30 June of each year.

3.2 The 2024/25 Accounts have been prepared in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom (ACOP) and requirements of International Financial Reporting Standards (IFRS). The ACOP seeks to achieve comparability of financial performance across all IJB's and therefore prescribes the format to be used in presenting income and expenditure information.

3.3 The Annual Accounts provide an overview of financial performance in 2024/25 for the HSCP Board.

4. Main Issues

4.1 The 2024/25 unaudited annual accounts for the HSCP Board (Appendix 1) have been prepared in accordance with appropriate legislation and guidance. An overview of the process is set out below.

Financial Governance & Internal Control

4.2 The regulations require the Annual Governance Statement to be approved by the HSCP Board or a committee of the Board whose remit include audit & governance. This will assess the effectiveness of the internal audit function and the internal control procedures of the HSCP Board.

4.3 The HSCP Board's Audit and Performance Committee was recommended to approve the 2024/25 Annual Governance Statement as a separate item on the agenda.

Unaudited Accounts

4.4 The regulations state that the unaudited accounts are submitted to the External Auditor no later than 30 June immediately following the financial year to which they relate.

4.5 Scottish Government guidance states that best practice would reflect that the HSCP Board, or committee whose remit includes audit and governance, should consider the unaudited accounts prior to submission to the external auditor. The HSCP Board annual accounts for the year ended 31 March 2025 (Appendix 1) will be considered at this meeting of the Audit and Performance Committee on 25 June 2025.

Right to Inspect and Object to Accounts

4.6 The public notice period of inspection should start no later than 1 July in the year the notice is published. This will be for a period of 3 weeks and will follow appropriate protocol for advertising and accessing the unaudited accounts.

Approval of Audited Accounts

4.7 The 2014 regulations require the approval of the audited annual accounts by the HSCP Board or a committee of the Board whose remit include audit and governance. This will take account of any report made on the audited annual accounts by the "proper officer" i.e. Chief Financial Officer being the Section 95 Officer for the HSCP Board or by the External Auditor by the 30 September immediately following the financial year to which they relate. In addition, any further report by the external auditor on the audited annual accounts should also be considered.

4.8 The 2014 regulations deadline for completing the audit of local government bodies and submitting the annual report to Audit Scotland is 30 September 2024. The Chief Financial Officer liaises closely with our external auditor (Forvis Mazars) and will keep HSCP Board members updated on the progress

of the audit and timescales for completion. The external audit report on the Accounts and the proposed audit certificate (ISA 260 report) will be made available to all members and will be submitted to a meeting of the Audit and Performance Committee for consideration prior to the meeting of the HSCP Board where the audited accounts are considered.

Publication of the Audited Accounts

4.9 The regulations require that the annual accounts of the HSCP Board be available in both hard copy and on the website for at least five years, together with any further reports provided by the External Auditor that relate to the audited accounts.

4.10 The annual accounts of the HSCP Board must be published by 31 October and any further reports by the External Auditor by 31 December immediately following the year to which they relate.

4.11 Key Documents: the regulations require a number of key documents (within the annual accounts) to be signed by the Chair of the HSCP Board, the Chief Officer and the Chief Financial Officer, namely:

Document	**Signatory**
Management Commentary	Chair of the HSCP Board Chief Officer
Statement of Responsibilities	Chair of the HSCP Board Chief Financial Officer
Remuneration Report	Chair of the HSCP Board Chief Officer
Annual Governance Statement	Chair of the HSCP Board Chief Officer
Balance Sheet	Chief Financial Officer

Unaudited Annual Report and Accounts (Appendix 1)

4.12 The unaudited annual report and accounts reflect the financial position reported to the HSCP Board throughout 2024/25 and finalises the outturn position to 31 March 2025. This sets out the unaudited position of a gross overspend of (£0.247m) (0.12%) before net planned transfers from earmarked reserves of £0.319m resulting in a net underspend of £0.072m added to un-earmarked reserves.

4.13 As reported to the 27 May HSCP Board the draft financial performance figures for the year end was a gross overspend and net underspend of (£0.241m) and £0.216m respectively. The final year end position for 2024/25 as reflected in the draft annual report and accounts (attached at Appendix 1) has changed from the figures reported in March to (£0.247m) and £0.072m respectively as detailed in the table below and is mainly due to additional recharges from the Council and transfer of some health funding to earmarked reserves.

Extract from 2024/25 Unaudited Annual Report and Accounts

West Dunbartonshire Integrated Joint Board Consolidated Health & Social Care	2024/25 Annual Budget £000	2024/25 Net Expenditure £000	2024/25 Underspend/ (Overspend) £000	2024/25 Reserves Adjustment £000	2024/25 Underspend/ (Overspend) £000
Older People, Health and Community Care	55,857	58,244	(2,387)	258	(2,645)
Physical Disability	3,852	3,557	295	0	295
Children and Families	31,736	31,616	120	(358)	478
Mental Health Services	14,009	13,627	382	323	59
Addictions	4,325	4,101	224	(355)	579
Learning Disabilities	21,850	21,069	781	(250)	1,031
Strategy, Planning and Health Improvement	2,244	2,082	162	(55)	217
Family Health Services (FHS)	35,107	35,174	(67)	0	(67)
GP Prescribing	21,718	22,626	(908)	0	(908)
Hosted Services - MSK Physio	7,980	8,108	(128)	(109)	(19)
Hosted Services - Retinal Screening	772	865	(93)	(112)	19
Criminal Justice	8	97	(89)	(117)	28
HSCP Corporate and Other Services	10,114	8,653	1,461	456	1,005
IJB Operational Costs	363	363	0	0	0
Cost of Services Directly Managed by West Dunbartonshire HSCP	**209,935**	**210,182**	**(247)**	**(319)**	**72**
Set aside for delegated services provided in large hospitals	45,781	45,781	0	0	0
Assisted garden maintenance and Aids and Adaptions	303	303	0	0	0
Total Cost of Services to West Dunbartonshire HSCP	**256,019**	**256,266**	**(247)**	**(319)**	**72**

4.14 The draft accounts under "Final Outturn Position 2024/25" provide details of the key messages which are reflective of the significant variance and pressures reported to the 27 May HSCP Board.

4.15 As covered in the draft accounts (under Note 12: "Useable Reserve: General Fund") the opening reserves balance, transfers in and out and the proposed final balance for both un-earmarked and earmarked reserves are shown below. The transfers include reduction in earmarked reserves of £0.319m which brings the balance to £14.831m. An extract is provided below.

Balance as at 31 March 2024 £000	Total Reserves	Transfers Out 2024/25 £000	Transfers In 2024/25 £000	Balance as at 31 March 2025 £000
(15,150)	Total Earmarked Reserves	5,034	(4,716)	(14,831)
(3,504)	Total Unearmarked Reserves	0	(72)	(3,576)
(18,654)	Total General Fund Reserves	5,034	(4,788)	(18,407)
	Overall Movement			**247**

4.16 The HSCP Board's Reserves Policy states that the HSCP should hold an un-earmarked reserve of 2% which equates approximately £4.412m, and for 2024/25 the final position is £3.576m which equates to a reserves level of 1.62%.

4.17 The main highlight to note within earmarked reserves is the creation of a new earmarked reserves for employers' superannuation and increases to service redesign and transformation.

4.18 We started the year with £15.150m earmarked reserves and during the year:

- £1.185m (Social Care only) was approved in March 2024 to balance the 2023/24 budget;
- £2.057m was drawn down to cover planned expenditure for addictions, learning disabilities, mental health, children and family priorities, participatory budgeting, digital developments, hosted services, and the cost of complex care packages; and
- £1.792m was reallocated to reflect known pressures following a robust review of all reserves undertaken to ensure that all earmarked reserves are appropriate and fully committed.

4.19 We also added £4.716m to earmarked reserves throughout the year with £1.393m being an increase to existing reserves ((mainly for the creation of additional social worker capacity, increase to mental health transitional funding and underwrite prescribing pressures) and £3.323m for the creation of new reserves (mainly for Local Authority employers' superannuation future commitments and recovery and renewal of services).

4.20 The financial position for public services remains extremely challenging and the HSCP Board must operate within significant budget constraints and pressures. The Scottish Government published its Public Sector Pay Policy in December 2024 which shows an improved position regarding inflationary expectations; however, its Medium-Term Financial Strategy has been delayed until 25 June 2025 due to the UK spending review on 11 June 2025.

4.21 To support the implementation of the two-year pay agreement, the Scottish Government must use the Medium-Term Financial Strategy (MTFS) to commit to multi-year funding settlements. This is essential to enable Councils, Health Boards, and Integration Authorities to strengthen their medium-term financial planning and to allow sufficient time for meaningful engagement with local communities. The requirement for strong financial management has never been more critical.

4.22 The significantly improved final outturn position for 2024/25 illustrates strong leadership and robust financial management to mitigate the inflationary and demographic challenges facing HSCP services. While welcome, work continues to progress on developing recurring savings options to address future projected budget gaps as well as replenishing un-earmarked reserves in line with the 2% in the short to medium term.

5. Options Appraisal

5.1 None required

6. People Implications

6.1 There are no people implications associated with this report.

7. Financial and Procurement Implications

7.1 There are no financial or procurement implications other than those detailed in the report.

8. Risk Analysis

8.1 As presented within every financial performance report throughout 2024/25 the reported unaudited overspend has arisen due to a number of key financial and economic pressures which are likely to continue into 2025/26. The main risks include:

- A significant pressure on the HSCP going forward relates to potential unfunded pay pressures. As reported to the 24 March HSCP Board the Council did pass through an in-year recurring share of the additional Scottish Government funding for the 2024/25 pay offer and it is expected that any new funding in 2025/26 for pay uplifts will cover council employed HSCP social care staff and that an appropriate share will also be passed over to the HSCP. This position will be subject to continual review as more definitive information is forthcoming regarding 2025/26 agreed pay deals and the impact of additional Scottish Government funding to our partners, with appropriate shares being passed through for local government and health board employed staff delivering HSCP delegated services.

- During 2024/25 while prescribing volumes increased by 3.48% the average cost per item decreased by 3.01% resulting in a broadly flat position from 2023/24 reflecting high engagement in relation to the prescribing efficiency programme delivery, strong local leadership, data-driven decision-making, and a commitment to delivering value while maintaining safe, person-centred care. While encouraging the year end position still reported an overspend of £0.908m. It is crucial that the positive progress on the 2024/25 efficiency programme is maintained.

- Global inflation and employers national insurance increases has impacted on providers leading to commissioning risk around a number of key contracts, i.e. national care home contract, adult social care fair work practices, fostering and residential care which present a significant pressure on the HSCP budget.

The HSCP Board will be regularly updated through the financial performance reports.

9. Equalities Impact Assessment (EIA)

9.1 None required.

10. Environmental Sustainability

10.1 None required.

11. Consultation

11.1 This report was prepared in conjunction with Health Board and Council colleagues.

12. Strategic Assessment

12.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the priorities of the Strategic Plan.

12.2 The report is in relation to a statutory function and is for HSCP Audit and Performance Committee approval.

12.3 This report links to the strategic financial governance arrangements of both parent organisations.

13. Directions

13.1 None required.

Name	Julie Slavin
Designation	Chief Financial Officer
Date	16 June 2025

Person to Contact	Julie Slavin – Chief Financial Officer, Church Street, WDC Offices, Dumbarton G82 1QL Telephone: 01389 737311 E-mail: julie.slavin@nhs.scot
Appendices:	Appendix 1 – Draft Unaudited Annual Accounts 2024/25
Background Papers	2024/25 Financial Performance Report as at Period 12 (27 May 2025) and 2025/26 Budget Setting Update (Revenue Estimates) – 24 March 2025 HSCP Board

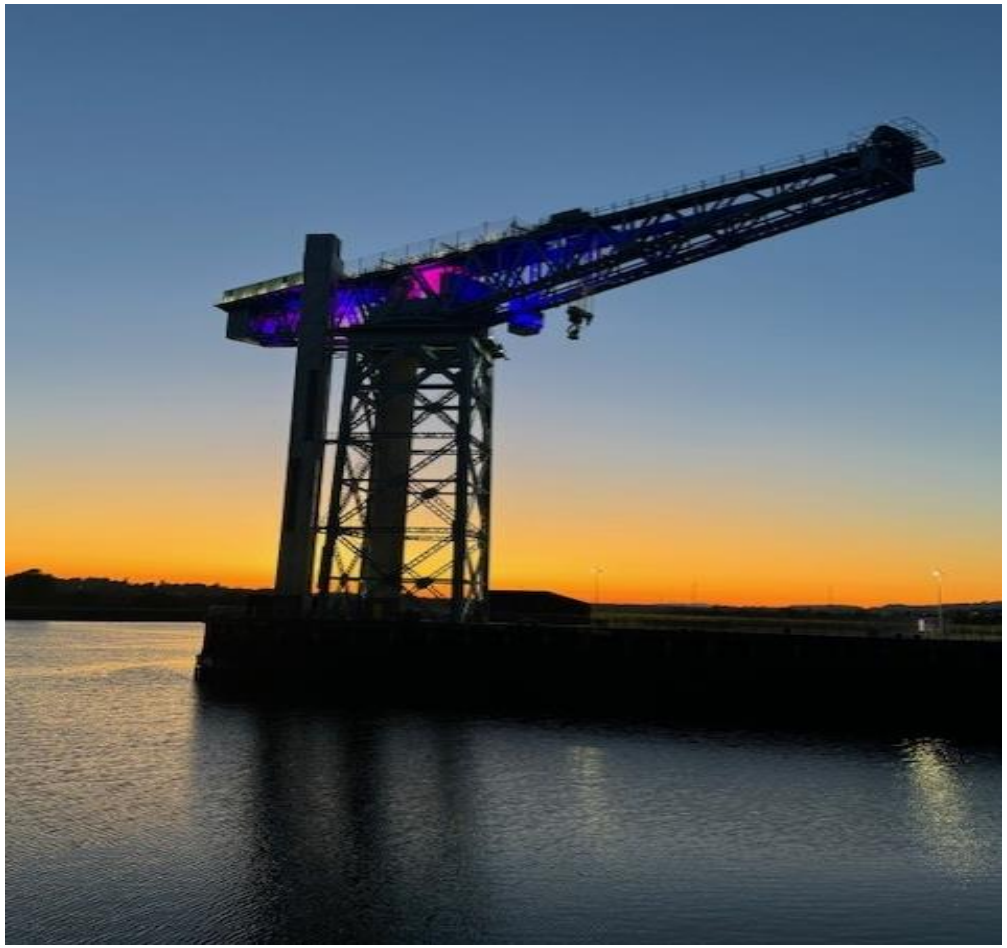
West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Integration Joint Board

Commonly known as
West Dunbartonshire
Health and Social Care Partnership Board

Unaudited Annual Report and Accounts for the Year Ended 31 March 2025

www.wdhscp.org.uk



Contents

Introduction

Welcome to the West Dunbartonshire Integration Joint Board's (IJB), hereafter known as the Health and Social Care Partnership Board (HSCP Board), Annual Report and Accounts for the year ended 31 March 2025.

The purpose of this publication is to report on the financial position of the HSCP Board through a suite of financial statements, supported by information on service performance and to provide assurance that there is appropriate governance in place regarding the use of public funds.

West Dunbartonshire Health and Social Care Partnership formally established 1st July 2015

2024/25 Integrated Budget of £210m

Management Commentary

Introduction

The Management Commentary aims to provide an overview of the key messages in relation to the HSCP Board's financial planning and performance for the 2024/25 financial year and how this has supported the delivery of its strategic outcomes as laid out in the Strategic Plan. The commentary also outlines future challenges and risks which influence the financial plans of the HSCP Board as it directs the delivery of high-quality health and social care services to the people of West Dunbartonshire.

Delivering health and social care services to support the people of West Dunbartonshire:

Population 88,750 (1.6% of Scotland's population)

Employing 2,207 health and social care staff across Adult, Children's and Justice services (1,768 FTE)

The Management Commentary discusses our:

- Remit and Vision;
- Strategy and Business Model;
- Strategic Planning for Our Population;
- Climate Change;
- Performance Reporting, including individual service summaries for 2024/25;
- Recovery and Renewal;
- Financial Performance for 2024/25; and
- Medium Term Financial Outlook.

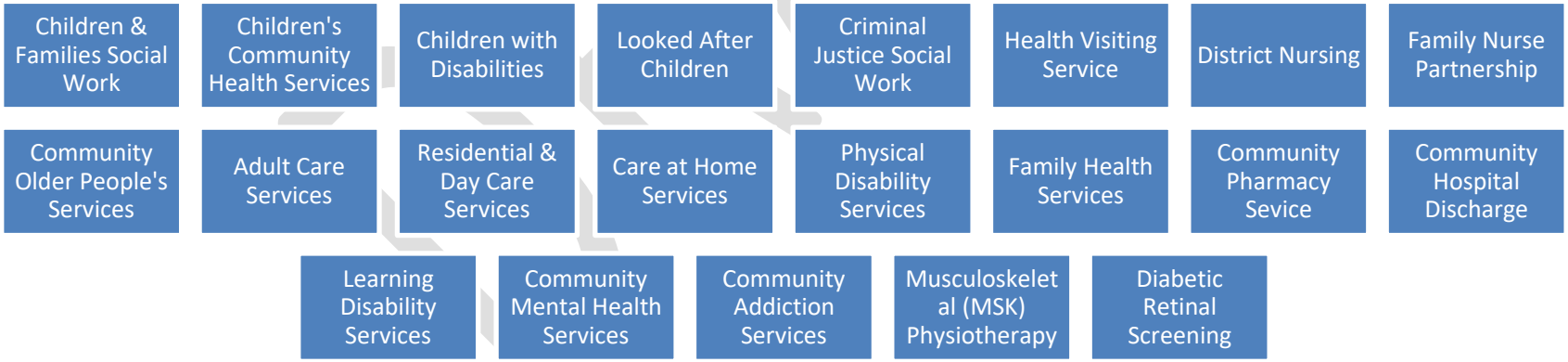
West Dunbartonshire HSCP Board Remit and Vision

The Public Bodies (Joint Working) Act (Scotland) 2014 sets out the arrangements for the integration of health and social care across the country. The West Dunbartonshire Integration Joint Board (IJB), commonly known as the HSCP Board was established as a "body corporate" by Scottish Ministers' Parliamentary Order on 1st July 2015.

The Integration Scheme sets out the partnership arrangements by which NHS Greater Glasgow and Clyde Health Board (the Health Board) and West Dunbartonshire Council (the Council) agreed to formally delegate all community health and social care services provided to children, adults and older people, criminal justice social work services and some housing functions. West Dunbartonshire HSCP Board also hosts the MSK Physiotherapy Service on behalf of all six Glasgow IJBs and the Diabetic Retinal Screening Service on behalf of the Health Board. This way of working is referred to as "Health and Social Care Integration". The full scheme can be viewed here (see Appendix 1, 1).

The HSCP Board directs the Health Board and the Council to work together in partnership to deliver delegated services. Here in West Dunbartonshire, the Health Board and Council deliver these services through the West Dunbartonshire Health and Social Care Partnership, often shortened to the HSCP. The HSCP is essentially the staff from both organisations working in partnership to plan and deliver the services under the direction of the HSCP Board.

Exhibit 1: West Dunbartonshire HSCP Board Delegated Services

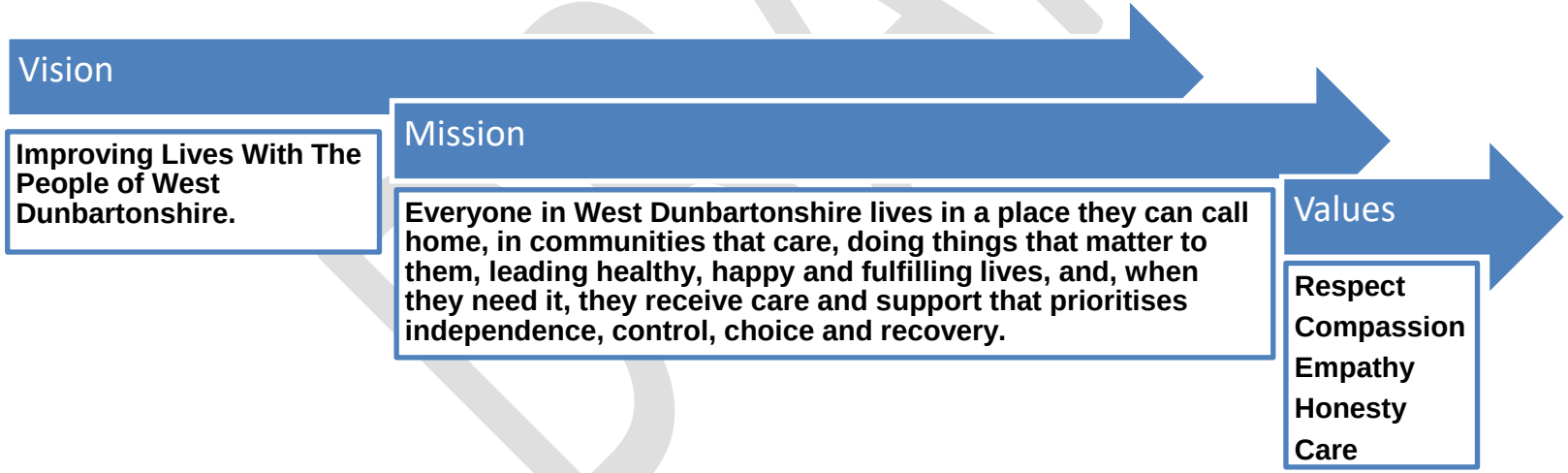


The 2014 Act requires that Integration Schemes undergo review within five years of establishment. A review was undertaken jointly by senior officers from all 6 HSCPs in the Greater Glasgow and Clyde area and partner bodies representatives. The group co-developed updated versions of the Schemes for their respective IJBs within Greater Glasgow and Clyde based on the principle of achieving general consistency in structure and content and reflecting changes in arrangements since publication of the first Schemes. Mandatory consultation on revised draft Schemes was carried out by the six IJBs in late 2023/early 2024. This led to further recommended changes being identified, which have been incorporated into the draft Schemes with a view to approving final versions of the Integration Schemes through local governance structures by Autumn 2025. In the meantime, the current Integration Scheme remains in force.

West Dunbartonshire HSCP Board's Strategy and Business Model

The HSCP Board approved its **Strategic Plan 2023 – 2026 "Improving Lives Together"** on 15 March 2023. The Strategic Plan contains four strategic outcomes which were designed to reflect the HSCP Vision of ***"Improving Lives with the People of West Dunbartonshire"***. The full plan can be viewed here (see Appendix 1, 2).

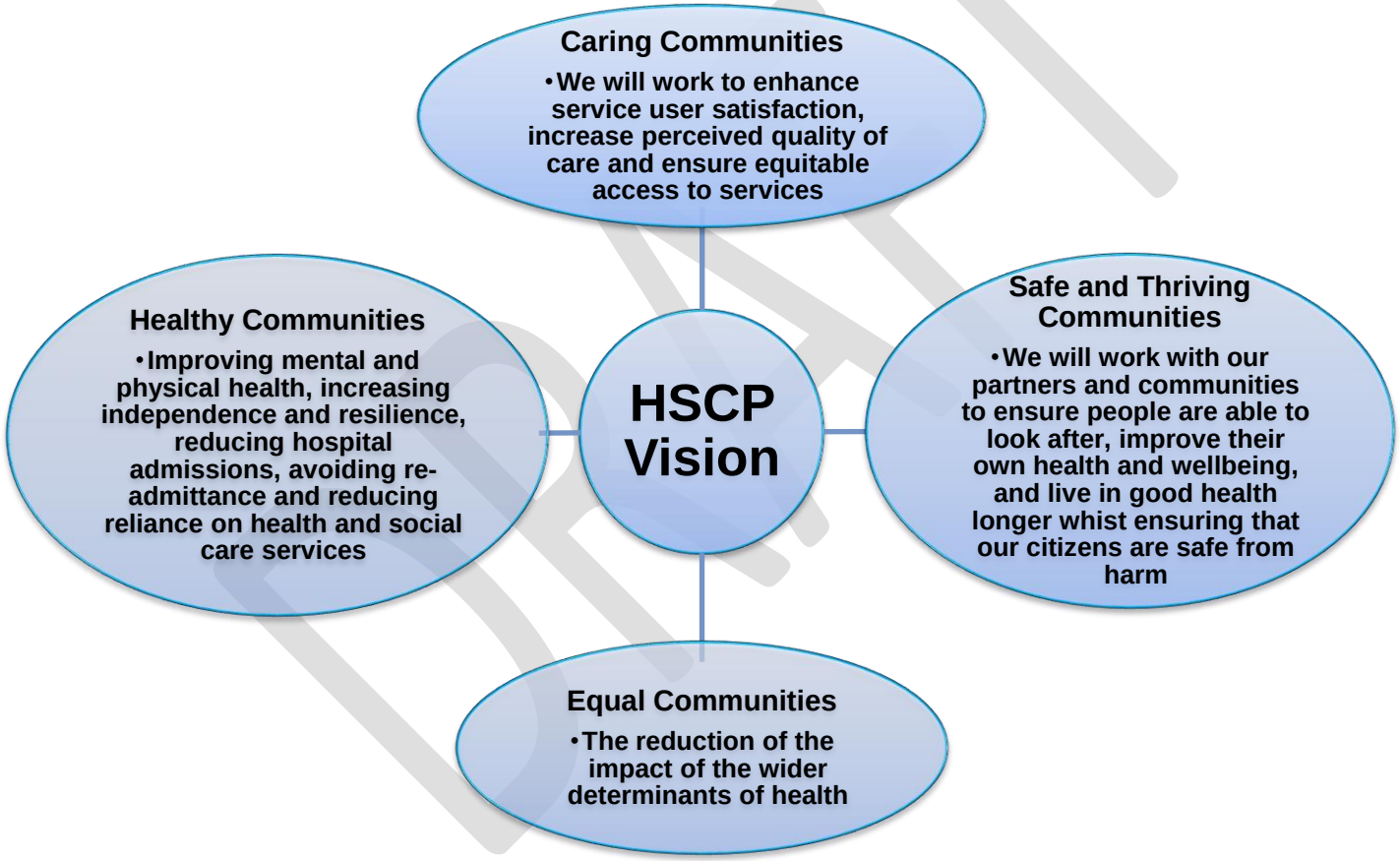
Exhibit 2: HSCP Vision, Mission and Values



The HSCP Board's over-arching priority is to support sustained and transformational change in the way health and social care services are planned and delivered, emphasising the importance of integrating services around the needs of individuals, their carers, and other family members over the medium to long term.

The delivery of our vision is structured around four strategic outcomes.

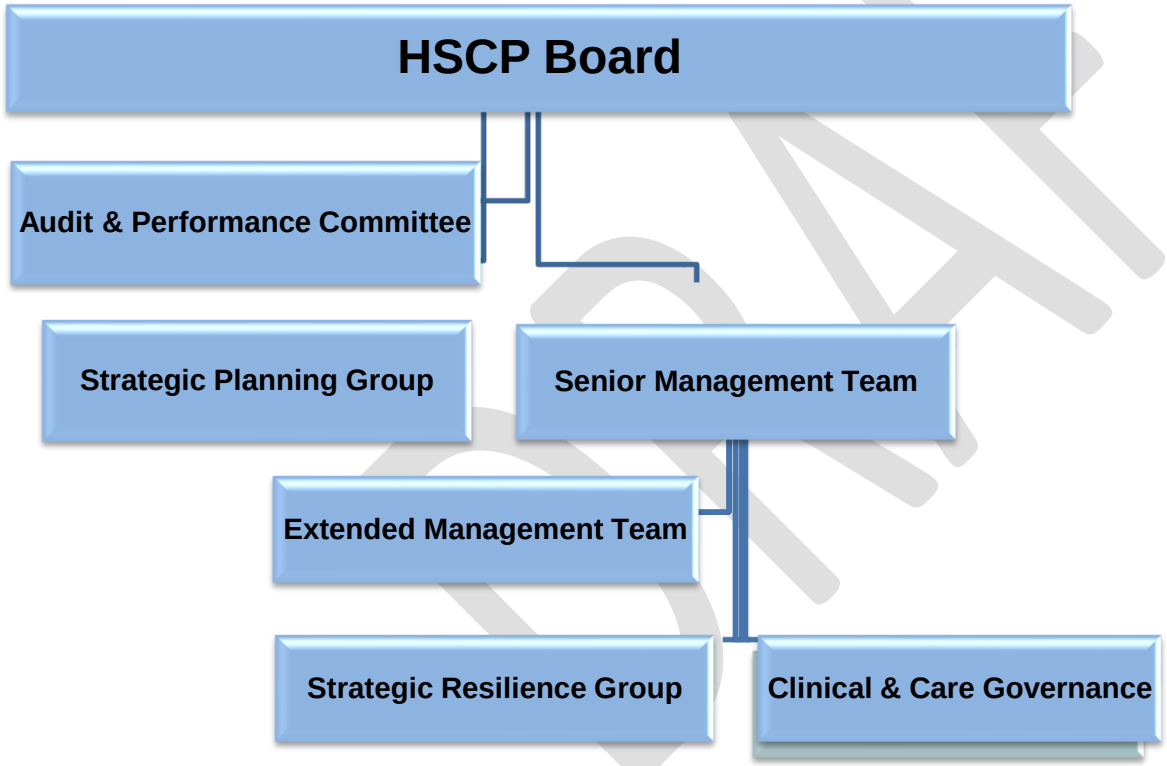
Exhibit 3: Strategic Outcomes



As set-out above, the HSCP Board is responsible for the strategic planning of integrated services as set out within Exhibit 1. The Board is also responsible for the operational oversight of the Health and Social Care Partnership (HSCP), which delivers integrated services; and through the Chief Officer, is responsible for the operational management of the HSCP.

The business of the HSCP Board is managed through a structure of strategic and financial management core leadership groups that ensure strong integrated working as shown in Exhibit 4 below.

Exhibit 4: High Level Overview of Structure



The HSCP Board membership consists of six voting members with each partner organisation nominating one member to assume the roles of Chair and Vice Chair.

The Council appoints three elected members, while the Health Board designates three non-executive members.

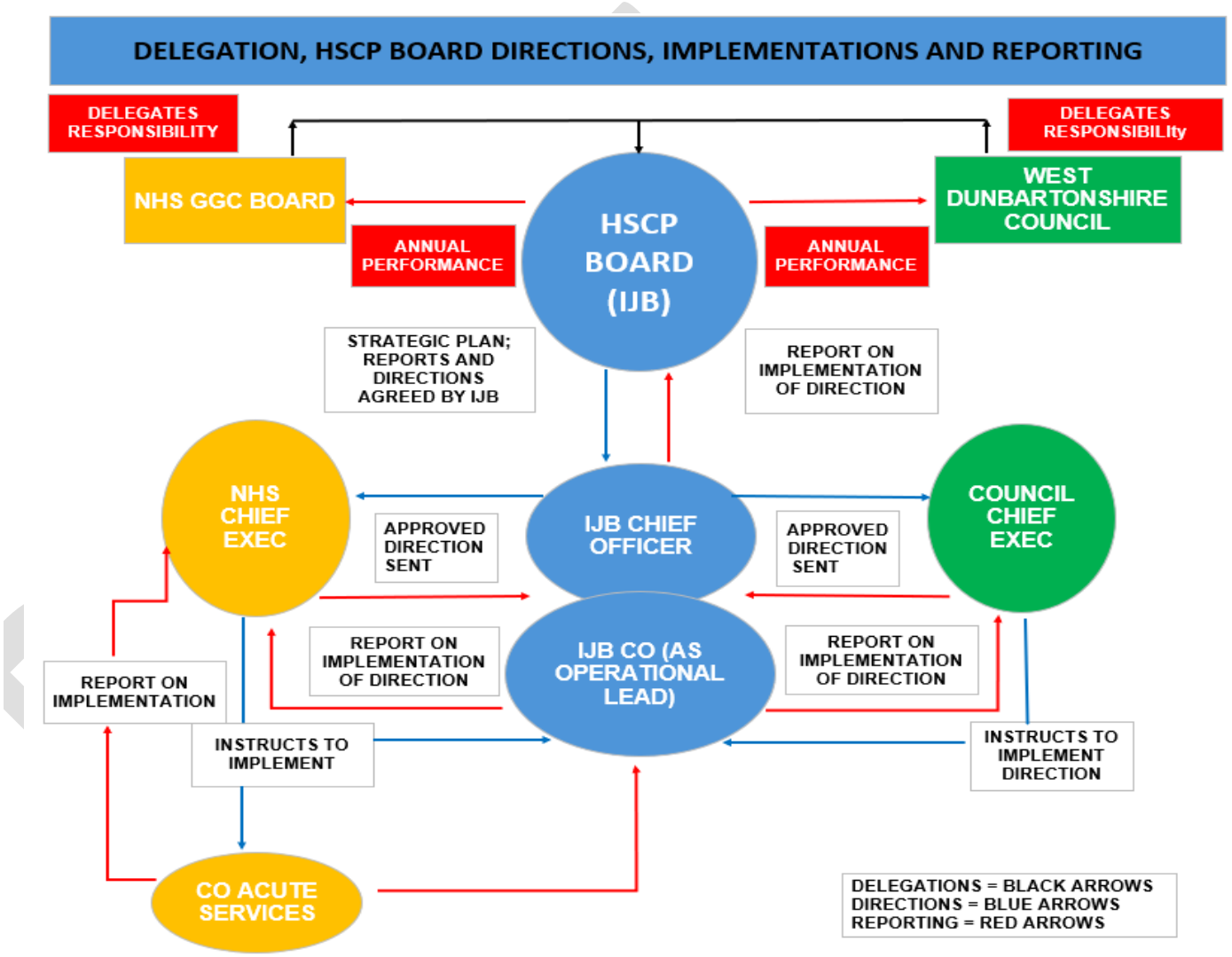
The HSCP Board also includes several non-voting professional and stakeholder members.

The HSCP Board and the Audit and Performance Committee meets six times and four times a year respectively.

Exhibit 5: Integration Arrangements via Directions

Directions from the HSCP Board to the Council and Health Board govern front-line service delivery in as much as they outline:

- What the HSCP Board requires both Council and Health Board to do;
- The budget allocated to this function(s); and
- The mechanism(s) through which the Council or Health Board's performance in delivering those directions will be monitored.



Strategic Planning for Our Population

West Dunbartonshire lies north of the River Clyde encompassing around 98 square miles of urban and rural communities across the two localities of Clydebank and Dumbarton & Alexandria.

The area has a rich past, shaped by its world-famous shipyards along the Clyde, and has significant sights of natural beauty and heritage from Loch Lomond to the iconic Titan Crane as well as good transport links to Glasgow. It has a population of 88,750 which accounts for approximately 1.6% of the Scottish population.

Exhibit 6: Map of West Dunbartonshire

The HSCP Board's primary purpose is to set the strategic direction for the delegated functions through its strategic plan. Our fourth strategic plan 'Improving Lives Together' was approved on 15 March 2023, covering the three-year period 2023 – 2026, and describes how we will use our resources to continue to integrate services in pursuit of national and local outcomes and is supported by a strategic delivery plan.

There are nine national health and wellbeing outcomes (see Exhibit 7 below) which provide the strategic framework for the planning and delivery of integrated health and social care services.

Exhibit 7: National Health and Wellbeing Outcomes

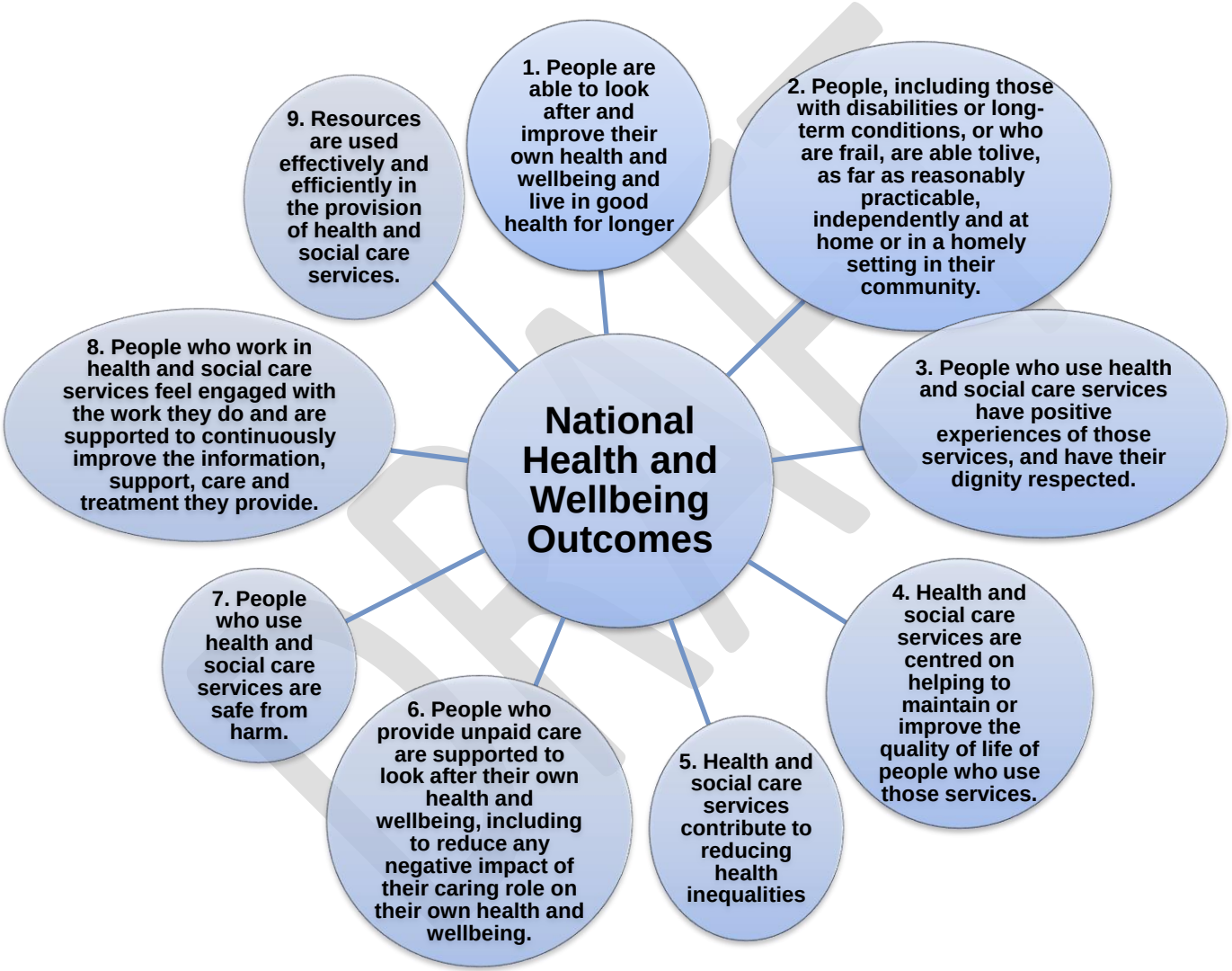


Exhibit 8: Cross Match of HSCP Strategic Outcomes with the National Health and Wellbeing Outcomes

Each of the HSCP Strategic Outcomes have been cross matched to the National Health and Wellbeing Outcomes as detailed below.

Caring Communities

- 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
- 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- 5. Health and social care services contribute to reducing health inequalities.
- 6. People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.
- 7. People who use health and social care services are safe from harm.
- 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- 9. Resources are used effectively and efficiently in the provision of health and social care services.

Safe and Thriving Communities

- 1. People are able to look after, improve their own health and wellbeing, and live in good health longer.
- 2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
- 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- 5. Health and social care services contribute to reducing health inequalities.
- 7. People who use health and social care services are safe from harm.
- 9. Resources are used effectively and efficiently in the provision of health and social care services.

Healthy Communities

- 1. People are able to look after, improve their own health and wellbeing, and live in good health longer.
- 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
- 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- 5. Health and social care services contribute to reducing health inequalities.

Equal Communities

- 1. People are able to look after, improve their own health and wellbeing, and live in good health longer.
- 2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
- 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- 5. Health and social care services contribute to reducing health inequalities.
- 7. People who use health and social care services are safe from harm.
- 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- 9. Resources are used effectively and efficiently in the provision of health and social care services.

West Dunbartonshire's demographic profile is well documented within the strategic plan. The plan clearly sets out the scale of the challenge around effective delivery of health and social care services in West Dunbartonshire in particular tackling multi-morbidity, poverty, addiction, domestic violence, and mental health. A key part in updating the Strategic Plan was the development of a Strategic Needs Assessment to enable the HSCP to continue to respond positively and plan for effective models of service delivery.

The West Dunbartonshire HSCP Strategic Needs Assessment 2022 (see Appendix 1, 3) has taken a 'population view' by using an epidemiological approach to describe:

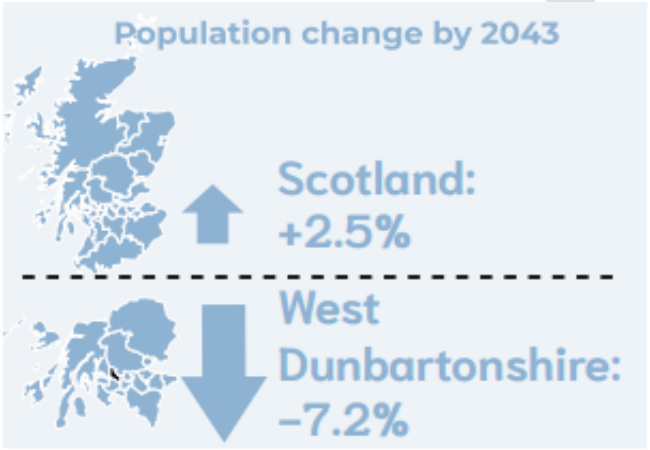
- Health and Social Care provision in the community;
- Why some population groups or individuals are at greater risk of disease e.g., socio-economic factors, health behaviours; and
- Whether the burden of diseases are similar across the population of West Dunbartonshire's localities.

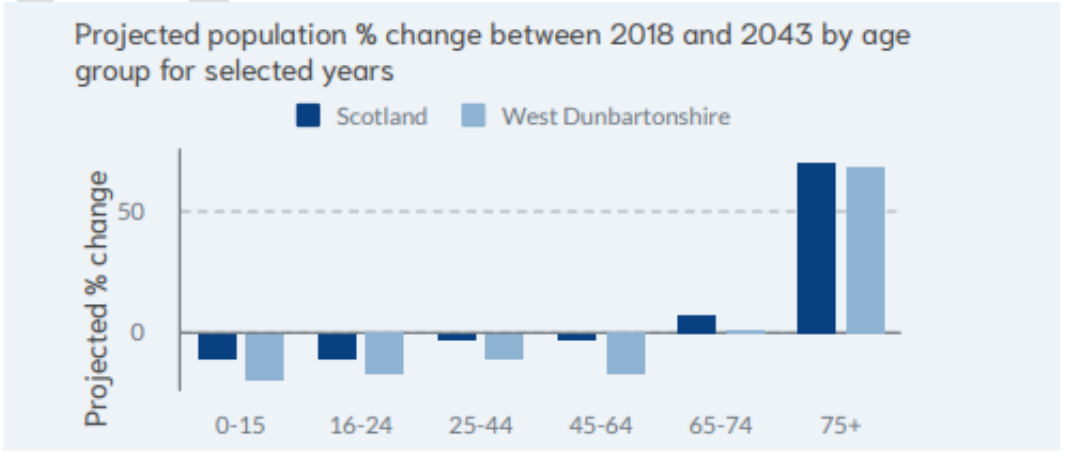
The main sections are structured around:

The SNA includes data for the financial year 2020/21 in which Scotland adopted emergency measures due to COVID-19. Therefore, the data should be interpreted in the context of the disruption the pandemic had on health and social care services and the impact on individuals' health. An extract of some of the key statistics is provided below within Exhibit 9.

Exhibit 9: Extract from SNA Executive Summary (see Appendix 1, 4)

Population



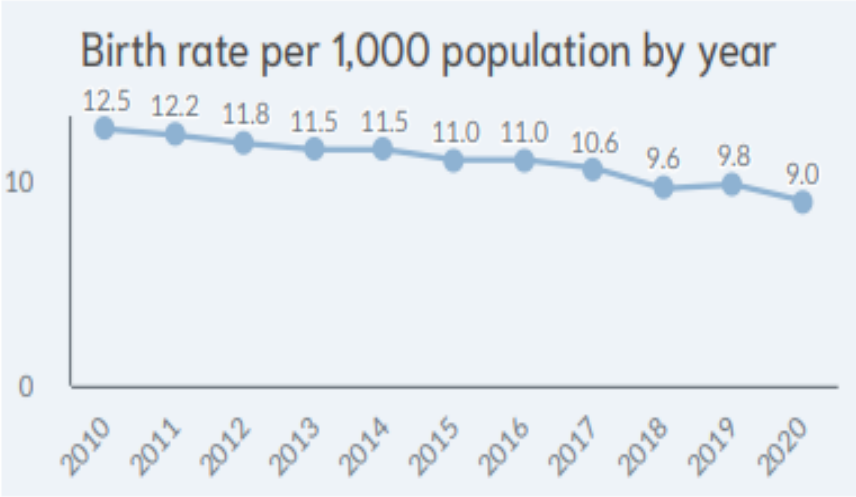


6.9% decrease

overall in the population (compared to a 7.7% **increase** nationally).

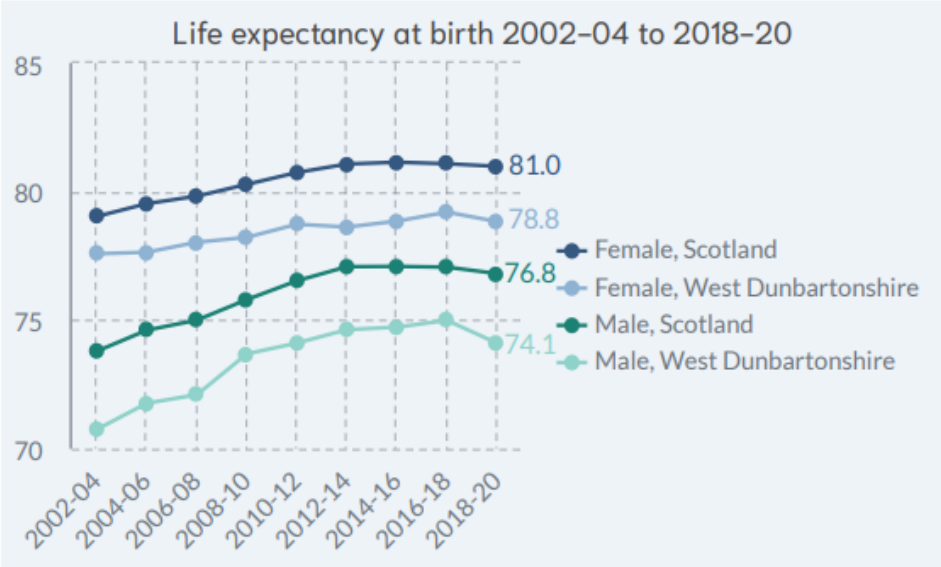
Younger age groups decreased but older age groups increased.

Population decline is due to a decreasing birth rate and net migration away from West Dunbartonshire.



9 births per 1,000 population

There has been a consistent decline in the birth rate in West Dunbartonshire over the last 10 years.



Leading causes of deaths in West Dunbartonshire:

for females	for males
dementia/Alzeimers (15.2%)	ischaemic heart disease (13.6%)
ischaemic heart disease (8.3%)	lung cancer (8.1%)

If all cancers were grouped together, cancer would be the leading cause of death.

Healthy life expectancy 2018–2020 in West Dunbartonshire:

58.5 years for females

58.1 years for males

Rates of **premature death** (age <75)

4x higher for the **most deprived** than the least deprived areas in Scotland

West Dunbartonshire contains the 3rd= highest share of the most deprived datazones in Scotland.

Food Insecurity

Of people in Scotland live in households with marginal, low or very low food security

Of those in relative poverty have marginal, low or very low food security

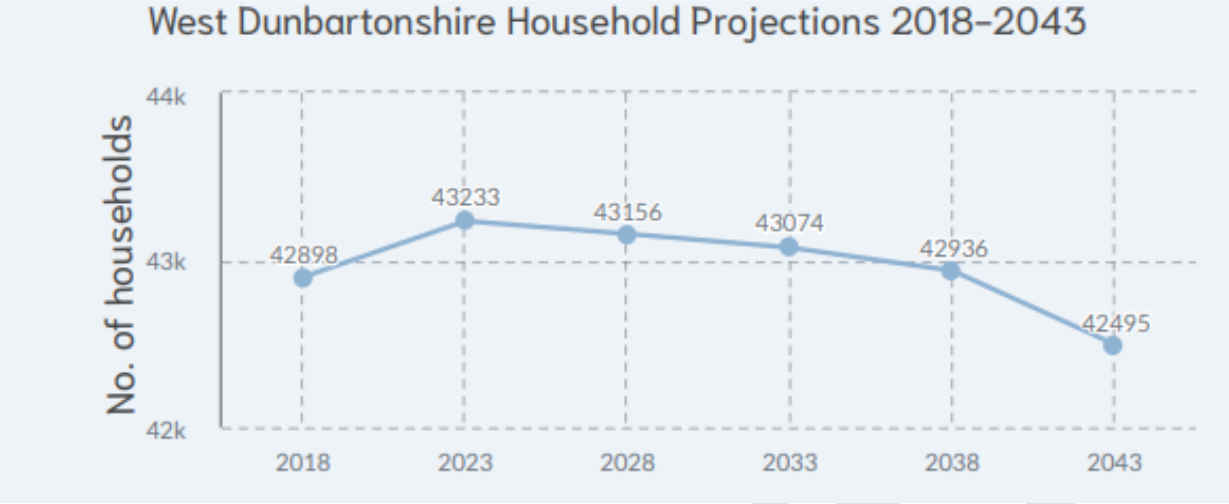
The impact of rising inflation and planned tax increases will affect the living standards of the whole population. People on fixed and low incomes will be disproportionally affected.

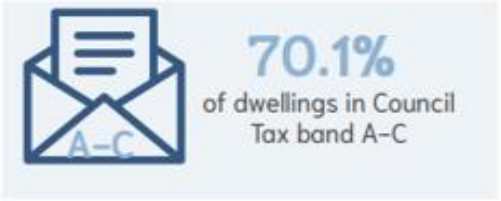
Fuel Poverty

Fuel poverty is defined by the Scottish Government as any household spending more than 10% of their income on energy – after housing costs have been deducted.

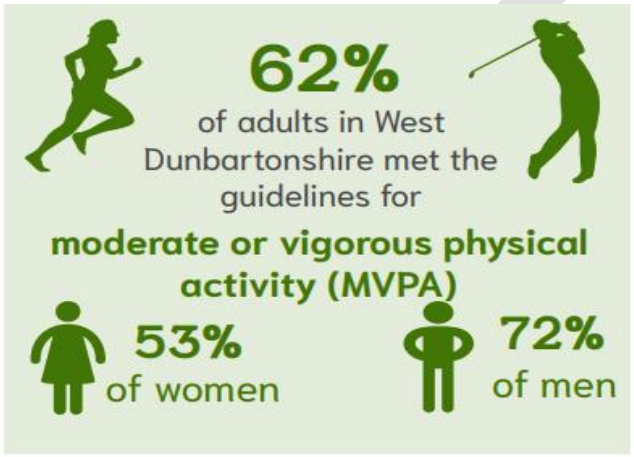
29% of West Dunbartonshire residents were in fuel poverty in **2019**

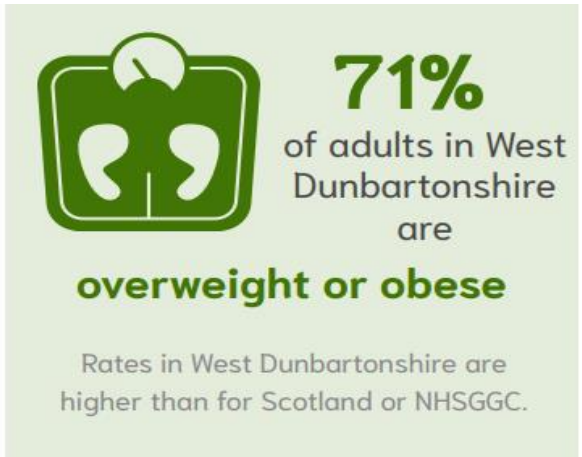
It is estimated this will rise to:
41% from April 2022

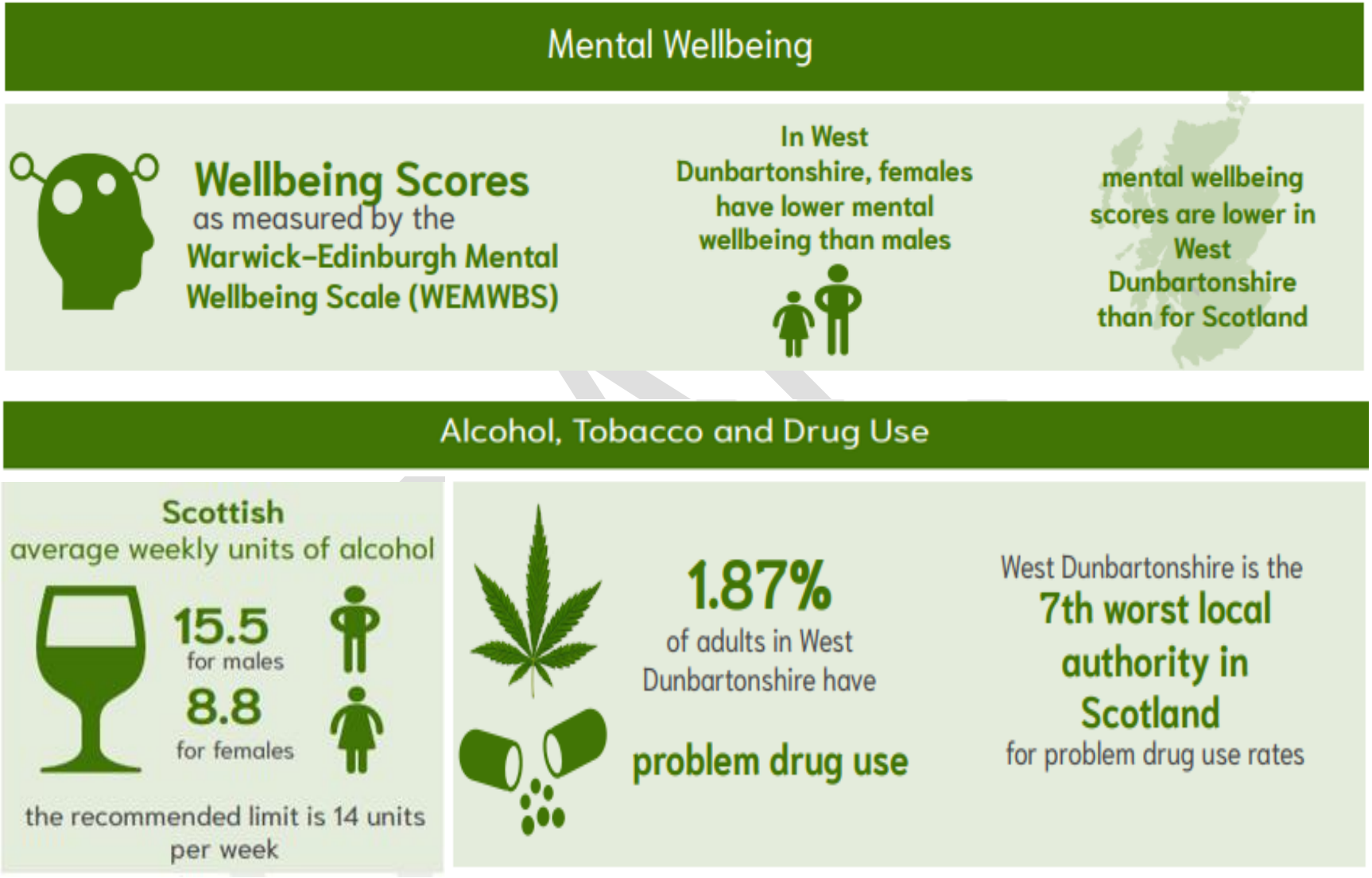




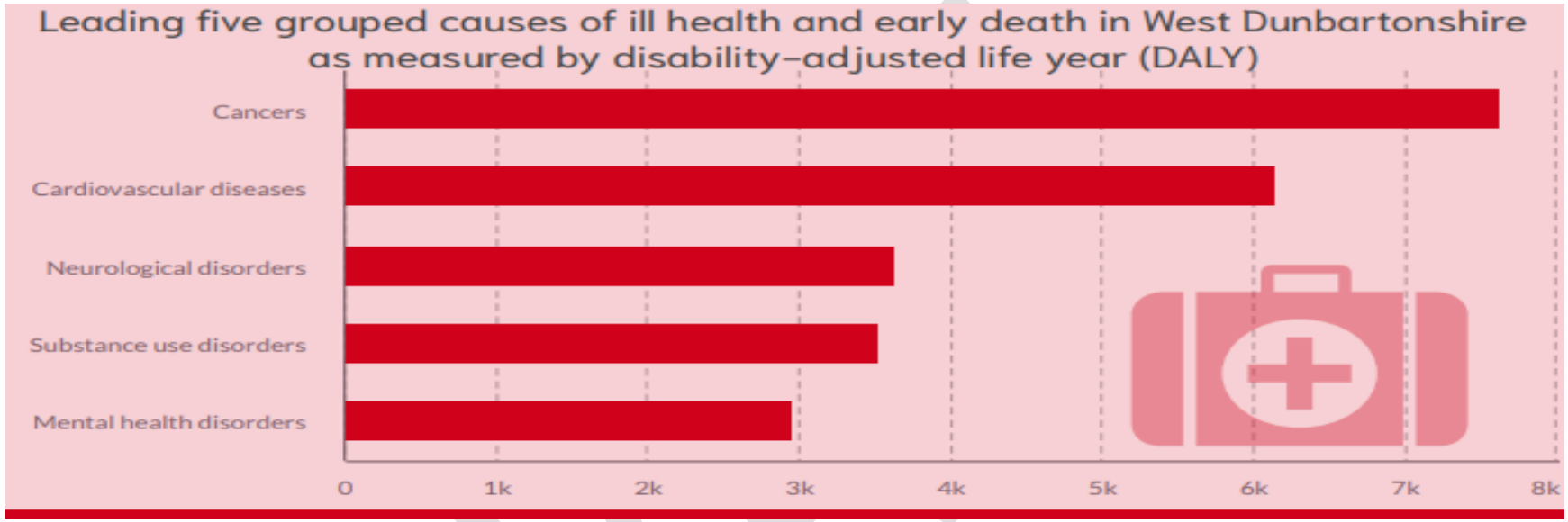
Individual Behaviours



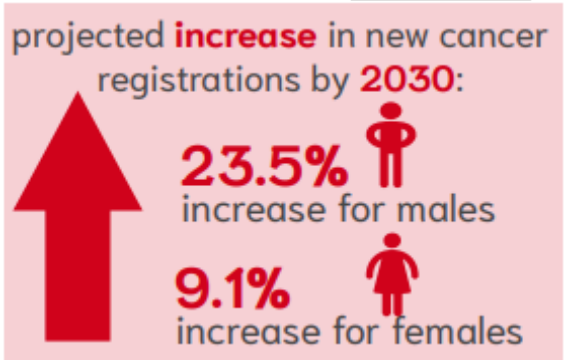


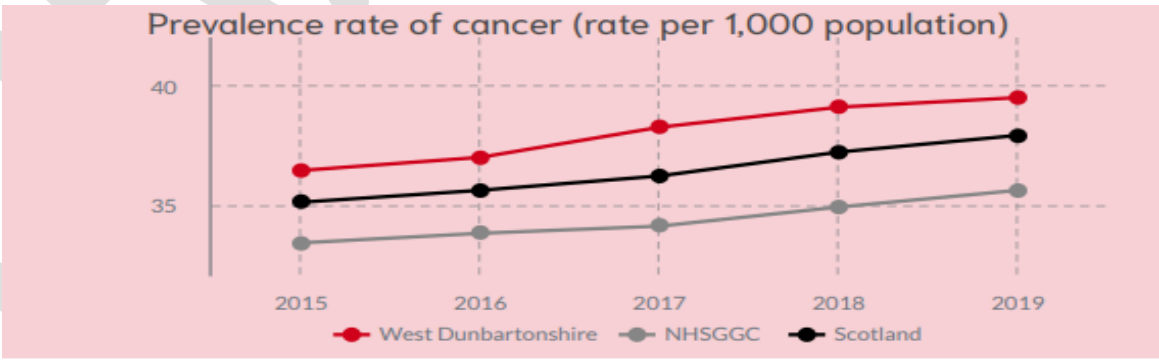

Mental Wellbeing
Wellbeing Scores
as measured by the
Warwick-Edinburgh Mental
Wellbeing Scale (WEMWBS)
In West
Dunbartonshire, females
have lower mental
wellbeing than males
mental wellbeing
scores are lower in
West
Dunbartonshire
than for Scotland
Alcohol, Tobacco and Drug Use
Scottish
average weekly units of alcohol
15.5
for males
8.8
for females
the recommended limit is 14 units
per week
1.87%
of adults in West
Dunbartonshire have
problem drug use
West Dunbartonshire is the
7th worst local
authority in
Scotland
for problem drug use rates

Burden of Disease



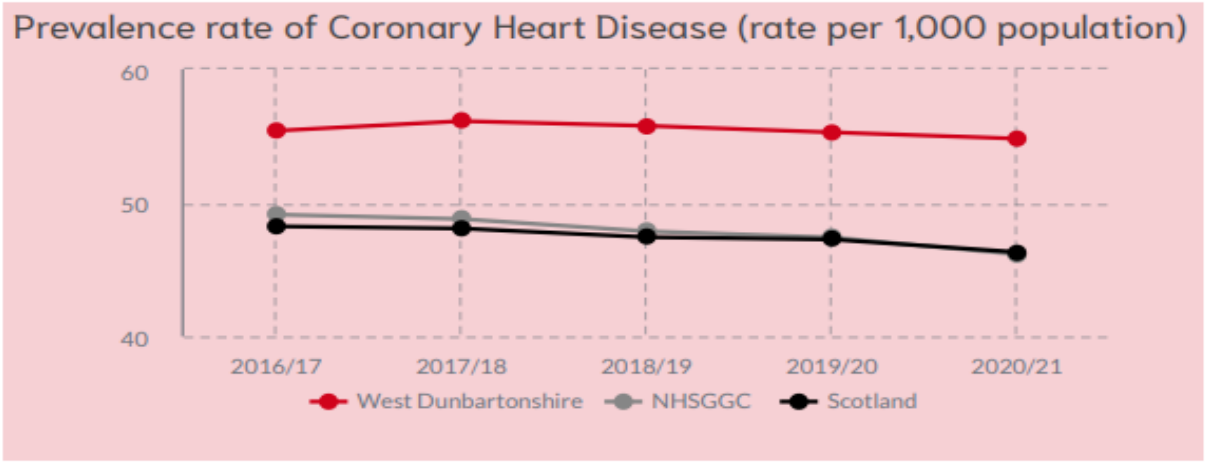
Cancer is the top burden of disease.





Cardiovascular Disease is the 2nd highest burden of disease.

in West Dunbartonshire in 2020/21
Prevalence rate of
Coronary Heart Disease
54.81 per 1,000



Neurological Disorders are the 3rd highest burden of disease.

688
people in West Dunbartonshire are living with dementia

projected **increase** in dementia by 2030/31:
16.3%

Substance Use Disorders are the 4th highest burden of disease.

Deaths per 100,000 population
Alcohol specific
28.51
Smoking specific
404
Drugs specific
35.66

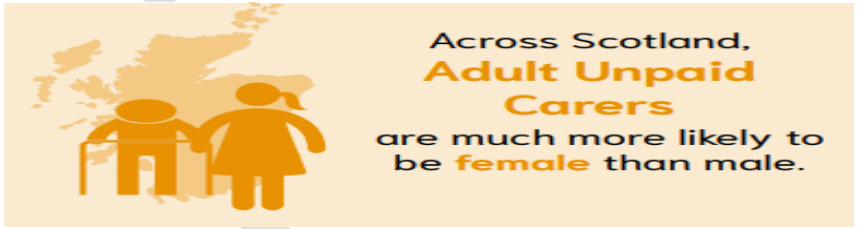
Rates are higher in West Dunbartonshire than NHSGGC or Scotland

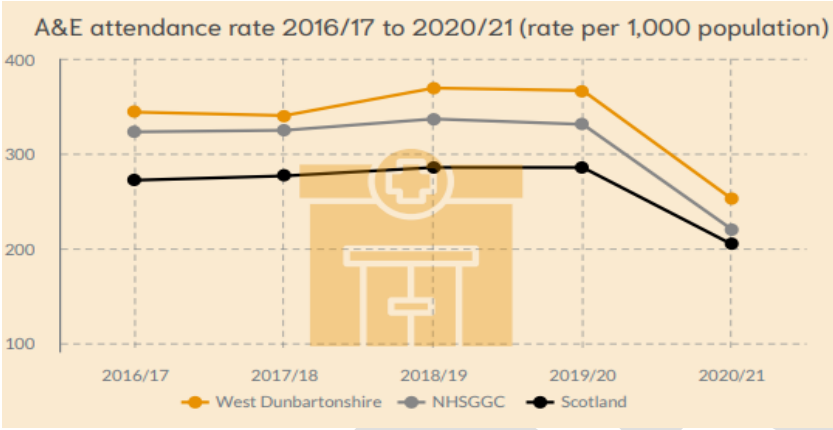
Mental Health Disorders are the 5th highest burden of disease.

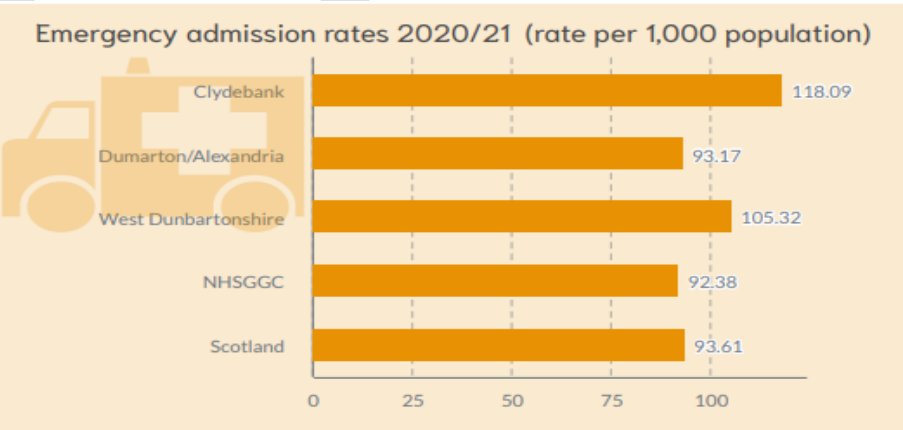
23.2%
of the population are **prescribed drugs for anxiety, depression or psychosis**

on average there are
11.8 suicides per year

Health and Care in the Community







Climate Change

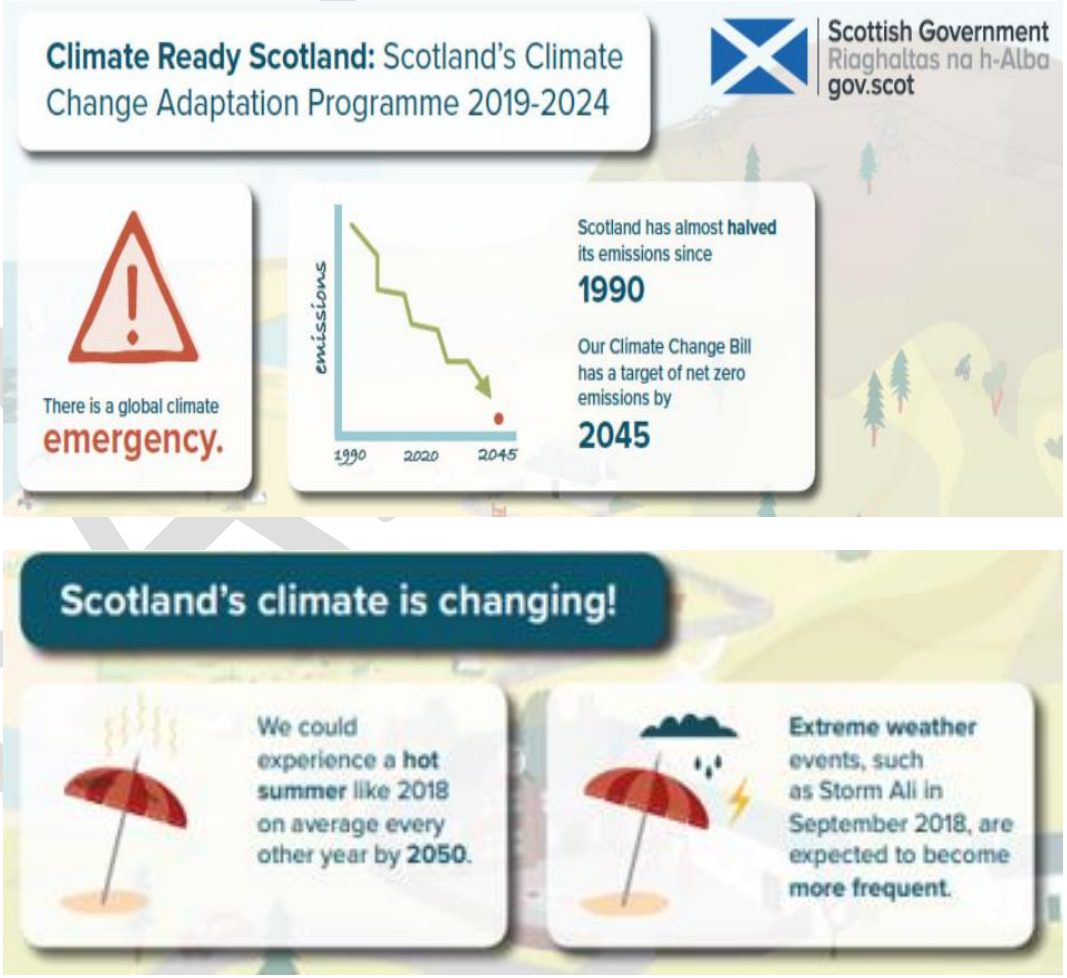
Tackling climate change is one of the Scottish Government's top four priorities as detailed within their 2024/25 Programme for Government. Public bodies have a duty to adapt their operations and demonstrate measurable climate-related improvements. Auditors of public bodies are mandated to report on climate change arrangements in their Annual Audit Reports.

As public authorities, Integration Joint Boards (IJBs) are also subject to wider statutory duties, including those related to climate change. Specifically, IJBs are required to:

- Produce an annual Climate Change Report under the Climate Change (Scotland) Act 2009, as amended by the Climate Change (Emissions Reduction Targets) (Scotland) Act 2019.

- Demonstrate compliance with the Public Bodies Climate Change Duties, which include:
    - Reducing greenhouse gas emissions.
    - Adapting to climate change impacts.
    - Acting sustainably in the delivery of their functions

These duties are reinforced by guidance from the Scottish Government and Audit Scotland, which emphasise the need for IJBs to embed climate considerations into strategic planning and operational delivery.



CLIMATE READY SCOTLAND: Second Scottish Climate Change Adaptation Programme 2019-2024

The HSCP Board does not have a specific climate change strategy or action plan. However, the Strategic Plan 2023–2026, "Improving Lives Together," acknowledges the context in which the HSCP operates and outlines its role in supporting the Health Board and the Council's sustainability goals.

Extract from Strategic Plan 2023 – 2026 “Improving Lives Together”

“The update to Scotland’s Climate Change Plan 2018–2032 recognises that the global pandemic has had a negative impact on our ability to meet statutory targets for net-zero emissions. This plan recognises climate change as a human rights issue and the transition to net zero as an opportunity to tackle inequalities. West Dunbartonshire HSCP and its partners must do all that they can to support vulnerable people through these challenges and make every effort to reduce their own carbon footprint.”

There has been no current or expected material impact to be reported within this year’s financial statements, however demand for services delegated to the HSCP Board are driven by demographics and socio-economic factors of which climate change will impact at some point. The HSCP is reviewing its property strategy in partnership with the Council and Health Board which will reflect the embedded flexible working policy that will rationalise the use of buildings and reduce staff travel, i.e. positive impact on reducing carbon emissions.

CLIMATE READY SCOTLAND: Second Scottish Climate Change Adaptation Programme 2019-2024

Performance Reporting 2024/25

The HSCP Audit and Performance Committee receives a Quarterly Public Performance Report at each meeting, which provides an update on progress in respect of key performance indicators and commitments. These can be viewed here (see Appendix 1, 5).

The Joint Bodies Act also requires all IJBs to produce an Annual Performance Report (APR), by the 31 July. The report content is governed by the 2014 Act and must cover the HSCP Board's performance against the 9 national outcomes and 23 national indicators.

The 2024/25 APR is scheduled to be presented to the HSCP Audit and Performance Committee on 25 June 2025 for approval and publication thereafter. The report can be viewed here (see Appendix 1, 6).

The performance report includes 51 indicators with ambitious targets, measuring progress against local and national benchmarks. These indicators help assess how well the HSCP Board is advancing integration objectives, particularly in supporting people to live independently in their communities.

The indicators also demonstrate how the HSCP Board delivers best value through strong governance, effective resource management, and a commitment to continuous improvement to achieve the best outcomes for the public. The Senior Management Team annually reviews Best Value arrangements for Audit and Performance Committee consideration in support of the annual accounts. The June 2025 report is available here (see Appendix 1,7).

Performance continued to be influenced by complex factors, with changing activity and demand remaining key drivers in 2024/25. Monitoring arrangements are being refined to strengthen scrutiny and accountability.

Some key areas of performance (as defined by the Scottish Government) over the past year are detailed below. The categorisation of the indicators aligns to the 2023 – 2026 strategic priorities detailed above and align to the nine national health and wellbeing outcomes (refer to Exhibit 7 and 8).

KEY

PI Status			
	Target achieved		Target missed by 15% or more
	Target narrowly missed		Data only - no target set

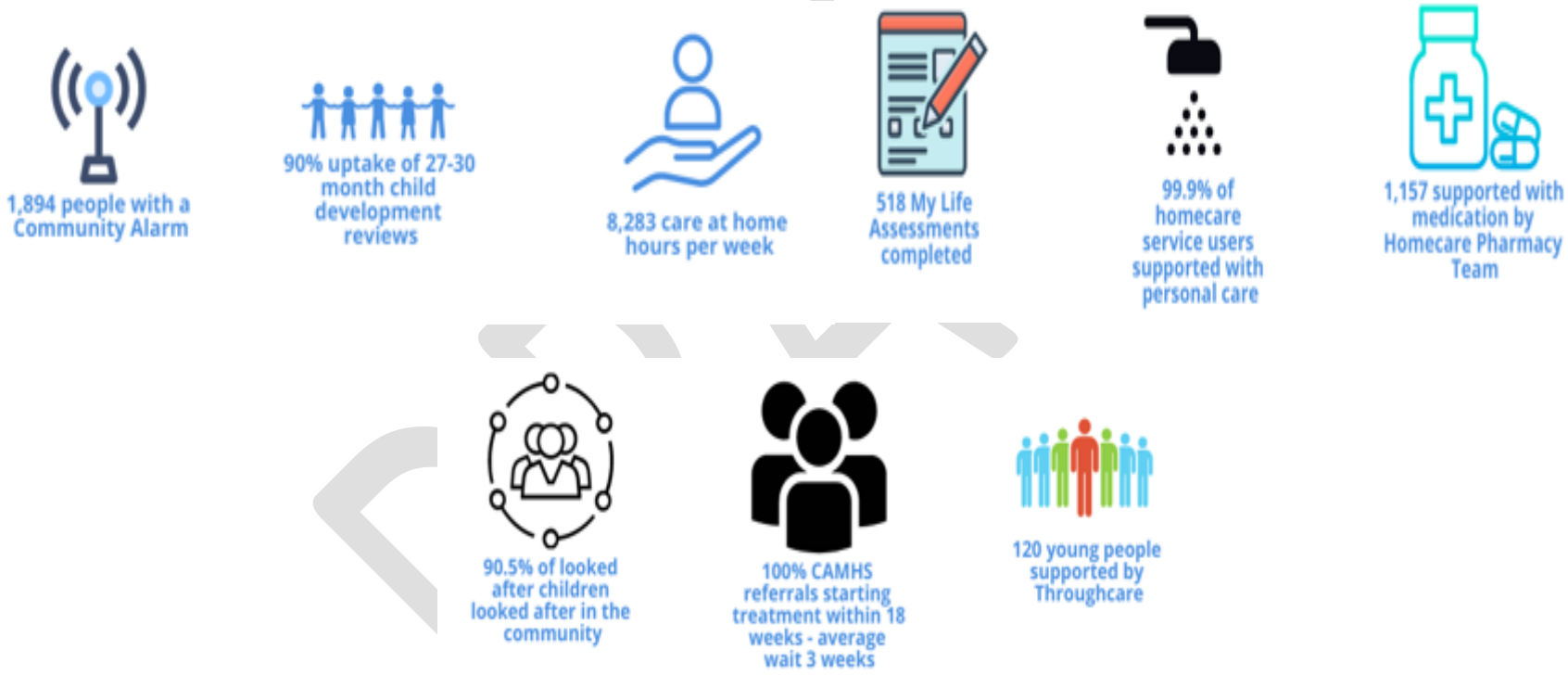
Exhibit 10: Extract from 2024/25 Annual Performance Report

Performance Indicator	2023/24	2023/24			5 Year Trend
	Value	Value	Target	Status	
Priority 1: Caring communities					
Percentage of carers who feel able to continue in their caring role when asked through their Adult Carer Support Plan	92.8%	90.9%	95%		
Balance of Care for looked after children: % of children being looked after in the Community	88.9%	90.5%	90%		
Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	100%	100%	90%		
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	60.2%	57.3%	90%		
Priority 2: Safe and thriving communities					
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	100%		
Number of acute bed days lost to delayed discharges (incl. Adults with Incapacity) Age 65 years & over	10,765	9,252	9,338		
Percentage of people who receive 20 or more interventions per week	40%	46.8%	40%		
Priority 3: Equal communities					
Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	80.30%	65.4%	80%		
Priority 4: Healthy communities					
Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	44%	41%	90%		
Prescribing cost per weighted patient (Annualised)	£193.03	Not Yet Available	£193.03	Not Yet Available	

Performance Highlights 2024/25

The following graphic present a pictorial view of performance highlights with more extensive detailed narrative following thereafter.

Exhibit 11 – Pictorial View of Performance Highlights



Service Updates 2024/25

Our Workforce

Workforce sustainability remains a strategic priority and a recognised risk across West Dunbartonshire HSCP. Ensuring we have the right people, in the right roles, at the right time is essential to delivering safe, high-quality, person-centred care. Our 3-Year Workforce Plan directly addresses this challenge, aligning with our Annual Delivery and Financial Plans to support recruitment, retention, and workforce development across all job families.

We are committed to creating the conditions for success: where leaders work together toward a shared vision, staff are supported to grow in their careers, and training and development opportunities are accessible to all. This approach not only strengthens service delivery but also builds the capacity and capability needed to transform for the future.

Central to this vision is the wellbeing of our workforce. Through regular campaigns and resources delivered in partnership with the Council and Health Board, we continue to promote physical and mental wellbeing.

Our people are at the heart of everything we do. We proudly celebrate their dedication and achievements throughout the year, culminating in our annual Staff Excellence Awards. The 2024 event showcased outstanding contributions across the partnership, with local winners nominated for the Health Board's Celebrating Success Awards in May 2025.

- **Team of the Year: West Dunbartonshire HSCP Mental Health Officers**

  Our Mental Health Officers work closely with medical and legal professionals to fulfil their statutory duty to protect and support individuals in mental health crisis. They consistently go above and beyond, delivering compassionate, person-centred care. Through strong multi-disciplinary collaboration and peer support, they ensure consistent, effective practice - always placing the individual at the centre of their care, with their voice heard and reflected in every assessment.

- **Leader of the Year: Joyce Habo, Business Support Supervisor & PA to Chief Officer**

  Joyce plays a key role in supporting West Dunbartonshire HSCP, leading with empathy, adaptability, and a strong focus on team wellbeing. Her collaborative approach fosters growth and resilience, even amid change. Respected across the organisation, she consistently delivers attentive, efficient support—balancing strategic priorities with genuine care for colleagues.

- **Employee of the Year and overall HSCP Winner: Gioia Sichi-Smith, Specialist Nurse & Senior Harm Reduction Nurse, Addiction Services**

  As a vital member of the Alcohol and Drug Recovery Service, Gioia supports some of the most vulnerable people in our community.

  Noticing low engagement with sexual health services, she undertook specialist training and now runs a weekly clinic offering screenings and harm reduction support. Through collaboration and outreach, Gioia is expanding this work - promoting regular healthcare and delivering awareness training to empower individuals on their recovery journey

- **Innovation of the Year: MSK Project Team (Streamlined Vetting Process)**

  Redesigning the referral vetting process was a key priority for the MSK Physiotherapy service, ensuring patients access the right care at the right time. A dedicated team—from Health Care Support Workers to Advanced Practice Physiotherapists—delivered the project on time, improving patient experience and optimising appointment capacity. Ongoing feedback from patients and staff continues to shape and enhance the process.

- **Volunteer of the Year – Allison Graham, Low Back Pain Advanced Physiotherapy Practitioner**

  Allison is an outstanding Physiotherapist, deeply attuned to the diverse needs of the community she serves. Beyond her clinical role, she actively supports under-represented groups through initiatives like the Milk Enterprise Project in Govanhill. Volunteering her time, she empowers women from asylum-seeking and refugee backgrounds—offering English practice, health discussions, tailored exercise classes, and even quizzes to support UK residency preparation.

Our Services

Care Homes

- **Residents from Crosslet House** have been part of the “Every Voice Choir” for over five years, performing in local supermarkets to raise awareness of Alzheimer’s. In September 2024, they joined “The Blue Bells” at Glasgow Art Gallery for Playlist for Life Day—an unforgettable experience featured on one of the national news channels.

- In February 2025, **caterers at Crosslet House and Queens Quay House** earned the Food for Life Served Here Bronze Award—serving over 50,000 healthy, sustainable meals annually. This marks a first for public sector food in Scotland, recognising their commitment to quality, local sourcing, and wellbeing.

Care at Home

The Care at Home service continues to face significant challenges, particularly as demographic demands grow faster than available financial resources. In response, a comprehensive redesign is underway to improve service delivery and ensure high standards of care. Phases 1 and 2 of the re-design have now been implemented, with 70% of the workforce transitioned to a new standard rota. The remaining staff will move to this model by March 2026, supporting fairer workforce distribution and improved efficiency across all areas.

A full Care Inspectorate inspection in April 2025 highlighted progress, particularly in leadership and care planning. The service is actively working through an agreed improvement plan, with ongoing support from the Care Inspectorate to drive further enhancements. To strengthen oversight, new reporting tools have been introduced—tracking overtime, agency use, absence rates, service user reviews, and visit compliance. These reports support regular supervision and informed decision-making by Team Leads.

Absence levels remain a key area for improvement. In response, updated operational guidance has been introduced to ensure staff are well supported on return to work and that attendance management processes are consistently applied.

Unscheduled Care

A new care home dashboard has been developed to align with the Call Before You Convey (CB4YC) initiative, helping to target efforts to reduce avoidable hospital admissions from care homes. This supports a wider strategy to improve care and maintain residents safely in their homes where appropriate.

Key improvement activities include:

- **Call Before You Convey (CB4YC):** Rolled out to all West Dunbartonshire care homes in November 2024, this initiative enhances support for residents during illness or deterioration, helping avoid unnecessary hospital transfers. A Pre-Weekend Ward Round allows care homes to flag at-risk residents for early review by the Care Home Liaison Nurse (CHLN), enabling timely interventions.

- **Condition-Specific Interventions:**
  - Chronic Obstructive Pulmonary Disease (COPD) reviews and provision of rescue medication.
  - District Nurse Test of Change for weekend prescribing of Urinary Tract Infection (UTIs), Upper respiratory Tract Infection (URTIs), and Cellulitis.
  - Enhanced End of Life Care advice, support by our District Nursing Team and Care Home Liaison Nurse.

These actions are improving care continuity, reducing pressure on emergency services, and supporting residents to remain in familiar surroundings whenever safely possible.

Children's Community Services

- **Early speech, language, and communication (SLC) development** is vital for children's long-term wellbeing and educational success. In West Dunbartonshire, several workstreams are underway to raise awareness of SLC needs and strengthen the skills and confidence of the workforce supporting children with speech, language, and communication needs (SLCNs). These include:
  - Building on Communication & Literacy Practitioners (CLP) for every early year's establishment.
  - Developed resources and enhanced CLP skills in screening and using assessment tools to better understand children's comprehension levels.
  - Upskilling of parents and other professionals with development of advice packs.
  - Roll out of "Up, Up, and Away" an evidence-based resource to staff in early years establishments.

- **The rollout of the Health Visiting Universal Pathway continues.** In 2023/24 and early 2024/25, a higher percentage of West Dunbartonshire children aged 13–15 months were identified with developmental concerns compared to the Health Board average. Speech, language, and communication delays, affecting 7% of children, remain the most common issue, prompting targeted improvement efforts.

- **A new Health Vulnerable Pregnancy Group has been established** to strengthen communication between midwifery, health visiting, and family nurse teams—supporting early intervention and referral pathways, including for children with neurodiversity.

- **A Quality Improvement project is underway** to explore the use of "Request for Assistance" within health visiting and school nursing services in West Dunbartonshire, aiming to streamline support pathways.

- **The West Dunbartonshire Breastfeeding Team** continues to promote, protect, and support breastfeeding, maintaining UNICEF Gold accreditation since 2018. Work is ongoing to gather evidence for the 2025 renewal, alongside a new antenatal initiative with midwifery colleagues to increase breastfeeding initiation rates.

- **The Family Nurse Partnership (FNP)** provides intensive, structured home visiting for first-time mothers aged 19 and under (and care-experienced mothers up to 22). The programme supports improved pregnancy outcomes, child development, and family stability through a strengths-based, motivational approach. To date, 215 clients have enrolled, with 82% engagement—83% of whom are from the most deprived areas, ensuring support reaches those most in need.

Prescribing

Drug pricing remains highly complex, influenced by factors such as UK and global inflation, interest rates, currency fluctuations, and national contract arrangements between NHS Scotland and Community Pharmacy Scotland (CPS). Locally, the HSCP's Prescribing Group—chaired by the Clinical Director—focuses on safe, effective prescribing aligned with the principles of Realistic Medicine.

Prescribing is the HSCP's largest area of discretionary spend after staffing, carrying significant financial risk. In 2024/25, the prescribing budget absorbed a £2.212m (10.6%) increase over the previous year, reflecting rising costs and demand. To mitigate this, a challenging efficiency programme of £1.332m was implemented across multiple initiatives.

In 2024/25 the HSCP achieved 93% of its prescribing efficiency targets, ranking joint 1st among HSCPs. Notable achievements include:

- Lidocaine savings: 224% of target achieved (2nd highest HSCP)
- Polypharmacy reviews: 402% of target achieved (4th highest HSCP)
- Apixaban switches: 76% of target achieved (3rd highest HSCP)

These results reflect strong local leadership, data-driven decision-making, and a commitment to delivering value while maintaining safe, person-centred care.

Learning Disability Services

- Following the successful relocation to Clydebank Health and Care Centre (CHCC) in 2023, **the Community Learning Disability Team has expanded its clinical offering, including the introduction of a dedicated Physiotherapy resource.** This has enhanced service delivery and helped maintain waiting times, even during periods of reduced staffing.

- Despite ongoing workforce challenges within the Social Work team, the service remains committed to meeting the critical and substantial needs of individuals with a learning disability. **Support continues to be delivered in line with West Dunbartonshire HSCP's Accessing Adult Social Care Policy and Eligibility Criteria,** ensuring that those most in need receive timely and appropriate care.

- **In line with the Scottish Government directive for annual health checks for individuals aged 16 and over with a learning disability**, the Health Board has established a dedicated Health Check Team. Hosted by East Renfrewshire HSCP, this team of Learning Disability Nurses began delivering checks in West Dunbartonshire in October 2024. By the end of May 2025, 201 individuals had been invited, with approximately half completing their checks and around 20% opting out.

These developments reflect the team's continued focus on improving access, reducing health inequalities, and delivering person-centred care, even in the face of resource pressures.

Mental Health Services

- **Following a review by the Mental Welfare Commission, the service has taken significant steps to strengthen compliance with statutory responsibilities for supervising private Guardians.** Outstanding reviews were identified, and processes have been updated to ensure adherence to prescribed timescales. This includes the introduction of fortnightly Guardianship Governance meetings to monitor progress and enhance reporting. Additionally, Adults with Incapacity (AWI) procedures and guidance have been revised to standardise information provided to prospective Guardianship applicants, with digital formats used where appropriate.

- **In relation to Social Circumstances Reports (SCRs), the Mental Health Team has made notable improvements.** SCRs required within 21 days of a Short-Term Detention Certificate are essential for reflecting individuals' circumstances and views under the Mental Health (Care and Treatment) (Scotland) Act 2003. A full review of the SCR process has led to more consistent documentation and timely completion. Monthly reporting to Mental Health Officers and senior managers now tracks all areas of MHO practice, with a 20% improvement in SCR completion rates in 2024/25 compared to the previous year.

Addictions

Medication Assisted Treatment (MAT) Standards, introduced in 2021 and implemented in 2022, aim to improve access, choice, and support for individuals affected by drug-related harms. A key priority is to reduce drug deaths and harms by ensuring people receive high-quality, person-centred treatment and care.

To support this, an experiential programme—co-designed by individuals with lived and living experience, alongside family members—was launched to evaluate how service users perceive their care. This qualitative approach ensures that MAT Standards are meeting the needs and expectations of those they are intended to support. See Exhibit 12 below:

Exhibit 12: MAT Standards Benchmarking by Reporting Year

Full implementation of the Medication Assisted Treatment (MAT) Standards was achieved in 2024/25, reflecting the HSCP's strong commitment to delivering high-quality, person-centred care. While MAT Standards 6 and 10 are reported directly to the Health Board and not included in the summary table, both have also been fully implemented.

NHSGGC Musculoskeletal (MSK) Physiotherapy

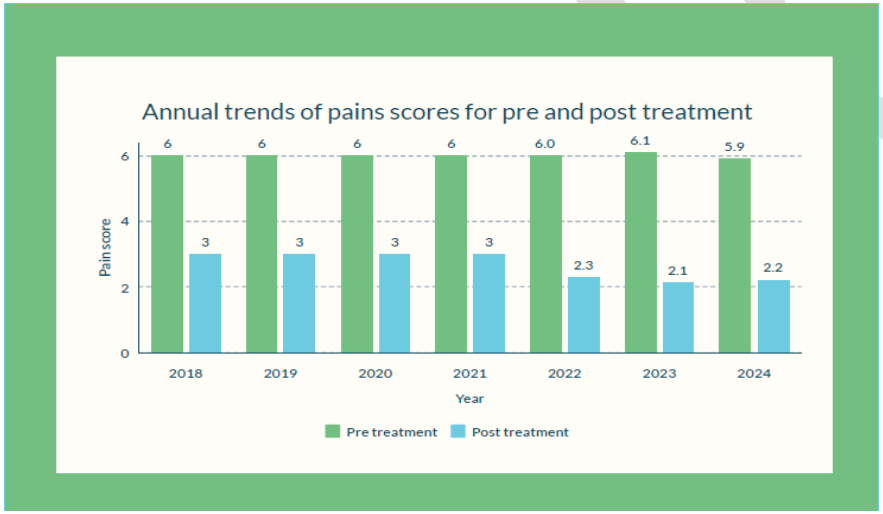
Musculoskeletal (MSK) conditions are a leading cause of disability and work absence, significantly impacting quality of life. The MSK Physiotherapy Service delivers a person-centred approach, offering tailored assessments and care plans focused on symptom relief, movement, exercise, and supported self-management.

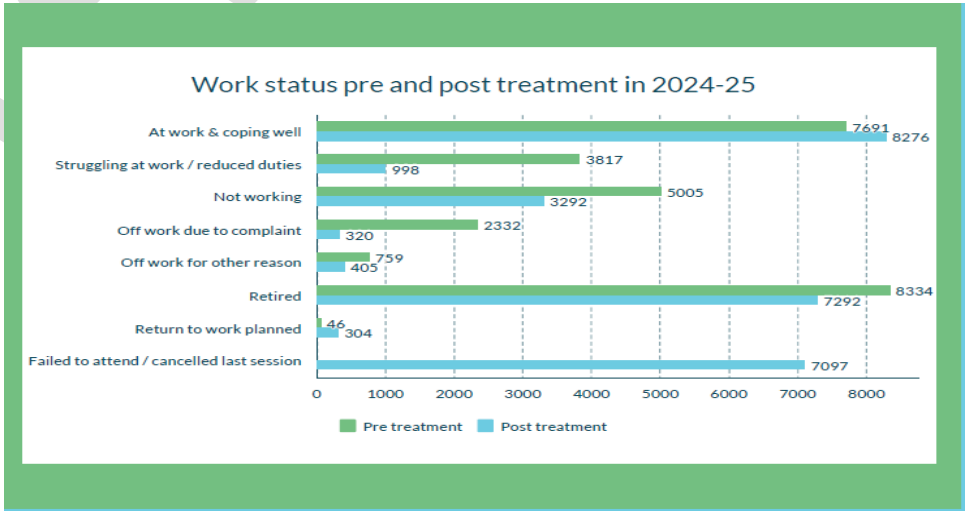
Demand for the MSK Physiotherapy Service continued to rise in 2024/25, with referrals increasing by 6.8% on top of a 13.3% rise the previous year. The service received a total of 78,746 referrals, averaging between 6,000 and 7,000 per month, highlighting sustained and growing need for MSK support.

Rising demand, combined with ongoing recruitment and turnover challenges, has impacted waiting times in the MSK service. Despite no increase in financial resources, the service continues to prioritise all urgent referrals within the Scottish Government's 4-week target. However, only around 40% of routine referrals are currently seen within this timeframe, falling short of the 90% target.

Despite ongoing challenges, the MSK Physiotherapy Service continues to deliver strong outcomes. Positive trends are evident in Patient Reported Outcome Measures (PROMs), including reductions in pain and better work status, as detailed in Exhibit 13 below.

Exhibit 13: Examples of Patient Reported Outcome Measures





Primary Care

- **As the Primary Care Improvement Plan progresses, the benefits of a multidisciplinary team (MDT) approach are increasingly evident.** Many patient presentations can now be effectively managed by the most appropriate healthcare professional, allowing GPs to focus on more complex cases.

- **GP Clusters across West Dunbartonshire continue to collaborate through Practice Quality Leads, supported by the Health Board's Quality Improvement Team and LIST analysts.** Cluster-led projects are tailored to local population needs, with 2024/25 initiatives including:

    - COPD management and rescue medication provision
    - Addressing late-stage cancer diagnoses, particularly lung cancer
    - Expanding access to Long-Acting Reversible Contraception through enhanced training
    - Medication safety audits
    - Improving healthcare access for veterans
    - Modernising general practice through increased use of digital tools

Self-Directed Support Policy and Work with Carers

- **The SDS Team is supporting two new "Support in the Right Direction" (SiRD) projects, including one dedicated to helping carers navigate their SDS journey and access short break funding.** Both projects benefit from SDS Team mentoring and in-house training—such as the *Just Enough Support* approach—and are actively promoted through HSCP staff, with referral pathways and quarterly planning meetings in place. By March 2025, regular engagement ensured open communication, effective referrals, and planning for future developments, including a Personal Assistants (PA) employer network and a stronger focus on early intervention and pre-assessment discussions for 2025/26.

- **The *Just Enough Support* model is now embedded in daily practice, reinforcing the importance of relationship-based social work and creative, person-centred support planning.** SDS Officers continue to offer weekly drop-in clinics for staff to discuss complex cases, processes, and planning. Quarterly training sessions also support staff development, including deeper understanding of Option 1 and its responsibilities.

Recovery and Renewal

On the 15 March 2023, the HSCP Board approved the Strategic Plan 2023 – 2026: Improving Lives Together. The Strategic Planning Group will monitor the progress of the Strategic Plan, supported by robust Delivery Plans.

While the immediate public health threat of COVID-19 has lessened, its legacy continues to shape the way we work—bringing both significant challenges and new opportunities for the HSCP. As we move into 2025/26, we recognise that demand for statutory services will keep growing. This ongoing pressure will have wide-ranging implications, particularly in terms of staffing and financial resources.

As of the end of 2024/25, the National Care Service (NCS) Bill had completed Stage 2 of its legislative journey. During this stage, the Bill underwent substantial amendments, most notably the removal of Part 1, which originally proposed the establishment of the National Care Service and the reform of Integration Authorities. Reflecting these changes, the legislation has been retitled the **Care Reform (Scotland) Bill**. On Tuesday 10 June 2025, the Scottish Parliament approved the Bill at Stage 3, marking its final passage through Holyrood.

The Care Reform (Scotland) Bill introduces a range of measures aimed at strengthening and modernising social care in Scotland, including:

- **Embedding Anne's Law in legislation**, ensuring that individuals living in adult care homes have the right to maintain contact with loved ones and designate an essential care supporter.
- **Enhancing support for unpaid carers** by establishing a statutory right to breaks, building on the £13 million already allocated to enable up to 40,000 carers to access short breaks through the voluntary sector.
- **Improving access to care information** and enhancing data sharing across care settings to support more coordinated and person-centred care.
- **Expanding access to independent advocacy**, ensuring individuals are heard and actively involved in decisions about their care.
- **Establishing a National Chief Social Work Adviser**, who will provide professional leadership and advocate for the sector as part of the development of a new National Social Work Agency.

These reforms are designed to support the continued integration of health and social care services. For West Dunbartonshire, this means working towards a system where individuals experience seamless, high-quality care and support that meets their needs and delivers positive outcomes.

Financial Performance 2024/25

The Statement of Accounts contains the financial statements of the HSCP Board for the year ended 31 March 2025 and has been prepared in accordance with The Code of Practice on Local Authority Accounting in the United Kingdom (the Code).

Financial performance is an integral element of the HSCP Board's overall performance management framework, with regular reporting and scrutiny of financial performance at each meeting of the HSCP Board. The full year financial position for the HSCP Board can be summarised as follows:

Table 1: Summary Financial Position 2024/25

1 April 2024 to 31 March 2025	West Dunbartonshire Council	Greater Glasgow & Clyde Heath Board	Total
	£000	£000	£000
Funds Received from Partners	(90,136)	(165,883)	(256,019)
Funds Spent with Partners	92,358	163,908	256,266
Deficit/(Surplus) in Year 2024/25	**2,222**	**(1,975)**	**247**

Note: Totals may not add due to rounding

The Comprehensive Income and Expenditure Statement (CIES) on page 79 details the cost of providing services for the year to 31 March 2025 for all health and care services delegated or hosted by the HSCP Board.

The total cost of delivering services amounted to £256.266m against funding contributions of £256.019m, both amounts including notional spend and funding agreed for Set Aside of £45.781m, (see Note 4 "Critical Judgements and Estimations" page 90). This therefore leaves the HSCP Board with an overall deficit on the provision of services of £0.247m prior to planned transfers to and from reserves, the composition of which is detailed within Note 12 "Usable Reserve: General Fund" page 96 and 97.

The HSCP Board's 2024/25 Financial Year

The HSCP Board approved the 2024/25 revenue budget on 28 March 2024. The report, set out the funding offers from our partners (the Health Board and the Council) as well as specific funding streams from the Scottish Government totalling £4.276m for support related to Scottish Living Wage and Free Personal Care uplifts and Scottish Recommended Allowance for Kinship and Foster Care.

The Board approved a total indicative net revenue budget of £197.512m (excluding Set Aside estimated budget of £40.596m).

This was supplemented with an allocation from earmarked reserves of £2.150m to close the gap between funding and estimated cost of services, resulting in a total opening budget of £199.662m.

Throughout 2024/25 there were a significant number of budget adjustments to account for additional Scottish Government funding on both a recurring and non-recurring basis.

Table 2: Budget Reconciliations 2024/25

2024/25 Budget Reconciliation	Health Care £000	Social Care £000	Total £000
Budget Approved on 28 March 2024	**109,242**	**90,420**	**199,662**
Rollover Budget Adjustments	426	0	426
Primary Care	3,214	0	3,214
Adult and Older People Services	2,032	0	2,032
Children's Services	249	343	592
Prescribing	579	0	579
Family Health Services	2,388	0	2,388
Other	2,650	542	3,192
Reported Budget 2024/25	**120,780**	**91,305**	**212,085**
Funded from Earmarked Reserves	**(678)**	**(1,472)**	**(2,150)**
Funded from Partner Organisations	**120,102**	**89,833**	**209,935**

Note: Totals may not add due to rounding

Final Outturn Position 2024/25

The latest Financial Performance Report can be found here (see Appendix 1, 8) was issued to the HSCP Board on 27 May 2025, projected a gross overspend of £0.241m (0.11%) for the financial year ended 31 March 2025 prior to planned transfers to/from earmarked reserves (including the drawdown of reserves approved to balance the budget) to leave a net underspend of £0.216m to be added to un-earmarked reserves.

The 2024/25 Financial Performance Reports included appendices detailing budget transfers, key variances, savings progress, and earmarked reserves. Approved savings and service redesign efficiencies totalled £7.132m across 2020/21 to 2024/25, with 79% (£5.649m) delivered as planned and the remainder covered by service underspends.

These financial statements finalise the outturn position for 2024/25 as at 31 March 2025. Again prior to planned transfers to/from earmarked reserves and after accounting for all known adjustments, the position is a gross overspend of £0.247m and a net underspend of £0.072m which are movements of £0.006m and £0.138m respectively from the May position.

Table 3 provides highlights of the main movements, while Tables 4 and 5 provides a high-level summary of the final outturn position by service area and by subjective analysis.

Table 3: Movement from May 2025 Projected Outturn

Reconciliation of Movements in Reported Position between Final Outturn and May 2025 HSCP Board Report	Final/Forecast Full Year £000's	(Drawdown) / Transfer to Earmarked Reserves £000's	(Drawdown) / Transfer to Unearmarked Reserves £000's
Final Adverse Variance Reported - Impact on Reserves	(247)	(319)	72
May 2025 Adverse Variance Reported - Impact on Reserves	(241)	(457)	216
Movement	**(6)**	**138**	**(144)**
Represented By:			
Transfer of Crosslet shower costs to WDC	11	0	11
West Dunbartonshire Vivup Commission Recharge	(4)	0	(4)
West Dunbartonshire Council OH Recharge	(9)	0	(9)
Children and Families Welfare Payment	(4)	0	(4)
District Nursing Funding added to Service Resigns and Reform reserve	0	138	(138)
Total	**(6)**	**138**	**(144)**

Note: Totals may not add due to rounding

Table 4: Final Outturn against Budget 2024/25 by Service Area

West Dunbartonshire Integrated Joint Board Consolidated Health & Social Care	2024/25 Annual Budget £000	2024/25 Net Expenditure £000	2024/25 Underspend/ (Overspend) £000	2024/25 Reserves Adjustment £000	2024/25 Underspend/ (Overspend) £000
Older People, Health and Community Care	55,857	58,244	(2,387)	258	(2,645)
Physical Disability	3,852	3,557	295	0	295
Children and Families	31,736	31,616	120	(358)	478
Mental Health Services	14,009	13,627	382	323	59
Addictions	4,325	4,101	224	(355)	579
Learning Disabilities	21,850	21,069	781	(250)	1,031
Strategy, Planning and Health Improvement	2,244	2,082	162	(55)	217
Family Health Services (FHS)	35,107	35,174	(67)	0	(67)
GP Prescribing	21,718	22,626	(908)	0	(908)
Hosted Services - MSK Physio	7,980	8,108	(128)	(109)	(19)
Hosted Services - Retinal Screening	772	865	(93)	(112)	19
Criminal Justice	8	97	(89)	(117)	28
HSCP Corporate and Other Services	10,114	8,653	1,461	456	1,005
IJB Operational Costs	363	363	0	0	0
Cost of Services Directly Managed by West Dunbartonshire HSCP	**209,935**	**210,182**	**(247)**	**(319)**	**72**
Set aside for delegated services provided in large hospitals	45,781	45,781	0	0	0
Assisted garden maintenance and Aids and Adaptions	303	303	0	0	0
Total Cost of Services to West Dunbartonshire HSCP	**256,019**	**256,266**	**(247)**	**(319)**	**72**

Note: Totals may not add due to rounding

Table 5: Final Outturn against Budget 2024/25 by Subjective Analysis

West Dunbartonshire Integrated Joint Board Consolidated Health & Social Care	2024/25 Annual Budget £000	2024/25 Net Expenditure £000	2024/25 Underspend/ (Overspend) £000	2024/25 Reserves Adjustment £000	2024/25 Underspend/ (Overspend) £000
Employee	92,301	92,391	(90)	899	(989)
Property	1,203	1,502	(299)	0	(299)
Transport and Plant	1,455	1,538	(83)	0	(83)
Supplies, Services and Admin	7,164	4,834	2,330	1,335	995
Payment to Other Bodies	68,184	69,744	(1,560)	(849)	(711)
Family Health Services	36,409	36,467	(58)	0	(58)
GP Prescribing	21,719	22,627	(908)	0	(908)
Other	3,115	2,689	426	0	426
Gross Expenditure	**231,550**	**231,792**	**(242)**	**1,385**	**(1,627)**
Income	(21,615)	(21,610)	(5)	(1,704)	1,699
Net Expenditure	**209,935**	**210,182**	**(247)**	**(319)**	**72**

Note: Totals may not add due to rounding

The Comprehensive Income and Expenditure Statement (CIES) on page 79 is required to show the surplus or deficit on services and the impact on both general and earmarked reserves. The final position for 2024/25 was an overall deficit of £0.247m with £0.319m and £0.072m drawn down and added to earmarked and un-earmarked reserves respectively. Earmarked reserves are detailed in Note 12 of these accounts on page 96 and 97 coupled with some additional information detailed below in the "Key messages".

While the CIES provides actual expenditure and income values for services in 2024/25 and their comparison to the previous financial year, it does not highlight the reported budget variations as the HSCP Board would consider them. Therefore, the tables above are presented to provide additional detail and context to the key financial messages listed below.

The key explanations and analysis of budget performance against actual costs for individual service areas are detailed below:

- **Older People, Health, and Community Care** – this service grouping covers older people's residential accommodation and day care, care at home, community health operations and other community health services with analysis as follows:

  - Older People Residential accommodation realised a net underspend of £0.162m mainly due to additional self-funder income partially offset by the cost of staff regrading and increased agency spend arising from recruitment challenges;
  - Older People Day Care realised a net underspend of £0.132m due to recruitment delays and vacancy management;
  - The Care at Home Service realised an overspend of £3.332m with the areas of largest cost pressure sitting within staffing and relates to the continued use of agency staff and payment of premium rate overtime. Redesign pathways to address these areas are ongoing with a refined overtime authorisation process now in place and further "deep dive" analysis to identify reasons for high use; and
  - Community health operations and other community health services realised a net underspend of £0.393m due to staff turnover, recruitment challenges.
- **Physical Disabilities** – net underspend of £0.295m mainly due to a reduction in the number of client service packages.
- **Children and Families** – net underspend of £0.478m mainly due to recruitment challenges, staff turnover, maternity leave and long-term sickness offset by an increase in client numbers within community placements, the backdated impact of changes to children's tax credits, and cost sharing changes to external residential placements.
- **Addictions** – net underspend of £0.579m mainly due to increases in staff turnover, sickness absences and clients transferring to older people services.
- **Learning Disabilities** – net underspend of £1.031m mainly due to staffing vacancies and client service reviews.
- **Strategy Planning and Health Improvement** – net underspend of £0.217m mainly due to ongoing recruitment challenges
- **GP Prescribing** – Net overspend of £0.908m mainly due to an increase in volume numbers year on year and an increase in the average cost of prescribing per item since the start of the year.
- **HSCP Corporate and Other Services** – net underspend of £1.005m mainly due to vacancy management and the release of uncommitted funding related to non-recurring savings.
- The **Set Aside** outturn position is shown as a nil variance as remains a notional budget to the HSCP Board. While the actual activity or consumption of set aside resources for the West Dunbartonshire population is detailed above, there is no formal cash budget transfer by NHSGGC. The actual expenditure share related to our HSCP for 2024/25 was calculated as £45.781m. This figure includes expenditure related to staff costs, increased bed activity, changes to pathways, cleaning, testing, equipment, and PPE, all fully funded by the Scottish Government.

In addition to the above the key explanations and analysis of budget performance against actual costs by subjective analysis are detailed below:

- **Employee Costs** – The net underspend is related to higher than budgeted levels of staff turnover and ongoing recruitment challenges.
- **Payment to Other Bodies** – The net overspend is mainly related to financial pressures within Children and Families.

- **Income** – The net over-recovery of income has mainly arisen within Older People Residential Care and is due to client contributions and property income being substantially more than budgeted.

Key Risks, Uncertainties and Financial Outlook

The HSCP Board Financial Regulations confirms the responsibility of the Chief Officer to develop a local risk strategy and policy for approval by the Partnership Board. The HSCP Board Financial Regulations can be viewed here (See Appendix 1, 9)

The HSCP Board's Risk Management Strategy and Policy was reviewed and updated during 2021/22 and is scheduled for further review in August 2025. The strategy and policy have been supplemented with a Risk Appetite Statement. Both documents are currently under review and are scheduled to be reported to the HSCP Board in August 2025, however the current documents can be viewed here on pages 33 to 57 (see Appendix 1, 10).

The risk appetite statement is based on the matrix within the guidance document Risk Appetite Matrix for Health and Social Care Partnership | Good Governance (good-governance.org.uk), can be viewed here on pages 91 to 107 (See Appendix 1, 11) and will be reviewed annually.

Risk Appetite Levels are defined as follows:

- **Avoid**: Avoidance of risk and uncertainty is a key organisational objective.
- **Minimalist**: Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.
- **Cautious**: Preference for safe delivery options that have a low degree of residual risk and may only have limited potential for reward.
- **Open**: Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc).
- **Seek**: Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk

A full review of the Strategic Risk Register is undertaken every six months with the latest review being presented to the 25 June 2025 Audit and Performance Committee for their approval and can be viewed here (see Appendix 1, 12).

There are twenty-one key strategic risks are summarised below with an extract of the main Financial Sustainability risk, the cause of the risk and the controls currently in place and in progress to reduce the likelihood and impact of the risk.

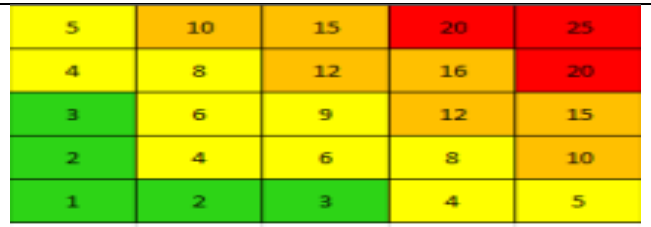
Table 6: Key Strategic Risks

Area of Risk	RAG Status	Current Score	Target Score
Strategy. Planning and Health Improvement			
Review and scrutiny of performance management information		12	8
Commissioning, procurement and monitoring of externally commissioned services		12	8
Risk of provider failure across all sectors		15	15
Failure to secure an alternative case management system		15	1
Inability to secure effective and sufficient support services including business support		16	16
Ability to effectively respond to a major emergency incident		12	12
Workforce			
Inability to develop and deliver sufficient workforce capacity to deliver strategic objectives		9	9
Risk of inability to cover planned or unlanned absence from existing workforce and wider HSCP services		4	2
Financial Sustainability			
Risk to financial sustainability within the short to medium term		20	9
Chief Social Work Officer			
Failure to ensure users of adult and children services receive an assessment of Individual Care Plans		16	8
Staff training and management: risk assessment and risk management across child, adult and public protection		16	8
Failure to meet legislative duties in relation to child and adult protection		12	8
Failure to ensure effective reporting and oversight to the CSWO though Clinilcal Care Governance sub group		16	8
Failure to meet legislative duties in relation to multi-agency public protection arrangements (MAPPA)		16	8
Failure to respond appropriately within required timeline to the National Historic Abuse Inquiry		12	9
Waiting Times			
Failure to meet waiting times in relation to Psychological Therapies		12	2
Failure to meet waiting times in relation to MSK Physiotherapy		15	2
Older People Services			
Failure to deliver the Care at Home service within budget while negotiating priority improvement workstreams		16	9
Failure to manage staffing resource within the Speech and Language Therapy service		9	2
Failing to ensure availability as required within Residential and Nursing Care Homes		9	4
Risk of pressures on Acute sites due to failure to reduce admissions and discharge timeously		12	6

Table 7: Extract of Financial Sustainability Risk from Strategic Risk Register

Description	Cause	Controls
Risk Owner: Chief Financial Officer West Dunbartonshire HSCP Board (IJB) being unable to achieve and maintain financial sustainability within the approved budget in the short to medium term due to the financial challenge of delivering services with increasing costs and demographic pressures against a backdrop of flat-cash allocations from partners	West Dunbartonshire HSCP Board (IJB) being unable to achieve and maintain financial sustainability within the approved budget in the short to medium term due to the financial challenge of delivering services with increasing costs and demographic pressures against a backdrop of flat-cash allocations from partners and depletion of reserves below 2% target as set out within our current Reserves Policy.	**Controls Currently in Place** 1. Active engagement with all partner bodies in budget planning process and throughout the year. This includes HSCP senior officers being active members of both council and health board corporate management teams. 2. Working in partnership across the 6 GGC HSCPs. Also working collectively in local and national forums for health and social care e.g. National Chief Officers Group, CIPFA Chief Financial Officers Section, Scottish Government Sustainability and Value Groups. Local and NHSGGC Prescribing Efficiency Programmes. CIPFA CFO Section working with Scottish Government and COSLA officials on the importance of timely notification of funding, the need to have recurring allocations that attract inflationary uplifts to support full delivery and financial sustainability of policies. 3. Regular financial reporting to the HSCP Board. Budget monitoring reports are prepared and informed by the range of actions, controls and mitigations. These reports support the HSCP Board to agree on any corrective actions required to support financial sustainability. All actions are predicated on the adherence to Financial Regulations, Standing Financial Instructions, Procurement Regulations and implementation of Directions issued by the Board. 4. Service Redesign Programmes managed by Project Boards and scrutinised by the Project Management Office (PMO). 5. Regular analysis of performance and financial data with updates to SMT. 6. Regular meetings with operational budget holders to monitor progress of savings as well as overall budgetary performance and corrective action taken as required. 7. Focus on service redesign programmes and regular programmes of review that support the outcomes of service users and patients. 8. Weekly Vacancy Management Panel to scrutinise and challenge recruitment requests. Balanced against reduction in use of agency staff.

		9. Regular review of the Medium-Term Financial Outlook (MTFO). The MTFO, the annual budget setting report and the regular financial performance reports update on key financial risks and any mitigating actions. 10. Robust Reserves Policy and protection of earmarked reserves to support short to medium term financial planning. This includes the creation, maintenance and application of some key earmarked reserves for GP Prescribing, Redesign and Transformation, Unachievement of Savings and Fair Work Practices. 11. Area Resource Group now well established and a key control in challenging best value aspect of packages. 12. Robust application of Eligibility Criteria in completion of My Life Assessments and regular reviews of current packages of care. Further supported by Supervision Policy. **Controls in Progress** 1. Accelerate and increase level of recurring savings programmes across services to close in-year gaps, future gaps and replenish reserves balances. 2. Continuing to refine commissioning processes linked to strategic priorities and eligibility and self-directed support. Establishment of regular meetings between Commissioning, Finance, Legal and Procurement. 3. Non-residential Social Care Charging Policy was reviewed and updated for 2025/26, after extensive consultation with a range of stakeholders. Plan to revisit this year to compare actual cost of providing a service versus current charge. Outcome will feed into the budget setting process. 4. Approval by HSCP Board in March 2025 to implement an Equivalency Model. Equivalency rates have to be set for 2025/26 to reflect Living Wage uplifts and will be phased in as individual reviews are undertaken.

Risk level (initial)	**5 x 5 Very High = 25**	
Risk level (current)	**5 x 4 Very High = 20**	
Risk level (target)	**3 x 3 Medium = 9**	
Status	**Tolerated**	

To further support the HSCP Board's assurance processes around the management of risk the Chief Internal Auditor's prepares an "Internal Audit Annual Strategy and Plan" which sets out the internal audit approach to annual audit planning as risk-based and aligns it to the HSCP Board's strategic planning processes and management's own risk assessment.

Reserves

The HSCP Board has the statutory right to hold Reserves under the same legal status as a local authority, i.e. "*A section 106 body under the Local Government (Scotland) Act 1973 Act and is classified as a local government body for accounts purposes..., it is able to hold reserves which should be accounted for in the financial accounts and records of the Partnership Board".* Reserves are generally held to do three things:

- create a working balance to help cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing – this forms part of general reserves;
- create a contingency to cushion the impact of unexpected events or emergencies; and
- provide a means of building up funds, often referred to as earmarked reserves, to meet known or predicted liabilities.

Reserves are a vital part of the HSCP Board's funding strategy, enabling financial stability and supporting delivery of national priorities. They also allow the Scottish Government to provide advance funding for known policy commitments.

The HSCP Board's Reserves Policy, which can be viewed here (Appendix 1, 13) recommends that its aspiration should be a un-earmarked reserves level of 2% of its net expenditure (excluding Family Health Services) which would equate to approximately £4.412m, and for 2024/25 the final position is £3.576m (see Note 12: Usable Reserve: General Fund) which equates to a reserves level of 1.62%.

Our overall movement in reserves is covered above in the "2024/25 Final Outturn against Budget" section. Detailed analysis of the movements in earmarked reserves is available at Note 12 Useable Reserves – General Fund.

Several commitments made in 2024/25 in relation to local and national priorities will not complete until future years (£11.781m) and is reflective of the scale and timing of funding received and the complexity of ongoing projects. These include national funding for Mental Health Recovery and Renewal and Alcohol and Drug Partnerships, and local funding for mental health transitional programmes, the "What Would It Take" Children and Families five-year strategy, ongoing work related to Unscheduled Care, development and implementation of a Property Strategy, Carers funding, and underwriting the Cost of Complex Care Packages.

We started the year with £15.150m earmarked reserves and during the year a total of £5.034m was drawn down as detailed below:

- £1.185m (Social Care only) approved in March 2024 to balance the 2024/25 budget;

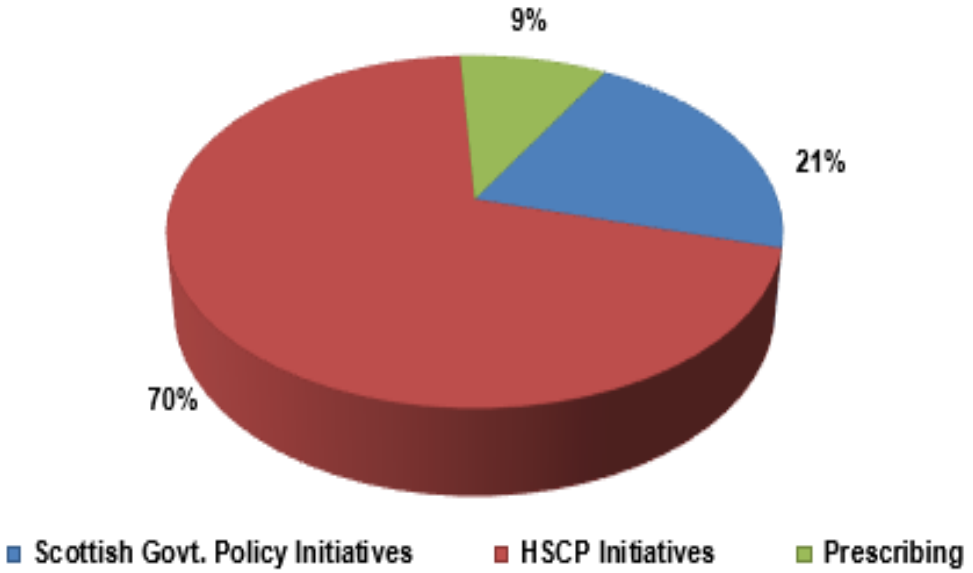
- £2.057m was drawn down to cover planned expenditure for addictions, learning disabilities, mental health, children and family priorities, participatory budgeting, digital developments, hosted services, and the cost of complex care packages; and

- £1.792m of earmarked reserves have been reallocated to reflect known pressures following a robust review of all reserves undertaken to ensure that all earmarked reserves are appropriate and fully committed.

We also added £4.716m to earmarked reserves throughout the year with £1.393m being an increase to existing reserves (mainly for the creation of additional social worker capacity, increase to mental health transitional funding and underwrite prescribing pressures) and £3.323m for the creation of new reserves (mainly for Local Authority employers' superannuation future commitments and recovery and renewal of services).

The final balance on earmarked reserves is £14.831m and a profile of the 2024/25 earmarked closing balance is detailed in Figure 1.

Figure 1: Profile of Earmarked Reserves



The analysis shows that:

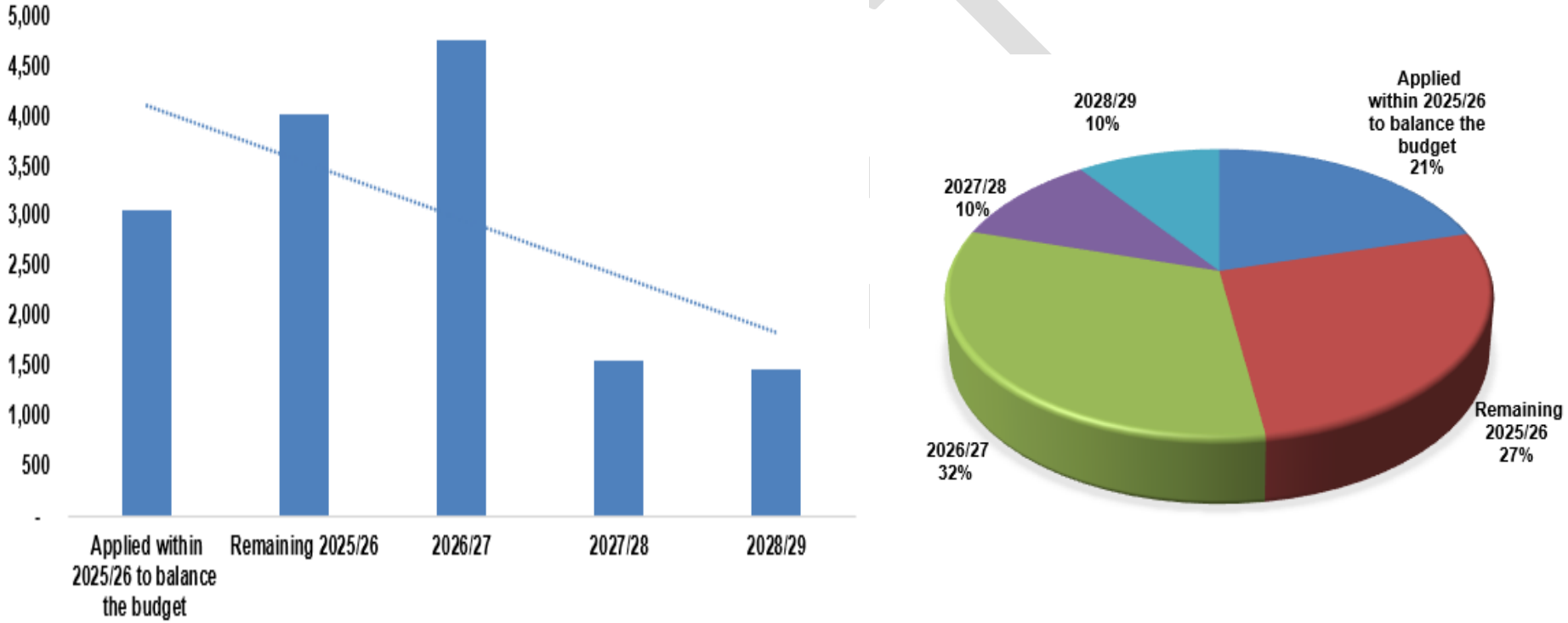
- 21% of reserves support Scottish Government policy commitments such as Unpaid Carers, Mental Health, Alcohol and Drugs Partnership, and Winter Pressures. Some funding flows depend on regular reporting of activity and costs;

- 70% relate to HSCP initiatives to support service redesign and transformation, community engagement and recovery and renewal in services; and

- 9% relates to reserves held for prescribing to mitigate potential volatility in pricing and short supply issues.

The review also included an analysis of the anticipated spend profile of earmarked reserves as summarised below and shows that approximately 48% of all earmarked reserves are anticipated to be drawn down in 2025/26 with 21% applied as part of the annual budget setting report to balance the budget.

Figure 2: Anticipated Spend Profile of Earmarked Reserves



The final balance of un-earmarked reserves is £3.576m which equates to approximately 1.62% of net expenditure (excluding Family Health Services). While this is below the 2% target detailed within the HSCP Board's Reserves Policy, work to replenish un-earmarked reserves is considered a priority with a view to increasing them back to, or beyond, 2% in the short to medium term, details of which is reflected in the refreshed Medium Term Financial Outlook.

Medium Term Financial Outlook

The HSCP Board approved the indicative 2025/26 Revenue Budget on the 24 March 2025. The identified budget gaps and actions taken to close these gaps, to present a balanced budget, considered current levels of service. The full report can be viewed here (Appendix 1, 14).

For 2025/26, both the Council and Health Board complied with Scottish Government funding directives to the HSCP Board. The Council maintained at least a flat cash position from 2024/25, with additional allocations for the Scottish Living Wage, Free Personal Care and Local Government pressures, as reflected by increases in some social care grant aided expenditure indicators. The Health Board applied a 3% uplift, with a commitment to pass on any further funding linked to pay negotiations. Both bodies also agreed to pass through a proportionate share of national insurance funding. However, while the Scottish Government indicated this would cover 60% of the cost, early estimates suggest it may only cover around 48% for local authority staff.

The Scottish Government published a Multi-Year Public Sector Pay Policy on 4 December 2024 which featured a 9% pay envelope from 2025/26 to 2027/28 compared to forecast inflation of under 7% across the 3-year period. In setting the 2025/26 budget the HSCP Board, reflecting both Health Board and Council assumptions, factored in a 3% uplift in pay for both health and social care staff, at a combined total cost of approximately £3.4m.

In mid-May 2025, health unions representing NHS staff on Agenda for Change pay scales reached a two-year agreement for 2025 to 2027. The deal not only surpassed financial expectations for both this year and the next but also includes an inflation protection clause, as shown below:

- 8% total pay increase for all staff in 2 stages:
  - 4.25% from 1 April 2025
  - 3.75% from 1 April 2026
  - Guaranteed to be at least 1% above Consumer Price Index (CPI) inflation each year

On 12 June 2025, following ongoing engagement with Trade Unions across the Scottish Joint Council (SJC), Craft Operatives and Chief Officials bargaining groups, COSLA formally wrote to union colleagues with an enhanced two-year final pay offer for 2025 to 2027 for the SJC workforce. The offer is:

- 7.64% total pay increase for all staff in 2 stages:
  - 4% from 1 April 2025
  - 3.5% from 1 April 2026

Union colleagues will now ballot Council staff regarding the new two year pay offer, however at the time of writing no agreement has been reached.

The recent NHS pay agreement, and SJC pay offer, effectively overrides the existing Public Sector Pay Policy, necessitating either its revision or at least a formal reference within the Scottish Government's forthcoming Medium Term Financial Strategy (MTFS). On 6 May 2025, the Scottish Government informed the Finance and Public Administration Committee of its intention to publish the seventh MTFS on 25 June 2025, a four-week delay from the originally anticipated 29 May release. This postponement is intended to incorporate the implications of the UK Spending Review, scheduled for 11 June, on the Block Grant outlook. However, the delay introduces an additional layer of uncertainty and risk to Scotland's financial planning and stability.

To support the implementation of the two-year pay agreement, the Scottish Government must use the Medium-Term Financial Strategy (MTFS) to commit to multi-year funding settlements. This is essential to enable Councils, Health Boards, and Integration Authorities to strengthen their medium-term financial planning and to allow sufficient time for meaningful engagement with local communities.

The HSCP Board remains committed to safeguarding core services amid mounting financial pressures across the short, medium, and long term. The Strategic Plan 2023–2026: *Improving Lives Together* outlines an ambitious vision to meet the evolving needs of the population. However, it also recognises the significant challenge posed by funding levels that do not keep pace with inflation or demographic change.

A continued reliance on single-year funding settlements from the Scottish Government exacerbates financial uncertainty. This presents two critical risks: instability in workforce planning and a potential decline in service quality. Without greater funding predictability, the ability to deliver sustainable, high-quality care is increasingly compromised.

The HSCP Board approved its own Medium-Term Financial Outlook (MTFO) 2024/25 to 2027/28 on the 19 November 2024 and can be viewed here (Appendix 1, 15). The MTFO sets out the broad key themes on how we will work towards minimising future pressures and support financially sustainability. These themes are:

- **Better ways of working** – integrating and streamlining teams including the benefits of information technology to deliver services more efficiently will release financial savings and protect front line services;

- **Community Empowerment** - support the vision for resilient communities with active, empowered and informed citizens who feel safe and engaged to be a main contributor to service change across health and social care;

- **Prioritise our services** – local engagement and partnership working are key strengths of the HSCP. We must think and do things differently and find new solutions to providing support to those who need it;

- **Equity and Consistency of approach** – robust application of Eligibility Criteria for new packages of care and review of current packages using the My Life Assessment tool; and

- **Service redesign and transformation** – build on the work already underway redesigning support to people to remain or return to their own homes or a homely setting for as long as possible. This will be across all care groups including older people, learning, physical and mental disabilities and children and families, in partnership with Housing services, third sector and local providers.

The indicative budget gaps set out with the November 2024 MTFO were revised to reflect the approved funding offers for 2025/26 as well as savings, management adjustments (e.g. turnover targets, service reviews). These are detailed in Table 8 below:

Table 8: Indicative Budget Gaps

Budget Gap Analysis	2025/26 £000	2026/27 £000	2027/28 £000
Social Care	98,456	107,271	113,430
Health Care	119,644	122,260	125,180
Set Aside	46,348	46,348	46,348
Total Indicative Spend	**264,448**	**275,879**	**284,958**
West Dunbartonshire Council	93,669	96,145	98,618
NHSGCC	116,665	116,665	116,665
Set Aside	46,348	46,348	46,348
Total Resources	**256,682**	**259,158**	**261,631**
Indicative Budget Gap	**7,766**	**16,721**	**23,327**
Management Adjustments	2,729	2,069	2,069
Savings Options	1,988	2,218	2,218
Superannuation Savings	0	3,046	0
Application of Reserves	3,049	385	190
Measures to Balance the Budget	**7,766**	**7,718**	**4,477**
Indicative Budget Gap	**0**	**9,003**	**18,850**

Note: Totals may not add due to rounding

The HSCP Board is clear that it needs to be as financially well placed as possible to plan for and deliver services in a difficult financial climate, whilst maintaining enough flexibility to adapt and invest where needed to redesign and remodel service delivery moving forward depending on the funding available in future years.

The indicative budget gaps for 2026/27 and 2027/28 are detailed in Table 8 and illustrate the scale of the risk.

Through 2025/26 the Financial Performance Reports will continue to reflect all quantifiable variations against the approved budget as well as anticipating and reporting on any material changes or risks.

Conclusion

Throughout 2024/25, West Dunbartonshire HSCP Board remained focused on delivering its strategic priorities while continuing to adapt and enhance services to meet evolving needs.

Our commitment to strong financial governance is reflected in our performance reporting and this annual report. The planned use of reserves has helped to stabilise our short- and medium-term financial position. While challenges remain, we are well-positioned to address them through robust governance and informed decision-making.

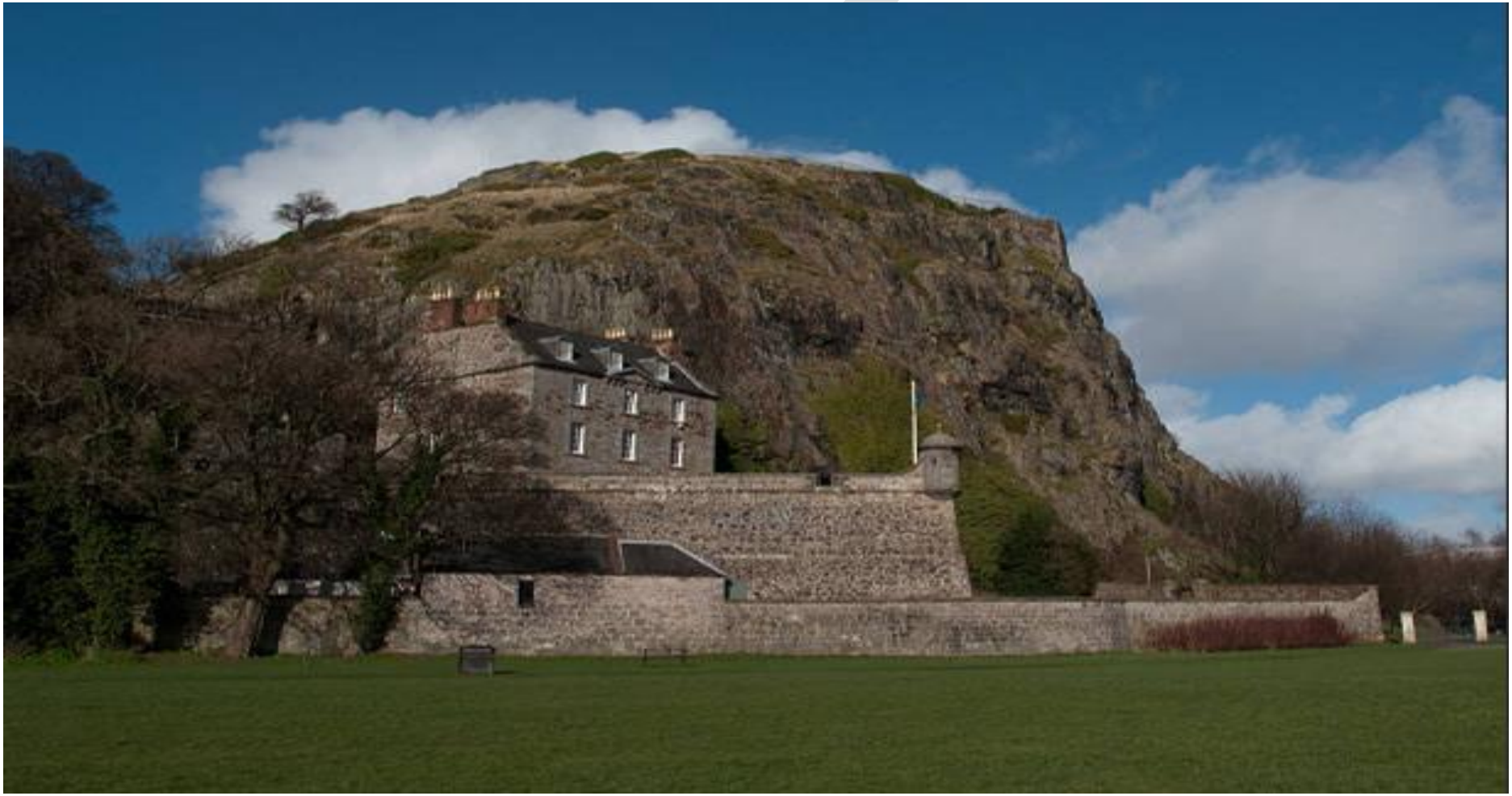
Looking ahead to 2025/26, we will build on our strong foundations—strengthening governance, deepening stakeholder engagement, managing risk proactively, and investing in our workforce and communities to ensure sustainable, high-quality services.

Michelle Wailes
HSCP Board Chair **Date: 25 June 2025**

Beth Culshaw **Date: 25 June 2025**
Chief Officer

Julie Slavin **Date: 25 June 2025**
Chief Financial Officer

Statement of Responsibilities



Responsibilities of the Health and Social Care Partnership Board

The Health and Social Care Partnership Board is required to:

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

I confirm that these Unaudited Annual Accounts were approved at a meeting of the Audit and Performance Meeting on 25 June 2025.

Signed on behalf of the West Dunbartonshire Health & Social Care Partnership Board.

Michelle Wailes **Date: 25 June 2025**
HSCP Board Chair

Responsibilities of the Chief Financial Officer

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

In preparing the Annual Accounts, the Chief Financial Officer has:

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

The Chief Financial Officer has also:

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

I certify that the financial statements give a true and fair view of the financial position of the West Dunbartonshire Health and Social Care Partnership Board as at 31 March 2025 and the transactions for the year then ended.

Julie Slavin CPFA **Date: 25 June 2025**
Chief Financial Officer

Remuneration Report

Introduction

The Local Authority Accounts (Scotland) Regulations 2014 (SSI No. 2014/200) require local authorities and IJB's in Scotland to prepare a Remuneration Report as part of the annual statutory accounts.

It discloses information relating to the remuneration and pension benefits of specified HSCP Board members and staff. The information in the tables below is subject to external audit.

Health and Social Care Partnership Board

The six voting members of the HSCP Board were appointed, in equal numbers, through nomination by Greater Glasgow and Clyde Health Board and West Dunbartonshire Council. Nomination of the HSCP Board Chair and Vice Chair post holder's alternates, every 3 years, between a Councillor from WDC and a NHSGGC Health Board representative.

Table 9: Voting Board Members from 1 April 2024 to 31 March 2025

Voting Board Members 2024/25	Position	Dates	Organisation
Michelle McGinty	Chair	1 April 2024 to 27 June 2024	West Dunbartonshire Council
	Voting Member	28 June 2024 to 31 March 2025	West Dunbartonshire Council
Fiona Hennebry	Chair	28 June 2024 to 31 July 2024	West Dunbartonshire Council
	Vice Chair	1 August 2024 to 31 March 2025	West Dunbartonshire Council
Rona Sweeney	Vice Chair	1 April 2024 to 30 June 2024	NHS Greater Glasgow & Clyde Health Board
	Voting Member	1 April 2024 to 30 June 2024	NHS Greater Glasgow & Clyde Health Board
Michelle Wailes	Vice Chair	1 July 2024 to 31 July 2024	NHS Greater Glasgow & Clyde Health Board
	Chair	1 August 2024 to 31 March 2025	NHS Greater Glasgow & Clyde Health Board
Clare Steel	Voting Member	1 April 2024 to 27 June 2024	West Dunbartonshire Council
Martin Rooney	Voting Member	1 April 2024 to 31 March 2025	West Dunbartonshire Council
Dr Lesley Rousselet	Voting Member	1 April 2024 to 30 June 2024	NHS Greater Glasgow & Clyde Health Board
Lesley MacDonald	Voting Member	1 July 2024 to 31 March 2025	NHS Greater Glasgow & Clyde Health Board
Libby Cairns	Voting Member	1 July 2024 to 31 March 2025	NHS Greater Glasgow & Clyde Health Board

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

Remuneration Policy

The HSCP Board's Financial Regulations set out the arrangements for remuneration of board members.

Payment of voting board members allowances, including travel and subsistence expenses will be the responsibility of the members' individual Council (West Dunbartonshire Council) or Health Board (NHS Greater Glasgow and Clyde Health Board), and will be made in accordance with their own schemes.

Non-voting members of the Board will be entitled to the payment of reasonable travel and subsistence expenses relating to approved duties.

For 2024/25 no taxable expenses were claimed by members of the HSCP board.

Senior Officers

The HSCP Board does not directly employ any staff. However, specific post-holding officers are non-voting members of the HSCP Board.

All staff working within the HSCP are employed through either the Health Board or the Council; and remuneration for senior staff is reported through those bodies. These posts are funded equally by both partner bodies.

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the HSCP Board must be appointed and the employing partner must formally second the officer to the HSCP Board. The employment contract for the Chief Officer will adhere to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the HSCP Board.

Other Officers

No other staff are appointed by the HSCP Board under a similar legal regime. Other non-voting board members who meet the criteria for disclosure are included in Table 10 below.

Table 10: Remuneration

Total Earnings 2023/24	Senior Officers	Salary, Fees & Allowance	Compensation for Loss of Office	Total Earnings 2024/25
£		£	£	£
129,755	B Culshaw (Chief Officer)	135,734	0	135,734
99,323	J Slavin (Chief Financial Officer)	103,795	0	103,795

The HSCP Board however has responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the HSCP Board. The following table shows the HSCP Board's funding during the year to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions.

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

Table 11: Pension Benefits

Senior Officers	In Year Contributions		Accrued Pension Benefits		
	For Year to 31/03/2024 £000	For Year to 31/03/2025 £000		For Year to 31/03/2024 £000	For Year to 31/03/2025 £000
B Culshaw Chief Officer	25	9	Pension Lump Sum	19 0	22 0
J Slavin Chief Financial Officer	21	23	Pension Lump Sum	15 0	18 0

The officers detailed above are all members of the NHS Superannuation Scheme (Scotland) or Local Government Scheme. The pension figures shown relate to the benefits that the person has accrued because of their total public sector service, and not just their current

appointment. The contractual liability for employer pension's contributions rests with the Health Board and the Council. On this basis there is no pension liability reflected on the HSCP Board balance sheet.

Disclosure by Pay Bands

As required by the regulations, the following table shows the number of persons whose remuneration for the year was £50,000 or above, in bands of £5,000.

Table 12: Pay Bands

Remuneration Band	Number of Employees 31/03/2024	Number of Employees 31/03/2025
£95,000 - £99,999	1	
£100,000 - £104,999		1
£125,000 - £129,999	1	
£135,000 - £139,999		1

Michelle Wailes **Date: 25 June 2025**
HSCP Board Chair

Beth Culshaw **Date: 25 June 2025**
Chief Officer

Annual Governance Statement

Introduction

The Annual Governance Statement outlines the governance arrangements of the HSCP Board (Integration Joint Board) in accordance with the "Code of Practice for Local Authority Accounting in the UK" (the Code). It also evaluates the effectiveness of the HSCP Board's internal control system, including the reliance on the governance frameworks of its partners.

Scope of Responsibility

The HSCP Board is committed to conducting its business in compliance with legal requirements and appropriate standards, ensuring that public funds are safeguarded, accurately accounted for, and utilised in an economical, efficient, and effective manner. The Board aims to foster a culture of continuous improvement in its operations and strives to ensure best value is achieved.

To fulfil these responsibilities, the HSCP Board has implemented robust governance arrangements to oversee its activities and their effectiveness, including the identification, prioritisation, and management of risk. An established Audit and Performance Committee supports the Board by addressing issues related to risk, control, performance, and governance, providing assurance through constructive challenge and ongoing enhancement across the partnership.

The Chief Internal Auditor reports directly to the HSCP Board's Audit and Performance Committee on all audit matters, with access rights to the Chief Officer, Chief Financial Officer, and Chair of the Audit and Performance Committee, as necessary.
The Chief Officer, with the Senior Management Team has established governance arrangements incorporating a system of internal control. This system is designed to manage risk at an acceptable level and support the achievement of the HSCP Board's policies, goals, and objectives. Additionally, the Board relies on the internal control systems of both Greater Glasgow and Clyde Health Board (NHSGGC) and West Dunbartonshire Council (WDC), which promotes compliance with their respective policies and facilitate the attainment of their organisational goals as well as those of the HSCP Board.

The HSCP Board has adopted governance practices consistent with the Chartered Institute of Public Finance and Accounting (CIPFA) and the Society of Local Authority Chief Executives (SOLACE) framework titled "Delivering Good Governance in Local Government." Based on the framework's seven core principles, a Local Code of Good Governance has been established, is reviewed annually, and demonstrates the HSCP Board's dedication to good governance. A copy of the code is available here (Appendix 1, 16) on the HSCP website.

Purpose of the Governance Framework

The governance framework is comprised of systems and processes and cultures and values by which the HSCP is directed and controlled. It is not static and is updated to reflect new legislative requirements and best practice.

The system of internal control is a significant element of the governance framework. Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. The system is maintained on an ongoing basis to identify, prioritise and manage the risks facing the organisation. It enables the HSCP Board to monitor and evaluate the achievements of the strategic outcomes laid out within its Strategic Plan and consider whether these have been delivered in an appropriate and cost-effective manner.

Governance Framework and Internal Control System

The HSCP Board serves as the principal decision-making entity, consisting of six voting members. Each partner organisation nominates one member to assume the roles of Chair and Vice Chair. West Dunbartonshire Council appoints three elected members, while NHSGGC Health Board designates three non-executive members. The HSCP Board also includes several non-voting professional and stakeholder members. Current stakeholder members represent the third sector, carers, and staff-side representatives, whereas professional members comprise the Chief Officer, Chief Financial Officer, Chief Nurse, General Practitioner (joint Clinical Director), and Chief Social Work Officer.

Chair
Michelle Wailes
Non-Executive Member

Vice Chair
Fiona Hennebry
Councillor

Voting Member
Lesley MacDonald
Non-Executive Member

Voting Member
Michelle McGinty
Councillor

Voting Member
Libby Cairns
Non-Executive Member

Voting Member
Martin Rooney
Councillor

The HSCP Board convenes six times annually, and all agendas, meeting documents, and minutes are accessible on the HSCP Board website. Audio recordings of each meeting are available for public download.

The governance framework operates within a system of internal financial controls, encompassing management and financial data, financial regulations, administrative procedures (including segregation of duties), management oversight, and a delegation and accountability structure. The development and maintenance of these systems are carried out by the Council and the Health Board as part of the operational delivery arrangements of the HSCP.

The key features of the HSCP Board's governance framework are summarised in Table 13 below:

Table 13: Summary of Governance Framework

Feature	Description	Summary
HSCP Board Constitution	Formally constituted by the Integration Scheme approved by Scottish Ministers under the Public Bodies (Joint Working) (Scotland) Act 2014, West Dunbartonshire Council and NHSGGC Health Board established local governance arrangements covering roles, workforce, finance, risk management, information sharing, and complaints. Integration Schemes must be reviewed every five years or upon request by the Council or Health Board. This review was jointly conducted by all six HSCPs in Greater Glasgow and Clyde, resulting in updated Schemes reflecting changes since the initial publication. Approval will proceed through local governance structures by Autumn 2025.	Governance framework established by Integration Scheme.
HSCP Board Members	HSCP Board members observe and comply with the Nolan Seven Principles of Public Life. Arrangements are in place to ensure Board members and officers are supported by appropriate training and development.	The Seven Principles of Public Life (also known as the Nolan Principles) apply to anyone who works as a public office holder.

Feature	Description	Summary
Audit and Performance Committee	The committee is a key part of the governance framework and meets publicly four times a year to ensure effective corporate governance.	Ensures sound governance, meets four times a year.
Constitutional Documents	Terms of Reference, Code of Conduct, Standing Orders and Financial Regulations, Directions Policy, Records Management and Complaints Handling Policy	Key constitutional documents that set out the scope, authority, governance and strategic decision making of the HSCP Board and Audit and Performance Committee.
Strategic Plan 2023 – 2026	The HSCP Board's Strategic Plan 2023 – 2026, "Improving Lives Together," outlines its vision, priorities, and goals. Developed by the Strategic Planning Group, it includes input from local partners and stakeholders.	Strategic Plan 2023 – 2026
HSCP Resilience Group	Integration Joint Boards are classed as Category One responders. The Chief Officer established this group with responsibility for reviewing business continuity plans and pandemic flu plans.	Reviews business continuity and pandemic plans.
Performance Management Framework	Provides regular performance and financial reports to the Senior Management Team, HSCP Board, and Audit and Performance Committee, assessing integrated arrangements, strategic priorities, and financial management.	Regular performance and financial reporting.
Medium-Term Financial Outlook	The Medium-Term Financial Outlook 2024/25 – 2027/28 identifies financial challenges and opportunities for the next three years and offers a framework for sustainability.	Financial planning and sustainability framework.
Programme Management Office (PMO)	Ensures the coordination of efforts across multiple programmes and projects aimed at achieving sustainable transformational change that maximises value delivery.	Coordinates transformational programmes and projects.

Feature	Description	Summary
Clinical and Care Governance Group	The group oversees and scrutinises clinical and care risk, quality, and effectiveness to ensure safety and person-centred care. It produces an annual report detailing its activities and findings.	Oversight of clinical and care risk and quality.
Risk Management Strategy	The Audit and Performance Committee reviews the strategic risk register twice a year. They approve the level of risk, its potential impact, and mitigation actions before referring them to the HSCP Board. The HSCP Board has evaluated the strategic risk levels and the suitability of mitigation actions according to its Risk Appetite Statement and Risk Management Policy.	Bi-annual scrutiny of risk management.
Reserves Policy	Reviewed annually during the budget setting process to determine a suitable amount of general and earmarked reserves.	Annual review of reserves policy.
CIPFA Financial Management Code	Self-assessment of compliance with the CIPFA Financial Management Code.	Compliance with financial management standards.
Performance Appraisal Process	All employees are required to undertake annual training, encompassing statutory and mandatory courses. This training aims to reinforce their obligations to protect service users, including maintaining information security and diversity and equality.	Employee appraisals and mandatory training.
Policy Register	Maintained to support regular reviews.	Supports regular policy reviews.
Participation and Engagement Strategy	The Participation and Engagement Strategy 2024-2027 aims to build active, inclusive, and strong community relationships between the Health and Social Care Partnership (HSCP) and the residents of West Dunbartonshire. This ensures our local communities can help shape and influence decision making to create services and policies that put the community at the heart of the HSCP's work.	This strategy outlines how all HSCP staff will engage with our residents and cements our goals for what we want to achieve over the next three years.

In addition to the HCSP Board Financial Regulations the HSCP complies with the financial regulations of its partner bodies both of which contain details on their approaches to managing the risk of fraud and corruption.

- West Dunbartonshire Council has adopted a response that is appropriate for its fraud and corruption risks and commits to maintain its vigilance to tackle fraud in accordance with the Code of Practice on Managing the Risk of Fraud and Corruption.

- NHSGCC has a formal partnership with NHS Counter Fraud Service, which details the action to be taken when fraud, theft, corruption, or other financial irregularities are suspected. This requires NHSGCC to adopt the Counter Fraud Standard and have a formal Fraud Policy and a Fraud Response Plan, which sets out the Board's policy and individual responsibilities.

Compliance with Best Practice

The HSCP Board's financial management arrangements conform to the CIPFA Financial Management Code, a series of financial management standards designed to support local authority bodies meet their fiduciary duties.

The HSCP Board's financial management arrangements conform to the governance requirements of the CIPFA statement *"The Role of the Chief Financial Officer in Local Government (2016)"*. To deliver these responsibilities the Chief Financial Officer (Section 95 Officer) must be professionally qualified and suitably experienced and lead and direct a finance function that is resourced and fit for purpose.

The HSCP Board complies with the requirements of the CIPFA Statement on *"The Role of the Head of Internal Audit in Public Organisations 2019"*. The HSCP Board's appointed Chief Internal Auditor has responsibility for the internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The Internal Audit service operates in accordance with CIPFA *"Public Sector Internal Audit Standards 2017".* From 1 April 2025 the new Global Internal Audit Standards came into effect for the UK Public Sector and a transition plan is in place to ensure the Internal Audit service is compliant with the requirements by 31 March 2026.

The HSCP Board's Audit and Performance Committee operates in accordance with CIPFA's *"Audit Committee Principles in Local Authorities in Scotland"* and *"Audit Committees: Practical Guidance for Local Authorities and Police (2022)"*. A self-assessment of compliance with the main elements of the CIPFA Audit Committee guidance was undertaken in January 2024 which concluded that the HSCP Board's Audit and Performance Committee complies with most of the main elements, and the opportunities to enhance current arrangements including production of an annual report, facilitation of a private meeting with Committee members and internal and external audit and a further review of membership, were approved by the Committee in February 2025 for implementation in 2025/26.

Review of Adequacy and Effectiveness

The HSCP Board is dedicated to continuous improvement and is responsible for conducting an annual review of its governance framework, including the system of internal control. The effectiveness of this framework is evaluated based on inputs from the Chief Officer and the Senior Management Team, who oversee the governance environment, as well as from internal and external audits and other review agencies such as the Care Inspectorate.

This review is further supported by processes within West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board. Within the Council, all Senior Officers annually complete a self-assessment governance questionnaire and certificate of assurance. The responses are incorporated into the review of West Dunbartonshire Council's governance framework. Similarly, within the Health Board, Service Managers complete and return a "Self-Assessment Checklist" to provide evidence of their review of key areas of the internal control framework. The Senior Management Team then evaluates these submissions and issues a Certificate of Assurance for their respective services.

HSCP Board Members can face conflicts between their responsibilities to the Board and other duties. To manage these, the HSCP Board requires members to declare potential conflicts of interest. The Chair must ensure these declarations are addressed according to the HSCP Board's Code of Conduct, which follows the Scottish Government's Model Code of Conduct on the Standards Commission website.

HSCP Board's Local Code of Good Governance Review

This is reviewed annually by the Chief Financial Officer and the Senior Management Team as part of the year end assurance processes for both partner organisations and the HSCP Board. For the 2024/25 review the Audit and Performance Committee, which met on 25 June 2025 noted that the self-evaluation review identified that current practices were mostly compliant, with no areas assessed to be non-compliant. A copy of the 2024/25 report is available here (See Appendix 1, 17)

Three new improvement actions have been identified, which are detailed in Table 14 below. An update of previously agreed improvement actions is also provided in Table 15 below. This includes the proposed closure of some completed actions and the addition of new actions to enhance the internal control environment. The priority for 2025/26 will be to advance the remaining ongoing actions to further strengthen the governance framework.

Table 14: New June 2025 Actions

Improvement Action	Lead Officer(s)	Target Date
Development of Business Impact Analysis documentation across the HSCP to support key Business Continuity Plans	Head of Strategy and Transformation	March 2026
Enhance current monitoring of improvement actions arising from external inspections to provide assurance to the HSCP Board that actions are robust and can be embedded	Heads of Service supported by Head of Strategy and Transformation	June 2026
Develop a more structured approach to self-evaluation.	Head of Strategy and Transformation	June 2026

Table 15: Update on Previously Agreed Actions

Improvement Action	Lead Officer(s)	Target Date	June 2025 Review
Ministerial Strategic Group Review on the Progress of Integration Action Plan	Chief Officer	Revised Date: December 2024	**COMPLETE as at 25 June 2025** On 19 September 2023, the Audit and Performance Committee was advised that no further MSG action updates were necessary. The Committee decided to require one more update at an unspecified future meeting. On 25 June 2025, the final update report recommended accepting that most actions had become standard practice, making further updates unnecessary.
Scheme of Delegation The HSCP Board should consider drafting its own Scheme of Delegation	Chief Financial Officer and Head of Strategy and Transformation	Revised Date: December 2024	**COMPLETE** The Council's Monitoring Officer believes a separate Scheme of Delegation for the IJB is unnecessary, as responsibilities are adequately covered by the Council's Scheme. The Audit and Performance Committee should close this action since further progress is unlikely.

Improvement Action	Lead Officer(s)	Target Date	June 2025 Review
Align more clearly the Strategic Plan to the Integrated Workforce Plan (IWP) to support the delivery of the approved strategic outcomes	Head of Strategy and Transformation and Head of Human Resources	Revised Date: December 2024 Further Revised Date: 31 March 2026	**ONGOING** The 20 February 2024 HSCP Board received an update report on completed actions and planned progress of outstanding actions. The Integrated Workforce Plan will be reviewed and aligned to the 2026-2029 Strategic Commissioning Plan.
Refresh the Medium-Term Financial Plan: 2022/23 – 2026/27	Chief Financial Officer	Revised Date: August 2024	**COMPLETE** The HSCP Board approved the refreshed Medium Term Financial Outlook (MTFO) 2024/25 to 2027/28 in November 2024. Ongoing review of the MTFO will be aligned to the refresh of the Strategic Plan if appropriate.
Undertaken CIPFA Self-Assessment of Good Practice for Audit Committees	Chief Internal Auditor and Chief Financial Officer	December 2024	**COMPLETE** HSCP Board members completed a self-assessment on 22 January 2025. The Audit and Performance Committee approved an improvement plan for Good Practice, with progress to be reported at a future HSCP Board meeting.
Further training in Complaints Handling Procedure	Head of Strategy and Transformation	December 2024	**COMPLETE** Training session undertaken with Extended Management Team on 22 March 2024. This has resulted in a slight increase in Stage 1 complaints as confidence increases across teams to recognise and record complaints more effectively. Q4 23/24 – 57, Q1 24/25 – 73; and Q2 24/25 – 83.

Improvement Action	Lead Officer(s)	Target Date	June 2025 Review
Refresh of Participation and Engagement Strategy	Head of Strategy and Transformation	December 2024	**COMPLETE** Participation and Engagement Strategy reviewed and approved by HSCP Board 19 November 2024. This has resulted in an increase in service user and citizen participation which was reported to the HSCP Board on 27 May 2025.
Establishment of Local Provider Forums to support the delivery of robust local commissioning frameworks	Head of Strategy and Transformation	March 2025	**COMPLETE** Provider Forums have been established across a variety of commissioned services. This initiative has fostered a more collaborative approach to commissioning and the development of more efficient local frameworks. Ultimately, this will result in improved outcomes for our service users and uphold Best Value principles.

HSCP Board's 2024/25 Audit Plan Progress

The HSCP Board's Annual Audit Plans ensure the Governance Framework is sound. Twenty days are allocated for these audits, which supplement the Council and Health Board's internal audit activities.

The Chief Internal Auditor of the HSCP Board presented the "Internal Audit Annual Strategy and Plan" for 2024/25 to the Audit and Performance Committee on 24 September 2024. This strategy and plan were formulated through a risk-based approach, concentrating audit efforts on areas of higher risk. These considerations included management's risk assessments, previous audit findings, and other relevant internal or external factors affecting the HSCP Board.

In addition to fulfilling annual reporting requirements and following up on action plans by the internal audit team, two significant undertakings were completed:

- the CIPFA Self-Assessment of Good Practice for Audit Committees (refer to the table above); and
- an audit of the HSCP Board's Budgetary Control Arrangements.

The results of this audit were reported at the 25 June Audit and Performance Committee meeting and can be accessed here (Appendix 1, 18). The audit concluded that the overall control environment was **satisfactory**, with two "green" (low risk) issues identified:

1. Finalisation of the Budgetary Control and Monitoring Procedures Manual; and
2. Finalisation of Budgetary Control and Finance Training Manual and roll-out to budget holders.

Update on Previous Governance Issues

The 2023/24 Annual Governance Statement did not identify any significant control issues for the HSCP Board. Updates of previous HSCP Board governance issues are covered under the "Review of Adequacy and Effectiveness" section above. Regular updates to the HSCP Board's Strategic Risk Register and assessment of the success of mitigating actions ensure that members are well sighted on current and emerging risks that could impact on the governance framework.

Our external auditor's 2023/24 Annual Audit Report did not raise any deficiencies or general observations in our internal control environment. Their commentary on the wider scope responsibilities, as set out in the Code of Audit Practice 2021 and sits alongside Best Value requirements detailed in the Local Government (Scotland) Act 1973, did identify a significant risk with regards to financial sustainability. The Code's wider scope framework is categorised into four areas:

1. financial management;
2. financial sustainability;
3. vision, leadership and governance; and
4. use of resources to improve outcomes.

Financial management arrangements and culture were deemed robust and well established. Vision, leadership, and governance identified the Strategic Plan priorities, supported by a delivery plan and arrangements that permit scrutiny and challenge. The use of resources to improve outcomes acknowledged financial and workforce challenges but concluded that the performance management framework offered visibility through regular reporting.

Financial sustainability in the medium to long term has been identified as a significant risk, with projected budget deficits in future years. Financial challenges such as inflation, pay awards, demographic pressures, and prescribing costs, coupled with either "flat-cash" settlements or funding increases below the rate of inflation, intensify the ongoing difficulty of identifying and implementing savings without negatively impacting service delivery.

The budget gaps are outlined in the HSCP Board's Medium Term Financial Outlook for 2024/25 to 2027/28, as well as in the 2025/26 Annual Budget Setting Report. Under the direction of the Chief Officer, service reviews within Learning Disability Services, Children and Families, and Care at Home, improved commissioning and procurement processes, and better alignment of resources to strategic outcomes will help the HSCP Board remain financially sustainable.

Governance Issues 2024/25

The 2024/25 Internal Audit Annual Report for the HSCP Board identifies no significant control issues.

As stated above the HSCP Board must also place reliance on the Council and Health Board's internal control framework. Both partner bodies Internal Audit Annual Reports have concluded their reviews of control procedures in key areas with the overall opinions being satisfactory with some improvement needed.

As stated above under "Review of Adequacy and Effectiveness" the Chief Officer of the HSCP completes a self-assessment of the HSCP's operational performance against West Dunbartonshire Council's local code. The Council's Chief Internal Auditor has considered this and has identified some areas for improvement which form part of the Council's Annual Governance Statement and progress will be monitored through the Performance Management Review Group (PMRG) and the Council's Audit Committee.

The Health Board's Internal Auditor's Annual Report was received on 18 June 2025, and the opinion is one that reasonable assurance can be placed on the adequacy and effectiveness of the current governance and control systems and processes.

Conclusion and Opinion on Assurance

Overall, the Chief Internal Auditor's evaluation of the control environment concluded that; based on the audit work undertaken, the assurances provided by the Chief Officers of the HSCP Board, West Dunbartonshire Council and Greater Glasgow and Clyde Health Board, the review of the local code and knowledge of the HSCP Board's governance, risk management and performance monitoring arrangements:

"It is my opinion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2025 within the Council and the Health Board from which the Health and Social Care Partnership Board requires to receive assurances and within the Health and Social Care Partnership Board itself."

Assurance and Certification

Whilst recognising that improvements are required, as detailed above, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP Board's governance arrangements.

We consider the internal control environment provides reasonable and objective assurance that any significant risks impacting on our principal objectives will be identified and actions taken to mitigate their impact and deliver improvement.

Systems are in place to regularly review and improve the internal control environment and the implementation of the action plan will be monitored by the HSCP Senior Management Team throughout the year.

Michelle Wailes **Date: 25 June 2025**
HSCP Board Chair

Beth Culshaw **Date: 25 June 2025**
Chief Officer

Comprehensive Income and Expenditure

Comprehensive Income and Expenditure Statement for the year ended 31 March 2025

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

2023/24 Gross Expenditure £000	2023/24 Gross Income £000	2023/24 Net Expenditure £000	West Dunbartonshire Integrated Joint Board - Health & Social Care Partnership	Notes	2024/25 Gross Expenditure £000	2024/25 Gross Income £000	2024/25 Net Expenditure £000
65,842	(8,632)	57,210	Older People Services		67,397	(9,153)	58,244
3,622	(220)	3,402	Physical Disability		3,794	(237)	3,557
33,923	(1,685)	32,238	Children and Families		33,797	(2,181)	31,616
16,766	(3,135)	13,631	Mental Health Services		16,809	(3,182)	13,627
4,156	(135)	4,021	Addictions		4,291	(190)	4,101
22,019	(872)	21,147	Learning Disabilities Services		21,733	(664)	21,069
34,232	(1,157)	33,075	Family Health Services (FHS)		36,670	(1,496)	35,174
22,667	0	22,667	GP Prescribing		22,626	0	22,626
8,512	(250)	8,262	Hosted Services - MSK Physio		8,375	(267)	8,108
883	(4)	879	Hosted Services - Retinal Screening		865	0	865
3,261	(2,987)	274	Criminal Justice		3,129	(3,032)	97
11,870	(876)	10,994	Other Services		11,942	(1,207)	10,735
372	0	372	IJB Operational Costs		363	0	363
228,125	**(19,953)**	**208,172**	**Cost of Services Directly Managed by West Dunbartonshire HSCP**		**231,791**	**(21,609)**	**210,182**
43,914	0	43,914	Set aside for delegated services provided in large hospitals		45,781	0	45,781
302	0	302	Assisted garden maintenance and Aids and Adaptions		303	0	303
272,340	**(19,953)**	**252,388**	**Total Cost of Services to West Dunbartonshire HSCP**		**277,875**	**(21,609)**	**256,266**
0	(244,859)	(244,859)	Taxation & Non-Specific Grant Income (contribution from partners)	7	0	(256,019)	(256,019)
272,340	**(264,811)**	**7,529**	**(Surplus) or Deficit on Provisions of Services and Total Comprehensive (Income) and Expenditure**		**277,875**	**(277,628)**	**247**

Note: Totals may not add due to rounding

Movement in Reserves Statement

Movement in Reserves Statement

This statement shows the movement in the year on the HSCP Board's reserves, refer to Table 16 below. Table 17 provides information for 2023/24 for comparison purposes. The movements which arise due to statutory adjustments which affect the General Fund balance are separately identified from the movements due to accounting practices.

Table 16: 2024/25 Movement in Reserves

Movement in Reserves During 2024/25	Unearmarked Reserves	Earmarked Reserves	Total General Fund Reserves
	£000	£000	£000
Opening Balance as at 31st March 2024	**(3,504)**	**(15,150)**	**(18,654)**
Total Comprehensive Income and Expenditure (Increase)/Decrease 2024/25	(72)	319	247
Closing Balance as at 31st March 2025	**(3,576)**	**(14,831)**	**(18,407)**

Note: Totals may not add due to rounding

Table 17: 2023/24 Movement in Reserves

Movement in Reserves During 2023/24	Unearmarked Reserves	Earmarked Reserves	Total General Fund Reserves
	£000	£000	£000
Opening Balance as at 31st March 2023	**(4,308)**	**(21,874)**	**(26,182)**
Total Comprehensive Income and Expenditure (Increase)/Decrease 2023/24	804	6,725	7,529
Closing Balance as at 31st March 2024	**(3,504)**	**(15,150)**	**(18,654)**

Note: Totals may not add due to rounding

Balance Sheet

Balance Sheet

The Balance Sheet shows the value of the HSCP Board's assets and liabilities as at the balance sheet date. The net assets are matched by the reserves held by the HSCP Board. See Table 18 below:

Table 18: HSCP Board Balance Sheet

2023/24 £000	BALANCE SHEET	Notes	2024/25 £000
19,093	Short Term Debtors	9	18,989
19,093	**Current Assets**		**18,989**
0	Short Term Creditors		0
(439)	Provisions	10	(582)
(439)	**Current Liabilities**		**(582)**
18,654	**Net Assets**		**18,407**
(3,504)	Usable Reserves: General Fund	12	(3,576)
(15,150)	Usable Reserves: Earmarked	12	(14,831)
(18,654)	**Total Reserves**		**(18,407)**

Note: Totals may not add due to rounding

The unaudited accounts were issued on 25 June 2025.

Julie Slavin CPFA **Date: 25 June 2025**
Chief Financial Officer

Notes to the Financial Statements

1. Material Accounting Policies

1.1 General Principles

The Financial Statements summarises the HSCP Board's transactions for the 2024/25 financial year and its position at the year-end of 31 March 2025.

The HSCP Board was established under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a joint venture between West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board.

The HSCP Board is a specified Section 106 body under the Local Government (Scotland) Act 1973 and as such is required to prepare their financial statements in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2024/25, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

1.2 Accruals of Income and Expenditure

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

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

1.3 Going Concern

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

The HSCP Board is required to prepare its financial statements on a going concern basis unless informed by the relevant national body of the intention for dissolution without transfer of services or function to another entity and these accounts are prepared on the assumption that the services of the HSCP will continue in operational existence for the foreseeable future.

We outline within our management commentary that like 2023/24 demographic pressures in 2024/25 have resulted in significant financial challenges within Children and Families (community placements and external residential care packages) and Older People Services (care at home), however robust financial management across the remainder of the services delegated to the HSCP has largely mitigated this pressure.

The HSCP Board's funding from, and commissioning of services to, partners has been confirmed for 2025/26. The medium-term financial outlook for the period to March 2028 was approved in November 2024 and identified budget gaps of between £7.3m and £14.9m for 2026/27 and 2027/28 depending on scenarios and not allowing for any additional funding that may offset this. The HSCP Board continues to work within the context of the recovery from the COVID-19 pandemic and other financial pressures. The Integration Scheme outlines the actions required in the event of an overspend which includes the implementation of a recovery plan to recover the overspend. If this is unsuccessful partner bodies can consider making additional funds available. Therefore, the HSCP Board considers there are no material uncertainties around its going concern status in the period up to September 2025.

1.4 Accounting Convention

The accounting convention adopted in the Statement of Accounts is an historic cost basis.

1.5 Funding

The HSCP Board is primarily funded through contributions from the statutory funding partners, WDC and NHSGGC. Expenditure is incurred as the HSCP Board commission's specified health and social care services from the funding partners for the benefit of service recipients in West Dunbartonshire and service recipients in Greater Glasgow and Clyde, for services which are delivered under Hosted arrangements.

1.6 Cash and Cash Equivalents

The HSCP Board does not operate a bank account or hold cash and therefore has not produced a cashflow statement for these annual accounts. Transactions are settled on behalf of the HSCP Board by the funding partners. Consequently, the HSCP Board does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner, as at 31 March 2025, is represented as a debtor or creditor on the HSCP Board's Balance Sheet.

1.7 Employee Benefits

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

The HSCP Board has a legal responsibility to appoint a Chief Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as employee costs. Where material the Chief Officer's absence entitlement as at 31 March 2025 is accrued, for example in relation to annual leave earned but not yet taken.

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

1.8 Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March 2025 due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March 2025, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the HSCP Board's Balance Sheet but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March 2025, whose existence will only be confirmed by later events. A contingent asset is not recognised in the HSCP Board's Balance Sheet but is disclosed in a note only if it is probable to arise and can be reliably measured.

There are no contingent liabilities or assets to disclose.

1.9 Reserves

The HSCP Board's reserves are classified as either Usable or Unusable Reserves.

The HSCP Board's only Usable Reserve is the General Fund. The balance of the General Fund as at 31 March 2025 shows the extent of resources which the HSCP Board can use in later years to support service provision or for specific projects.

Within usable reserves the HSCP Board holds earmarked funds to meet specific service commitments and take forward service redesigns and reform agendas. The HSCP Board's Reserve Policy recommends the holding of contingency reserves at 2% of net expenditure. Decisions in relation to the earmarking/un-earmarking of funds are made by the HSCP Board, normally as part of the account closure process.

1.10 Indemnity Insurance

The HSCP Board has indemnity insurance for costs relating primarily to potential claim liabilities regarding HSCP Board member and officer responsibilities. Greater Glasgow and Clyde Health Board and West Dunbartonshire Council have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide.

Unlike NHS Boards, the HSCP Board does not have any 'shared risk' exposure from participation in CNORIS. The HSCP Board's participation in the CNORIS scheme is therefore analogous to normal insurance arrangements.
Known claims are assessed as to the value and probability of settlement. Where it is material the overall expected value of known claims taking probability of settlement into consideration is provided for in the HSCP Board's Balance Sheet.

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

1.11 VAT

The VAT treatment of expenditure in the HSCP's accounts depends on which of the partner agencies is providing the services as these agencies are treated differently for VAT purposes.

Where the Council is the provider, income and expenditure exclude any amount related to VAT, as all VAT collected is payable to HRMC and all VAT is recoverable from it. The Council is not entitled to fully recover VAT paid on a very limited number of items of expenditure and for these items the cost of VAT paid is included within service expenditure to the extent that it is irrecoverable from HMRC.

Where the NHS is the provider, expenditure incurred will include irrecoverable VAT as generally the NHS cannot recover VAT paid and will seek to recover its full cost as income from the Commissioning HSCP.

2. Prior Year Re-Statement

There are no prior year re-statements.

3. Accounting Standards Issued Not Yet Effective

The Code requires the disclosure of information relating to the expected impact of an accounting change that will be required by a new standard that has been issued but not yet adopted.

The HSCP Board considers that there are no such standards which would have significant impact on its Annual Accounts.

4. Critical Judgements and Estimation Uncertainty

Within Greater Glasgow and Clyde, each IJB has responsibility for services which it hosts on behalf of the other IJB's. In delivering these services the IJB has primary responsibility for the provision of the services and bears the risks and reward associated with this service delivery in terms of demand and the financial resources required. As such the IJB is considered to be acting as 'principal', and the full costs should be reflected within the financial statements for the services which it hosts. This is the basis on which West Dunbartonshire's IJB accounts have been prepared and is based on the Code of Practice.

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

5. Events After the Reporting Period

Events after the balance sheet date are those events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the statement of accounts is authorised for issue. Two types of events may be identified:

- those that provide evidence of conditions that existed at the end of the reporting period – the Financial Statements are adjusted to reflect such events; and

- those that are indicative of conditions that arose after the reporting period - the Financial Statements are not adjusted to reflect such events, but where this would have a material effect, the nature and estimated financial impact of such events is disclosed in the notes

The unaudited accounts were authorised for issue by the Chief Financial Officer on 25 June 2025. Events taking place after this date are not reflected in the financial statements or notes. Where events taking place before this date provided information about conditions existing on 31 March 2025, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

6. Expenditure and Income Analysis by Nature

There are no statutory or presentational adjustments which reflect the WDHSCP Board's application of the funding received from partners.

The movement in the General Fund balance is therefore solely due to the transactions shown in the Comprehensive Income and Expenditure Statement.

Table 19 provides a summary Expenditure and Funding Analysis.

Table 19: Expenditure and Income Analysis

2023/24 £000	West Dunbartonshire Integrated Joint Board Health & Social Care Partnership Consolidated Health & Social Care Services	2024/25 £000
93,357	Employee Costs	92,390
1,568	Property Costs	1,502
1,321	Transport	1,538
5,044	Supplies and Services	4,848
67,198	Payment to Other Bodies	69,730
22,667	Prescribing	22,626
34,050	Family Health Services	36,467
2,887	Other	2,656
33	Audit Fee	34
302	Assisted Garden Maintenance and Aids and Adaptations	303
43,914	Set Aside for Delegated Services Provided in Large Hospitals	45,781
(19,953)	Income	(21,609)
(244,859)	Taxation and non specific grant income	(256,019)
7,529	**Surplus on the Provision of Services**	**247**

Note: Totals may not add due to rounding

7. Taxation and Non-Specific Grant Income

The funding contribution from the NHS Greater Glasgow and Clyde Health Board shown in Table 20 includes £45.781m in respect of 'set aside' resources relating to acute hospital and other resources.

These are provided by the Health Board which retains responsibility for managing the costs of providing the services.

The HSCP Board however has responsibility for the consumption of, and level of demand placed on, these resources.

Table 20: Taxation and Non-Specific Grant Income

2023/24 £000	Taxation and Non-Specific Grant Income	2024/25 £000
(115,647)	NHS Greater Glasgow and Clyde Health Board	(120,102)
(84,996)	West Dunbartonshire Council	(89,833)
(43,914)	NHS GGCHB Set Aside	(45,781)
(302)	Assisted garden maintenance and Aids and Adaptions	(303)
(244,859)	**Total**	**(256,019)**

Note: Totals may not add due to rounding

8. Hosted Services

Consideration has been made on the basis of the preparation of the 2024/25 accounts in respect of MSK Physiotherapy and Retinal Screening Services hosted by West Dunbartonshire HSCP Board for other IJBs within the NHSGGC area. The HSCP Board is considered to be acting as a "principal", with the full costs of such services being reflected in the 2024/25 financial statements.

The cost of the hosted services provided by WDHSCP to other IJBs for 2024/25 is detailed in the Table 21 below. Also included within the table is cost incurred by West Dunbartonshire HSCP on behalf of other IJB's within the NHSGCC areas in relation to Old Age Psychiatry. These costs arise solely due to cross boundary bed activity and are not regarded as a true hosted service.

Table 21: Services Hosted by West Dunbartonshire HSCP

2023/24 £000 Net Expenditure by WD HSCP	Host Integrated Joint Board	Service Description	2024/25 £000 Net Expenditure by WD HSCP
7,665	West Dunbartonshire	MSK Physiotherapy	7,522
801	West Dunbartonshire	Retinal Screening	792
102	West Dunbartonshire	Old Age Psychiatry	32
8,568		**Cost to GGC IJBs for Services Hosted by WD**	**8,346**

Note: Totals may not add due to rounding

Similarly, other IJBs' within the NHSGGC area act as the lead partnership (or host) for a number of delegated services on behalf of the WD HSCP Board. Table 22 below, details those services and the cost of providing them to residents of West Dunbartonshire, based on activity levels, referrals and bed days occupied.

Table 22: Services Hosted by Other IJB's

2023/24 £000 Net Expenditure by WD HSCP	Host Integrated Joint Board	Service Description	2024/25 £000 Net Expenditure by WD HSCP
880	East Dunbartonshire	Oral Health	897
3,453	East Dunbartonshire	Specialist Children's Service	4,278
658	East Renfrewshire	Learning Disability	427
6	East Renfrewshire	Augmentative and Alternative Communication	16
512	Glasgow	Continence	462
643	Glasgow	Sexual Health	671
2,288	Glasgow	Mental Health Central Services	2,195
1,139	Glasgow	Addictions - Alcohol and Drugs	677
1,011	Glasgow	Prison Healthcare	970
208	Glasgow	Health Care Police Custody	221
4,474	Glasgow	General/Old Age Psychiatry	4,806
2	Renfrewshire	General/Old Age Psychiatry	31
10	Inverclyde	General/Old Age Psychiatry	4
515	Renfrewshire	Podiatry	547
302	Renfrewshire	Primary Care Support	322
16,103		**Cost to WD for Services Hosted by Other IJBs**	**16,524**

Note: Totals may not add due to rounding

9. Table 23: Debtors

2023/24 £000	Short Term Debtors	2024/25 £000
0	NHS Greater Glasgow and Clyde Health Board	0
19,093	West Dunbartonshire Council	18,989
19,093	**Total**	**18,989**

Note: Totals may not add due to rounding

10. Table 24: Provisions

The following provision relates to un-recovered charges (bad debt) for specific social care delegated services.

2023/24 £000	Provisions	2024/25 £000
439	Bad Debt Provision	582
439	**Total**	**582**

Note: Totals may not add due to rounding

11. Related Party Transactions

The HSCP Board has related party relationships with the Greater Glasgow and Clyde Health Board and West Dunbartonshire Council. The nature of the partnership means that the HSCP Board may influence, and be influenced by, its partners. The following transactions and balances included in the HSCP Board's accounts are presented to provide additional information on the relationships.

Both NHSGGC and WDC provide a range of support services to the HSCP Board which includes legal advice, human resources support, some financial services and technical support. Neither organisation levied any additional charges for these services for the year ended 31 March 2025.

Key Management Personnel: the non-voting Board members employed by the WDC and NHSGGC and recharged to the HSCP Board include the Chief Officer, the Chief Financial Officer, and the Chief Social Work Officer.

In addition to the non-voting members other key management personnel recharged to the HSCP Board include the Head of Planning & Health Improvement and two staff representatives.

Details of the remuneration for some specific post-holders are provided in the Remuneration Report.

Table 25: Transactions with Greater Glasgow and Clyde Health Board

2023/24 £000		2024/25 £000
(159,561)	Funding Contributions Received from the NHS Board	(165,883)
158,905	Expenditure on Services Provided by the NHS Board	163,908
(656)	**Net Transactions with NHS Board**	**(1,975)**

Note: Totals may not add due to rounding

Table 26: Transactions with West Dunbartonshire Council

2023/24 £000		2024/25 £000
(85,298)	Funding Contributions Received from the Council	(90,136)
93,111	Expenditure on Services Provided by the Council	91,995
372	Key Management Personnel: Non Voting Members	363
8,185	**Net Transactions with West Dunbartonshire Council**	**2,222**

Note: Totals may not add due to rounding

12. Useable Reserve: General Fund

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

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.
- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the HSCP Board's risk management framework.

Table 27: Summary of Reserves Movements

Table 27 summarises the main movements in earmarked reserves across high-level categories of:

- Scottish Government Policy Initiatives
- HSCP Initiatives
- Prescribing.

Balance as at 31 March 2024 £000	Total Reserves	Transfers Out 2024/25 £000	Transfers In 2024/25 £000	Balance as at 31 March 2025 £000
	Scottish Govt. Policy Initiatives			
(2)	Covid	2	0	0
(0)	Primary Care	0	0	(0)
(4,407)	Adult and Older People Services	1,921	(377)	(2,863)
(148)	Childrens Services	79	0	(69)
(219)	Carers Funding	30	0	(189)
(67)	Other	67	0	0
	HSCP Initiatives			
(1,853)	Service Redesign / Transformation	550	(312)	(1,614)
(1,973)	Complex Care	650	0	(1,323)
(50)	Community Empowerment	50	0	0
(4,223)	Recovery / Renewal in Services	1,545	(2,054)	(4,732)
	Superannuation	0	(1,522)	(1,522)
(1,236)	Other	140	(54)	(1,149)
	Prescribing			
(972)	Prescribing	0	(397)	(1,369)
(15,150)	Total Earmarked Reserves	5,034	(4,716)	(14,831)
(3,504)	Total Unearmarked Reserves	0	(72)	(3,576)
(18,654)	Total General Fund Reserves	5,034	(4,788)	(18,407)
	Overall Movement			**247**

Note: Totals may not add due to rounding

13. External Audit Costs

In 2024/25 the HSCP Board incurred external audit fees in respect of external audit services undertaken in accordance with the Code of Audit Practice. See Table 28 below:

Table 28: External Audit Fees

2023/24 £000		2024/25 £000
33	Fees Payable	34

Independent Auditor's Report

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Appendix 1: List of Website Links

List of Website Links

1. Integration Scheme
2. West Dunbartonshire Health and Social Care Partnership Strategic Plan 2023–2026: Improving Lives Together
3. WD HSCP Board's Strategic Needs Assessment June-2022.pdf
4. WD HSCP Board's Strategic Needs Assessment Executive Summary.pdf
5. WD HSCP Board's Performance Reports
6. Annual Performance Report: Audit & Performance Committee section - West Dunbartonshire HSCP
7. Best Value Review: Audit & Performance Committee section - West Dunbartonshire HSCP
8. WD HSCP May 2025 Financial Performance Report
9. wd-hscp-board-financial-regulations-revised-february-2024.pdf
10. WD HSCP June 2021 Risk Strategy and Policy Report
11. WD HSCP Risk Appetite Statement
12. Updated Strategic Risk Register: Audit & Performance Committee section - West Dunbartonshire HSCP
13. WD HSCP Board's Reserves Policy
14. Supplementary Agenda - HSCP Board - 24 March 2025
15. medium-term-financial-outlook-2024.pdf
16. WD HSCP Board's Local Code of Good Governance++
17. Local Code Annual Review: Audit & Performance Committee section - West Dunbartonshire HSCP
18. Internal Audit Progress Report: Audit & Performance Committee section - West Dunbartonshire HSCP

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

AUDIT AND PERFORMANCE COMMITTEE

Report by Val Tierney, Chief Nurse

25 June 2025

Subject: West Dunbartonshire HSCP Annual Clinical & Care Governance Report 2024

1. Purpose

1.1 Within the Health and Social Care Partnership the Chief Officer is accountable for ensuring the clinical and care governance requirements specified in the approved integration schemes are appropriately discharged. Clinical and care governance is the mechanism by which that responsibility is discharged. The Clinical and Care Governance Annual Report 2024 describes the clinical and care governance oversight arrangements in West Dunbartonshire HSCP and the progress made in assuring and improving the quality of health and social care. The purpose of this report is to provide assurance that health and care governance systems are in place to support the HSCP in monitoring and improving the quality of health and care that it provides. This includes services that are hosted, provided jointly with partner organisations, or commissioned from external providers. The principal achievements, risks and challenges to care quality are reflected in the report.

2. Recommendations

2.1 Members of the IJB are asked to approve the report. This report will be sent to NHS Greater Glasgow and Clyde (NHSGGC) Health Board as all Health and Social Care Partnerships are requested to provide an Annual Report covering the role and remit of the group and any future plans for review and evaluation of care quality.

3. Background

3.1 Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured and that staff are supported in continuously improving the quality and safety of care. This ensures that good performance is highlighted, and poor performance is identified and addressed.

3.2 The aim in monitoring clinical and care quality aligned to the principles of good governance, is to engage and involve people in ensuring clinical and care quality is associated with public transparency, meaningful accountability requirements and robust organisational arrangements for clinical governance.

3.3 The report is structured around the three main domains set out in the National Quality Strategy: Safe, Effective, and Person-Centred Care. The report covers the main priority areas for West Dunbartonshire HSCP.

3.4 Each HSCP is requested by NHSGGC to provide an Annual Report of the clinical and care governance activity.

4. Main Issues

4.1 The report describes West Dunbartonshire HSCP Clinical and Care Governance arrangements confirming these are in accordance with the Clinical and Care Governance Framework as set out by the Public Bodies (Joint Working) (Scotland) Act 2014, which details 'Five Process Steps to Support Clinical and Care Governance and that these align with the seven core components of Clinical and Care Governance as set out by NHS Greater Glasgow & Clyde.

4.2 The approach to clinical and care governance within the HSCP is maturing in alignment with NHS Greater Glasgow and Clyde (NHSGGC) Health Board's statutory duty for care quality (The Health Act 1999) and West Dunbartonshire Council Social Work and Social Care governance framework. This approach recognises the complex interdependencies in delivering safe effective person-centred care in an integrated context.

4.3 This annual Clinical and Care Governance report illustrates the progress made in developing our care assurance processes. It details how care governance arrangements have been strengthened across services and describes ongoing developments to ensure we have the same level of maturity in terms of scrutiny, reporting capability, and robust quality control and assurance processes across all service areas including those services commissioned by the HSCP.

4.4 The report demonstrates the significant efforts deployed to achieve continuous improvement and support the delivery of value-based health and social care services, focussed on achieving the best outcomes for our service users while using resources wisely. Improvements to date are evident and illustrated via

4.4 Selected examples from service have been used to demonstrate the quality-of-service provision. These are not exhaustive but illustrate the range of activity ongoing to realise the three quality ambitions of safe, effective, and person centred and reflect our efforts to strive for continuous quality improvement.

5. Options Appraisal

5.1 N/A

6. People Implications

6.1 There are no human resource implications.

7. Financial and Procurement Implications

7.1 N/A

8. Risk Analysis

8.1 NHSGGC duty for care quality applies to all services provided with respect to prevention, diagnosis and treatment of illness and includes services that are provided jointly with partner organisations. This legal responsibility for quality of care is equal in measure to their other statutory duties. Failure to discharge these responsibilities risks

breaching a statutory duty for care quality and could also result in reputational risk to the organisation. Failure to assure clinical and care governance across the new integrated arrangements could result in poor standards of care, poor outcomes for service users and their families.

8.2 Staff recruitment, retention and financial challenges all pose a credible risk to care quality making it critically important that we continued to strengthen our assurance and oversight arrangements to secure assurance and mitigate emerging threats.

8.3 The Care Home sector remains vulnerable. Enhanced support, oversight and assurance arrangements for local care homes ensure that emerging risks were identified early, robustly managed and care quality maintained. This has provided a solid foundation for partnership working to support ongoing quality improvement ambitions.

8.4 Care governance arrangements have been strengthened across services, and progress has been made to ensure we have the same level of maturity in terms of scrutiny, reporting capability, and robust quality control and assurance processes across all service areas including those services commissioned by the HSCP.

9. Equalities Impact Assessment (EIA)

9.1 Not required as the report does not introduce new policy or strategy. Robust clinical and care governance ensures that the needs of protected groups are considered. All aspects of clinical and care governance seek to address avoidable variations in outcomes for service users.

10. Environmental Sustainability

10.1 N/A

11. Consultation

11.1 All service areas are invited to contribute to the report. The report has been shared with West Dunbartonshire HSCP Senior Management Team and HSCP Clinical and Care Governance Committee.

12. Strategic Assessment

12.1 Robust clinical and care governance contributes to the achievement of National Wellbeing Outcomes, West Dunbartonshire HSCP's strategic priorities, the national standards for health and social care and the national quality ambitions for the delivery of safe, effective person-centred care.

13. Directions

13.1 No directions are issued with this report.

Name: Val Tierney

Designation.
Chief Nurse

Date 28.05.2025.

Person to Contact: Val. Tierney@ggc.scot.nhs.uk

Appendices:

Appendix 1
West Dunbartonshire Clinical and Care Governance Work-plan 2024-25

Appendix 2
West Dunbartonshire Clinical and Care Governance Work-plan 2025-26

Appendix 3:
West Dunbartonshire Annual Clinical and Care Governance Report 2024

Background Papers

West Dunbartonshire HSCP
Clinical and Care Governance Work Plan 2024-2025

The essential function of Clinical and Care Governance Groups is to support the delivery of consistently high quality clinical care, and to provide assurance that appropriate clinical governance mechanisms are in place.

A Clinical and Care Governance work plan is a living document that captures the active programmes of work being undertaken by a Clinical and care Governance Group. Items on the work plan should link to the Reporting Schedule/ Annual Cycle or Business, so that updates for approval, decision making or focused discussion; or for assurance, noting or information, are planned and tabled at the meeting as required.

Key items that you may wish to consider within the work plan are listed below, these provide an aide memoire and are not exhaustive.

SAFE CARE

- Board safety priorities
- Work generated from the review of themes/ trends and learning from clinical incidents, SAERs (Significant Adverse Event Reviews) and M&Ms
- Areas of work relating to key organisational risks including medicines governance, consent to treatment, clinical communication and interfaces in the pathway of care

EFFECTIVE CARE

- Prioritised quality improvement programmes, which will improve and sustain the delivery of the service
- Development of a plan to increase the Quality Improvement capability within the Sector / Directorate / HSCP
- Work related to the development or management of clinical standards including locally developed clinical guidelines

PERSON CENTRED CARE

- Work generated from the analysis of themes/ trends and outcomes from Patient Feedback and Complaints

ASSURANCE

- Commissioning of projects that ensure greater transparency of data, enabling access and support to clinical teams, so information is practically applied in support of quality improvement
- Adequacy of the escalation of feedback resulting from external quality publications and guidelines e.g., SIGN (Scottish Intercollegiate Guidelines Network), NICE (National Institute for Clinical Excellence)
- Areas of work relating to high-risk issues of infection prevention and control, medicines governance, Child protection/ Adult protection, clinical communication, and interfaces in the pathway of care
- Adequacy of the established controls assurance for clinical and care quality

1. SAFE CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
1.1	Ensure there is evidence and oversight of systematic monitoring, assessment and management of risk to care quality.	Develop SMT/ CCG Core quality data set / report to provide oversight care quality related reporting across H&SC (to include Internal and external inspection/ self-evaluation and progress with related improvement plans)	Significant progress – continues to be strengthened. Social Work and Social care Governance Sub group established		VT /MJ/L
		Planning and Commissioning Quality Team to develop and implement quality reporting tool for all commissioned services	Report produced for all externally commissioned registered services. HOS provide report for their areas on internal HSCP registered services		MJC
		Quarterly Exception reports provided by all service areas. Heads of service have CCG mechanisms in place to monitor assessment and risk to care quality.	complete		ALL
		Improve compliance with Datix and SAER policy and compliance with NHSGGC KPI – quarterly scrutiny Datix /SAER reports	Update to ESMT to improve compliance with KPI Training in completion of SAER s encouraged to increase capacity		HOS
1.2	**Systemic development is required to capture reportable**	**1.2.1 Systemic development is required to capture reportable incidents across social work and social care services**	No system in place to support – but enhanced oversight of		

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
	incidents across social work and social care services		complaints and notifications to CI		
1.3	**Improve oversight of work generated from the review of themes/ trends and learning from clinical incidents, SAERs (Significant Adverse Event Reviews) and Learning Reviews**	Via WD HSCP CCG Quarterly Meetings Via NHHs GGC CP QI Oversight Group Via NHS GGC **Learning disability Mental and ADRS CCG groups** **Via NHSGGC Primary care Clinic and Care governance Group** **Learning Brief shared and circulated and also seven minute briefings**			

2. EFFECTIVE CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
2.1	We will increase the Quality Improvement Capability across West Dunbartonshire HSCP Establish baseline and set some targets	Establish baseline of no of staff with SCIL / SClip and			
2.2	We will strengthen our arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes to build on our local approach to support the sector	Quarterly report from CCHST Annual report from CCHST – X2 per year Care Assurance Visits HSCP Quarterly Quality and Monitoring Compliance Visits – Commissioning and Quality Team (includes Complaints / ASP) External Inspection reports – CI	Annual report completed 2024 shared with SMT and A&P		VT
2.3	Effective arrangements are in place to monitor standards of care quality	CI reports	Template Quarterly monitoring of		MJC

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
	for services provided by the third and independent sector.	HSCP Quality and Commissioning Team – provide report on monitoring reports for all commissioned services – quarterly	commissioned services revised		
2.5	Effective arrangements are in place to monitor standards of care quality of hosted services	Quarterly Exception report MSK Physio – Annual report – includes proms and prems Retinal Screening –report compliance with national KPI standards	Robust mechanisms in place via NHSGGC Screening group DRS – and via msk physiotherapy services		

3. PERSON-CENTRED CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update		
3.1	The HSCP enables service users and carers / community to make a complaint about integrated health and social care services	Quarterly reports to A&P / CCG	FT; complaints process being revised for C@H in line with Care Inspectorate feedback / area for improvement,		
	The HSCP enables service users and carers / community to provide feedback	Implementation of Care Opinion MSK Physiotherapy Patient related experience measures (Prems)	FT: DN; s completed SU feedback. Recent engagement with SU's		

	Project/ Aim	Monitoring/ Assurance Arrangements	Update		
			regarding day care Modernisation. Needs to be built in as an routine process across services with a standardised pro forma		
	The HSCP can demonstrate learning from complaints from complaints/ service user feed- back and the related	Complaints reporting mechanism and annual report in place	Monitoring of learning from complaints at service level is evident but patchy requires to be strengthened to enables themes identified and evidence of action and learning strengthened		

4. ASSURANCE

	Project/ Aim	Monitoring/ Assurance Arrangements		
4.1	Publish an annual clinical and care governance report clear, robust, with accurate and timely information on	Annual CCG Report		

	Project/ Aim	Monitoring/ Assurance Arrangements		
	the quality of health and social care services in West Dunbartonshire.			
		4.2.2 Via the implementation of (nursing) CCAT Quarterly Report **Excellence in Care across** Excellence in Care (healthcareimprovementscotland.org)		
4.3	We will work in an integrated way to support teams through health care inspection	Oversight of preparation and planning for anticipated inspection –		
4.4	Improve oversight of all regulatory inspections progress against all existing inspection improvement plans	Exception Report to CCG Quarterly All regulatory inspections to be reported to sub group and then escalated by exception to CCG. (Lesley)Reports re commissioned services shred with CCG social work social care sub group.	FT; completed. Business as usual	HOS
4.5	Effective arrangements are in place to monitor standards of care quality	CCAT Reports Nursing – quarterly Self-evaluation plan social work and social care services (tbc) External Inspections e.g. HIS CI MWC Quarterly Exception reports provided by all service areas. Heads of service have CCG mechanisms in place to monitor assessment and risk to care quality.		ALL

5. COMMISSIONED/ PROJECT WORK

	Project/ Aim	Monitoring/ Assurance Arrangements		
	Development and Implementation of WSHSCP Quality Framework	West Dunbartonshire CCG group IJB audit and Performance Committee		MJC

West Dunbartonshire HSCP
Clinical and Care Governance Draft Work Plan 2025-2026

The essential function of Clinical and Care Governance Groups is to support the delivery of consistently high quality clinical care, and to provide assurance that appropriate clinical governance mechanisms are in place.

A Clinical and Care Governance work plan is a living document that captures the active programmes of work being undertaken by a Clinical and care Governance Group. Items on the work plan should link to the Reporting Schedule/ Annual Cycle or Business, so that updates for approval, decision making or focused discussion; or for assurance, noting or information, are planned and tabled at the meeting as required.

Key items that you may wish to consider within the work plan are listed below, these provide an aide memoire and are not exhaustive.

SAFE CARE

- Board safety priorities
- Work generated from the review of themes/ trends and learning from clinical incidents, SAERs (Significant Adverse Event Reviews) and M&Ms
- Areas of work relating to key organisational risks including medicines governance, consent to treatment, clinical communication and interfaces in the pathway of care

EFFECTIVE CARE

- Prioritised quality improvement programmes, which will improve and sustain the delivery of the service
- Development of a plan to increase the Quality Improvement capability within the Sector / Directorate / HSCP
- Work related to the development or management of clinical standards including locally developed clinical guidelines

PERSON CENTRED CARE

- Work generated from the analysis of themes/ trends and outcomes from Patient Feedback and Complaints

ASSURANCE

- Commissioning of projects that ensure greater transparency of data, enabling access and support to clinical teams, so information is practically applied in support of quality improvement
- Adequacy of the escalation of feedback resulting from external quality publications and guidelines e.g., SIGN (Scottish Intercollegiate Guidelines Network), NICE (National Institute for Clinical Excellence)
- Areas of work relating to high-risk issues of infection prevention and control, medicines governance, Child protection/ Adult protection, clinical communication, and interfaces in the pathway of care
- Adequacy of the established controls assurance for clinical and care quality

1. SAFE CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
1.1	Ensure there is evidence and oversight of systematic monitoring, assessment and management of risk to care quality.	Develop SMT/ CCG Core quality data set / report to provide oversight care quality related reporting across H&SC (to include Internal and external inspection/ self-evaluation and progress with related improvement plans)			VT /MJ/L
		Planning and Commissioning Quality Team to develop and implement quality reporting tool for all commissioned services			MJC
		Quarterly Exception reports provided by all service areas. Heads of service have CCG mechanisms in place to monitor assessment and risk to care quality.			ALL
		Improve compliance with Datix and SAER policy and compliance with NHSGGC KPI – quarterly scrutiny Datix /SAER reports			HOS
		Quarterly update report from HSCP Clinical and Care governance committee to IJB audit and performance / SMT			VT
1.2	**Systemic development is required to capture reportable incidents across social work and social care services**	**1.2.1 Systemic development is required to capture reportable incidents across social work and social care services**			MJ LJ Sc FT
1.3	**Improve oversight of work generated from the review of themes/ trends and learning from clinical incidents, SAERs (Significant Adverse Event Reviews) and Learning Reviews**	Via WD HSCP CCG Quarterly Meetings Via NHHs GGC CP QI Oversight Group Via NhS GGC Learning disability Mental and ADRS CCG groups Via NHSGGC Primary care Clinic and Care governance Group Learning Brief shared and circulated and also seven minute briefings			HOS

2. EFFECTIVE CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
2.1	We will increase the Quality Improvement Capability across West Dunbartonshire HSCP Establish baseline and set some targets	Establish baseline of no of staff with SCIL / SClip and			
2.2	We will strengthen our arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes to build on our local approach to support the sector	Quarterly reports from West Dunbartonshire Collaborative Care Home Support team to NHSGGC care Home framework group Annual report from CCHST – X2 per year Care Assurance Visits HSCP Quarterly Quality and Monitoring Compliance Visits – Commissioning and Quality Team (includes Complaints / ASP) External Inspection reports – CI			VT
2.3	Effective arrangements are in place to monitor standards of care quality for services provided by the third and independent sector.	CI reports HSCP Quality and Commissioning Team – provide report on monitoring reports for all commissioned services – quarterly Oversight vis West Dunbartonshire Social work and Social care CCGG sub group			MJC
2.5	Effective arrangements are in place to monitor standards of care quality of hosted services	Quarterly Exception report WD CCG Committee MSK Physio – Annual report – includes proms and prems – monthly update SMT Retinal Screening –report compliance with national KPI standards- monitored via Nhsggc Screening Oversight Board	Robust mechanisms in place via NHSGGC Screening group DRS – and via msk		

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
			physiotherapy services		

3. PERSON-CENTRED CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update		
3.1	The HSCP enables service users and carers / community to make a complaint about integrated health and social care services	Quarterly reports to A&P / CCG			
	The HSCP enables service users and carers / community to provide feedback	Implementation of Care Opinion MSK Physiotherapy Patient related experience measures (Prems)			
	The HSCP can demonstrate learning from complaints from complaints/ service user feed- back and the related	Complaints reporting mechanism and annual report in place			

4. ASSURANCE

	Project/ Aim	Monitoring/ Assurance Arrangements		
4.1	Publish an annual clinical and care governance report clear, robust, with accurate and timely information on the quality of health and social care services in West Dunbartonshire.	Annual CCG Report		
		4.2.2 Via the implementation of (nursing) CCAT Quarterly Report		

	Project/ Aim	Monitoring/ Assurance Arrangements		
		Excellence in Care across Excellence in Care (healthcareimprovementscotland.org)		
4.3	We will work in an integrated way to support teams through health care inspection	Oversight of preparation and planning for anticipated inspection –		
4.4	Improve oversight of all regulatory inspections progress against all existing inspection improvement plans	Exception Report to CCG Quarterly All regulatory inspections to be reported to sub group and then escalated by exception to CCG. (Lesley)Reports re commissioned services shred with CCG social work social care sub group.		HOS
4.5	Effective arrangements are in place to monitor standards of care quality	CCAT Reports Nursing – quarterly Self-evaluation plan social work and social care services (tbc) External Inspections e.g. HIS CI MWC Quarterly Exception reports provided by all service areas. Heads of service have CCG mechanisms in place to monitor assessment and risk to care quality.		ALL

5. COMMISSIONED/ PROJECT WORK

	Project/ Aim	Monitoring/ Assurance Arrangements		
	Development and Implementation of WSHSCP Quality Framework	West Dunbartonshire CCG group IJB audit and Performance Committee		MJC

West Dunbartonshire Council

West Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

West Dunbartonshire Health and Social Care Partnership

Clinical & Care Governance Annual Report 2024

1. Introduction

- **Background to Service and Report**

Introduction

1.1 Each Health and Social Care Partnership is requested by NHS Greater Glasgow and Clyde to provide an Annual Clinical and Care Governance Report. The Health Act 1999 requires that NHSGGC "put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals".

1.2 The report outlines arrangements for Clinical and Care governance in WDHSCP and is framed around the three Quality ambitions outlined in NHS Scotland Quality Strategy; Safe, Effective, Person Centred Care. The Healthcare Quality Strategy sits within the context of the Patients' Rights Act which became law in Scotland in 2011. This provides a legal basis requiring the NHS in Scotland to provide care, which is person centred, safe and effective.

1.3 This report demonstrates West Dunbartonshire Health and Social Care Partnerships (WDHSCP) approach to assuring and improving the quality of health and care services we provide. Recognising the complex interdependencies in delivering safe effective person centred care in an integrated context, it includes West Dunbartonshire Council Social Work and Social Care governance framework.

1.4 This report describes West Dunbartonshire HSCPs arrangements for scrutiny of care quality, across the services which the HSCP provides, and those that it commissions. This report presents some of our key activities during the reporting period and describes how we are building capacity and capability for this work. A selection of activities and interventions are highlighted to demonstrate our strong focus on quality improvement, these are illustrative rather than comprehensive.

West Dunbartonshire Health and Social Care Partnership

2.1 West Dunbartonshire Health and Social Care Partnership (HSCP) was established on 1st July 2015 as the Integration Authority for West Dunbartonshire in response to the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

2.2 The Vision of West Dunbartonshire Health and Social Care Partnership is '*Improving lives with the people of West Dunbartonshire'* through achievement of our strategic outcomes.

2.3 West Dunbartonshire HSCP employs over 900 health, social work and social care staff. There is also a significant workforce in the independent NHS contractor service for example, GPs, Dentists, Optometrists, and Community Pharmacists and third sector and independent social care providers. West Dunbartonshire HSCP hosts Musculoskeletal Physiotherapy and Diabetic Retinopathy services on behalf of NHSGGC.

2.4 Between 2018 and 2028, the population of West Dunbartonshire is projected to decrease from 89,130 to 87,141. This is due to fewer babies being born each year and more people moving out of the area than moving in. 18% of the population are aged 0-15, and 9.7% of the population are aged 16-24. In terms of overall size, the 45 to 64 age group remains the largest at 25, 6646 (29%).People aged 65 and over make up 19% of West Dunbartonshire's population, which is similar to Scottish population.

2.5 West Dunbartonshire contains the third equal highest share of the most deprived data zones out of Scotland's 32 local authority areas. 22.6% of children live in low income families. Life expectancy is lower than the Scottish average with those living in the most deprived communities spending, on average, 24 years fewer in good health than those living in the least deprived areas. With those in the most deprived areas also dying younger, they spend more than one third of their lives in poor health. Healthy life expectancy has decreased in West Dunbartonshire to 58.1 years for males and 58.5 for females.

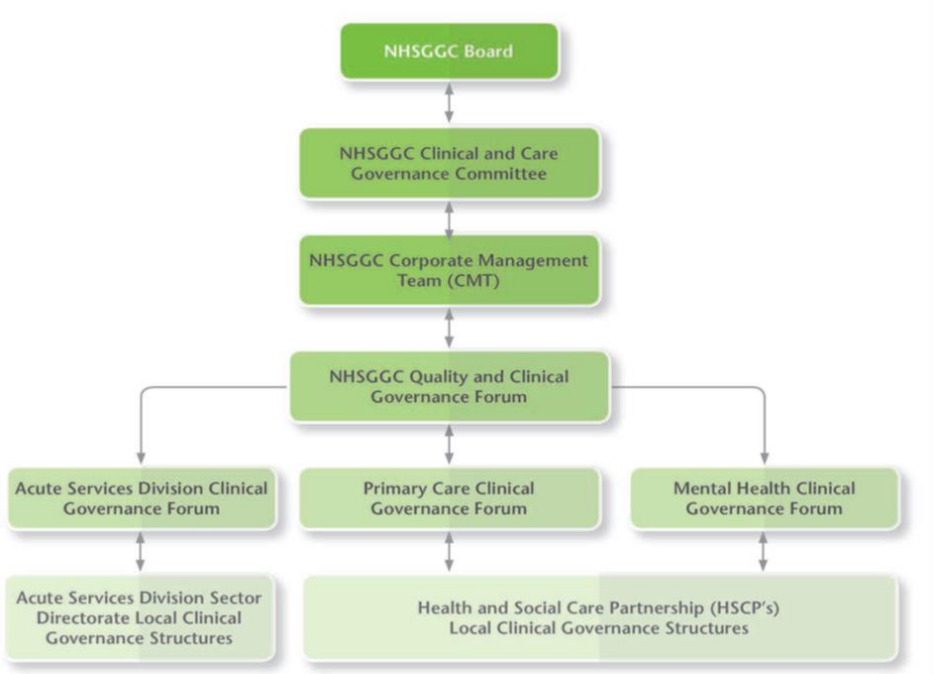
2.6 Delayed hospital discharges and high use of unscheduled care remain challenging. We need to promote a preventative agenda, support a shift in the balance of care from acute to community services, using a collaborative approach that ensures people have choice and control over the services they receive. Delivering the best possible outcomes for the people of West Dunbartonshire is contingent on, supporting our staff to deliver high quality care and, optimising the use of resources to deliver high quality community-based services, particularly for those with higher levels of need, while keeping more people safe at home. The wide range of improvement activity to support this endeavour is reflected throughout this report.

2.7 The Partnership continues to be challenged with funding pressures, staff shortages in certain areas, an ageing population and high demand for services. Budget Setting has highlighted the financial pressures the Partnership is facing. There is evidence that poor quality increases costs through harm, waste and variation. It is imperative therefore that we remain assured of our ability to deliver high quality care whilst overcoming financial constraints. The challenging fiscal environment we face across all of our public services is evident not only this year but in years to come making it vitally important that we continue to scrutinise and provide assurance on the quality of the care services we provide to ensure best value and optimum outcomes for service users and their families.

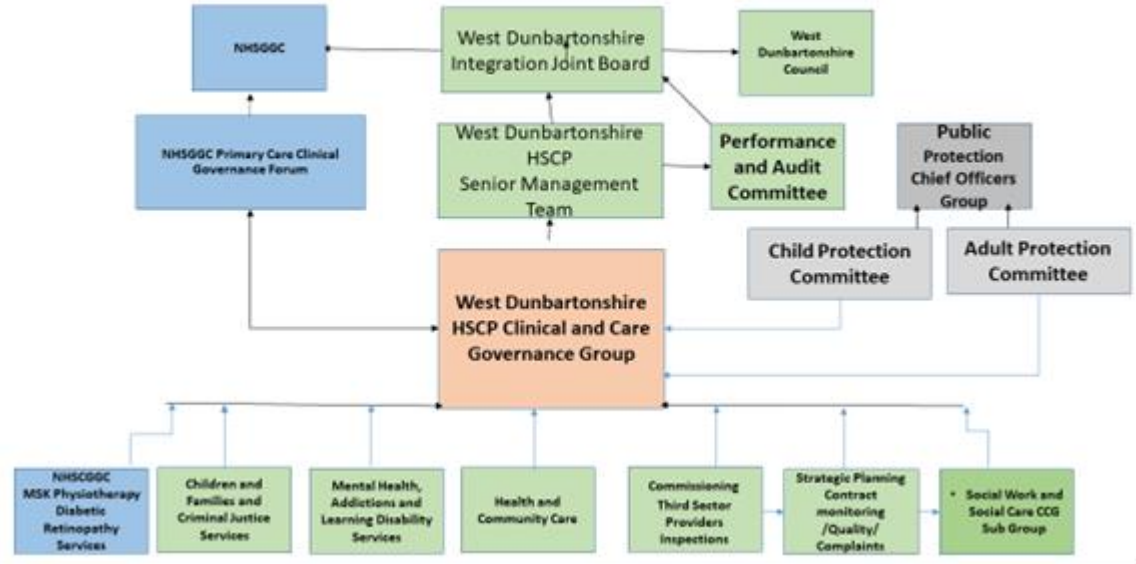
3. Clinical Governance Arrangements

- **Schematic of Clinical Governance Structure**

3.1 NHSGGC Corporate Level Clinical and Care Governance Arrangements



3.2 West Dunbartonshire HSCP Clinical and Care Governance Arrangements



- **Maintenance of Clinical Governance Arrangements**

3.3 West Dunbartonshire HSCP CCG meet quarterly to assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The group assess, monitor, mitigate and escalate risks as appropriate. A co-ordinated risk management system is implemented using risk registers, complaints, feedback and an adverse events/incident system, ensuring that this focuses on learning, assurance and improvement.

3.4 Heads of Service (HOS), Chief Nurse, Chief Social Work Officer, Clinical Director and Hosted services provide quarterly exception reports to the HSCP CCG setting out how they assess, monitor, and continuously improve the quality and safety of their services. Registered services delivered by the HSCP report via HOS. The CSWO Officer provides a quarterly exception report from the Social Work and Social Care Governance sub group. The Lead Optometrist for independent contractors within NHSGGC also reports via WDHSCP CCG. Externally commissioned registered services are monitored via the HSCP Contracts, Commissioning and Quality Team.

3.5 Care Inspectorate Reports for internal and external registered services are reported via Clinical and Care Governance Group and the IJB Audit and Performance Committee.

3.6 An Annual Clinical and Care Governance report is prepared for NHSGGC Health Board and West Dunbartonshire Integration Joint Board Audit and Performance Committee.

- **Remit of West Dunbartonshire HSCP Clinical Governance Group**

3.7

I. Consider matters relating to strategic plan development, governance, risk management, service user feedback, complaints, standards, care assurance, education, professional registration, validation, learning, continuous improvement and inspection activity.

II. Provide assurance to the Health & Social Care Partnership Board, the Council and NHSGGC, via the Chief Officer, that the professional standards of staff working in Integrated Services are maintained and that appropriate professional leadership is in place.

III. Review significant and adverse events and ensure learning is applied. Support staff in continuously improving the quality and safety of care. Ensure that service user / patient views on their health and care experiences are actively sought and listened to by services.

IV. Create a culture of quality improvement and ensure that this is embedded in the organisation by facilitating improvement activity including self-evaluation and clinical governance actions. Provide oversight and assurance regarding the quality and safety of care including public protection, inspections and contract monitoring.

V. The Clinical Director chairs the HSCP CCG group and the Chief Social Work Officer is Co- Chair. The membership includes the Chief Nurse, the Heads of Service from all HSCP services areas including hosted services and a representative form NHSGG&C Clinical Risk Department.

VI. There has been ongoing reflection on the purpose and direction of the group and the role of clinical and care governance, and promotion of the quality agenda within the Strategic Plan.

- **Clinical and Care Governance Work Plan**

3.8 The CCG work plan for 2024 (Appendix 1) demonstrates progress with the systemic developments to support capture and oversight of reportable incidents across social work and social care services. Development of Care-First system strengthened quality and performance reporting on Social work and Social Care services. Clear, robust, accurate and timely information on the quality of service performance has enhanced oversight and systematic monitoring, assessment and management of risk to care quality. Progress and preparation for the implementation of 'Care Opinion' to enables service users and carers / community to provide feedback on the service they receive is also evident. The 2025 work-plan priorities are detailed in Appendix 2.

- **How emerging concerns over the quality and safety of care or services are recognised and escalated**

3.9 Datix is the NHS Greater Glasgow & Clyde incident risk management and patient safety system used to capture clinical incident activity within health services delivered by West Dunbartonshire HSCP including Board Wide Musculoskeletal (MSK) Physiotherapy and Diabetic Retinal Screening Services (DRSS). The system is used to systematically identify and measures risks faced by the organisation with the focus on learning so that we might reduce or eliminate future risk.

3.10 All incidents are ascribed a severity score using NHSGGC risk matrix and severity impact assessment. Minor and negligible incidents may require to be investigated in addition to the review and approval process. This is at the discretion of the line manager who receives the report. If the severity is minor or low this does not mean that the incident can be ignored. These incidents represent small failures and vulnerabilities that may signal action to avoid repeat or escalation of a situation. The opportunity for learning exists at times without a significant adverse outcome for the patient, e.g. a near miss or a lower impact incident which exposes potential clinical system weaknesses that could lead to further significant harm.

3.11 Moderate rated incidents are reviewed by the Local Management Teams and action plans drawn up to eliminate or reduce the risk of recurrence. If the rating is a 4- Major, or 5- Extreme, there must be an investigation of causation. For all incidents severity graded 4 or 5 there is discussion and with the Clinical Risk Team, Clinical Director and Manager to determine whether the severity of the incident is such that it merits formal classification as a 'Significant Incident' requiring a Significant Adverse Event review. This is not necessarily the case for all category 4/5 incidents. Most category 4/5 incidents occur in mental health and addiction services. Incidents are rarely due to a single act or omission. Usually an incident occurs because of a combination of actions, events and the surrounding circumstances

3.12 From the full range of clinical incidents reported there is a smaller set of instances where there is a risk of significant harm to patients. We ensure these incidents are appropriately investigated to minimise the risk of recurrence by applying lessons

learned. These events are referred to as Significant Adverse Events (SAE). These are usually incidents that have been categorised as severity 4 or 5.

3.13 Work has been undertaken to strengthen the content of monthly data reports received by SMT to ensure these capture key performance metrics across the range of service areas strengthening our quality control mechanisms by ensuring that clear robust, accurate and timely information on the quality of service performance is effectively scrutinised and used to inform self- evaluation activity that informs improvement priorities supports continuous improvement in the quality of health and social care service planning and delivery.

3.14 The Clinical Director / Chief Nurse / CSWO complete an exception report four times per year to submit to NHSGGC Primary Care Clinical and Care Governance Forum (PCCCGF).

3.15 HSCP Services also report via NHSGGC board wide Mental Health, Learning Disability, and Specialist Children's Services Clinical and Care Governance Systems.

3.16 WD CCG exception report is scrutinised by the HSCP Senior Management Team as per local governance arrangements to ensure all pertinent matters are reported and emerging risks highlighted and escalated appropriately via NHSGGC Primary care clinical Governance Group. This informs completion and review of risk and informs the HSCP strategic risk register which is reviewed on a quarterly basis via the IJB Audit and Performance sub- committee.

3.17 Excellence in Care is a national approach which aims to ensure people have confidence they will receive a consistent standard of high-quality of care no matter where they receive treatment in NHS Scotland. West Dunbartonshire nursing teams undertake a planned programme of self-evaluation using a ratified combined care assurance assessment tools (CCAT). These report on core nursing and midwifery family specific quality indicators. The CCAT Care Assurance and Improvement tool allows staff to view and understand their data over time, respond appropriately and plan improvement. This ensures effective arrangements are in place to enable these health care professionals to be accountable for standards of care and services provided.

- **Compliance with Statutory Requirements and Duties**

3.18 Effective implementation of clinical and care governance for integrated health and social care services requires co-ordination across a range of services, including the third sector with the people we serve at the centre.

3.19 The Integration Joint Board and Senior Extended Management Team promote an organisational culture that promotes human rights and social justice, values partnership working and affirms the contribution of staff through the application of best practice.

3.20 West Dunbartonshire HSCP is committed to moving away from transactional based commissioning to a more outcomes focused collaborative commissioning underpinned by ethical commissioning standards. Standardising our approach to commissioning supports the future implementation of the Service Improvement and Quality Assurance

Frameworks in line with WD HSCPs strategic plan. Ensure that the rights, experience, expertise, interests and concerns of service users, carers and communities inform and are central to the planning,

3.21 Services aim to make sure everyone has access to vital support when they need it, regardless of their background, age, or circumstances. All proposals for service development / modification require and equality impact assessment to be undertaken.

3.22 The Health and Care (Staffing) (Scotland) Act (HCSSA) passed by the Scottish parliament in May 2019 came into force on the 1st April 2024.The legislation provides a statutory basis for the provision of appropriate staffing in health and care services, to enable safe and high quality care and improved outcomes for service users. NHS GGC Health Board has delegated healthcare functions to West Dunbartonshire Integration Authority and they must be included in all reporting. The HSCP was required to submit the first quarterly assurance report to the Health Board by April 2025. We are able to provide reasonable assurance with compliance levels with respect to the guiding principles and duties within the act across health services delivered by West Dunbartonshire HSCP. Actins to secure substantial assurance have been identified. Local authorities and integration authorities consider the requirements of the Act when they plan or secure care services, and report on this annually to the Scottish Ministers. Care reporting is scheduled annually with the first report required by the end of June 2025.

3.23 Staff are supported when they raise concerns in relation to practice that endangers the safety of service users and other wrong doing in line with local policies for whistleblowing and regulatory requirements.

3.24 There are established lines of communication and professional accountability from point of care to Executive Directors and Chief Professional Officers accountable for clinical and care governance. This includes strengthening the articulation of the mechanisms for taking account of professional advice.

3.25 Quality monitoring and governance arrangements are in place that include compliance with professional registration and codes of practice , legislation, standards, guidance and these are regularly open to scrutiny.

3.26 The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

- **Processes for Professional Support and Learning**

3.27 The Chief Social Work Officer has a core responsibility to provide professional oversight and leadership regarding the provision of social work services and to ensure that the social services workforce practices within the standards and codes of practice as set out by the Scottish Social Services Council (SSSC). This complementary activity is captured within the Chief Social Work Officers Annual Report which is shared with the Clinical and Care Group to provide assurance on statutory social work functions.

3.28 The Chief Nurse post is to lead, and promote systemic improvements in clinical care and Healthcare Quality to the nursing staff within the HSCP and foster a culture which values continuing professional development and strives for excellence in all aspects of the delivery of patient safety and care. The role provides professional and clinical leadership support to the HSCP, ensuring that a framework is in place to make certain all nursing staff are appropriately managed and are clinically and professionally developed to ensure they are, efficient, effective, engaged and highly motivated in line with the National Nursing and Midwifery Quality Assurance Framework and the NHS Greater Glasgow and Clyde Healthcare Quality Strategy.

3.29 The Clinical Directors are critical members of the team with a number of key roles including – Advisor to our Integrated Board, link between GPs and the HSCP providing an overview of the Primary Care improvement Plan. They provide clinical leadership and expertise to improve the quality and effectiveness of healthcare services within the partnership. They ensure that services align with national and local priorities, promoting good governance and working collaboratively to deliver high-quality care.

3.30 Practitioners have access to regular supervision as per their organisational policies. This is a formal process where qualified supervisors provide guidance, support, and development to health, social work and social care professionals, focusing on their l practice and skills. It's a relationship-based approach that facilitates reflection, learning, and improved care. Supervision helps new and experienced professionals, and it's a vital part of continuing professional development.

3.31 All staff undertake regular statutory training as mandated by law and their statutory bodies, and mandatory training determined by the organization or service commissioners based on risk assessments and policies. In addition all staff undertake Personal Development Planning and Review (PDP&R), a process that helps individuals develop their skills and potential by identifying their needs, setting goals, and taking action to achieve them. It involves regular conversations between individuals and their managers/reviewers to discuss progress, challenges, and future opportunities.

4. Safe Care
Safe: 'There will be no avoidable injury or harm to people from the care they receive, and an appropriate, clean and safe environment will be provided for the delivery of all services at all times'.

- **Incident Management, Reporting and Investigation**

4.1 Datix is the NHS Greater Glasgow & Clyde incident reporting system. 602 incidents were reported between January and December 2025. Clinical incidents were reported across 25 incident categories. The top 10 incident categories are shown in Table 2. The composition of these is similar to previous year report.

Table 1: Top 10 Incident Categories

Category	
Slips, Trips and Falls	**121**
Pressure Ulcer Care	**118**
Other Incidents	**111**
Medication - Prescribing	**66**
Violence and Aggression	**41**
Medication - Dispensing/Supply	**24**
Medication - Administration	**24**
Communication	**17**
Information Governance	**14**
Challenging Behaviour	**10**
Treatment Problem	**10**
Grand Total	**556**

4.2 Slips, trips and falls account for the highest recorded category (121). The majority of Slips, trips and falls occurred within Mental Health Services, 95.5% of Mental Health falls occurred in the Older Peoples Mental Health Service. The majority of the incidents were considered minor resulting in minor or no harm to the patient. One fall was commissioned as a Serious Adverse Event Review. Falls within inpatient areas is correlated to aggression within our inpatient settings, with some inpatients falling as a result of altercations with peers. The inpatient team have worked closely with the falls co-ordinator to review our current practices and implement appropriate measures to reduce the number of slips, trips and falls. All staff are up to date with their falls training and we are following best practice and policy. Teams are also reviewing how to improve management of aggression across inpatient wards and all patients have stress and distress care plans in place.

4.3 There were 118 Pressure Ulcer Care incidents reported during this period. Health and Community Care (District Nursing) Services recorded the highest number of pressure

ulcer incidents (115) and the majority of these incident were categorised as unavoidable. One incident progressed to a SAER.

4.4 Other Incidents was the third highest category, with 111 incidents occurring. Many 'other incidents' appear to be adult support and protection and sudden illness/deterioration or collapse. During 2024 West Dunbartonshire CCG were supported by NHSGGC Clinical Governance Support Unit to create packaged reports on Datix submitted in relation to adult and child protection to strengthen identification and oversight of these incidents.

4.5 The Diabetic Retinal Screening Service (DRS) reported 5 incidents. Including 3 slips trips and falls. The severity of these incidents were categorised as minor or negligible.

4.6 MSK Physiotherapy reported 51 incidents. 6 incidents involving communication, 6 information governance, 6 health records, 1 medication- administration, 1 security incident, 11 slips trips and falls, 1 suicide and 3 treatment problems. Datix are reviewed for themes on an ongoing basis. The slips, trips and falls were deemed unavoidable (many of these were incidents in the physiotherapy gyms which were supervised and unavoidable). The incident recorded "suicide" was suicidal thoughts and appropriate care was taken. There has been an ongoing theme around incorrect appointment letters being handed to patients with their return appointment details (i.e. letters relating to another patient). This is due to communal printers and staff have been reminded to check the patient name and CHI number before handing over the letter.

Incident Outcomes

4.7 When an incident is submitted, the reporter records the outcome. This is verified as a final outcome by the reviewer and approver. Table 2 displays the final outcomes of the 571 incidents which have been finally approved. 31 incidents were awaiting a final outcomes when the report was created.

Table 2: Incident Outcomes

Final Outcome	Grand Total
Minor Injury/Illness	284
No injury, harm or adverse outcome	142
Near miss	73
Not Recorded	31
Death	29
Unable to Assess Outcome	14
Moderate Injury/Illness	10
Disruption to services	9
Other	7
Ill Health	2
Blood products wasted	1

Grand Total	**602**

4.8 All incidents are ascribed a severity score using NHSGGC risk matrix and severity impact assessment. Minor and negligible incidents may require to be investigated in addition to the review and approval process. This is at the discretion of the line manager who receives the report. If the severity is minor or low this does not mean that the incident can be ignored. These incidents represent small failures and vulnerabilities that may signal action to avoid repeat or escalation of a situation. The opportunity for learning exists at times without a significant adverse outcome for the patient, e.g. a near miss or a lower impact incident which exposes potential clinical system weaknesses that could lead to further significant harm.

4.9 Moderate rated incidents are reviewed by the Local Management Teams and action plans drawn up to eliminate or reduce the risk of recurrence. If the rating is a 4- Major, or 5- Extreme, there must be an investigation of causation. For all incidents severity graded 4 or 5 there is discussion and with the Clinical Risk Team, Clinical Director and Manager to determine whether the severity of the incident is such that it merits formal classification as a 'Significant Incident' requiring a Significant Adverse Event review. This is not necessarily the case for all category 4/5 incidents. Most category 4/5 incidents occur in mental health and addiction services. Incidents are rarely due to a single act or omission. Usually an incident occurs because of a combination of actions, events and the surrounding circumstances.

- **Implementation of the Management of Significant Adverse Event Policy**

Significant Adverse Event Reviews (SAER)

4.10 From the full range of clinical incidents reported there is a smaller set of instances where there is a risk of significant harm to patients. We ensure these incidents are appropriately investigated to minimise the risk of recurrence by applying lessons learned. These events are referred to as Significant Adverse Events (SAE). These are usually incidents that have been categorised as severity 4 or 5. These may lead to a significant adverse event review (SAER).

4.11 The purpose of the review is to determine whether there are learning points or improvements for the service and wider organisation. It is then our responsibility to implement those improvements that are identified as producing a greater level of safety for those we care for.

4.12 Table 3. SAER Commissioned by Service Area January–December 2024

ID	Specialty	Incident date	Risk Commissioned Date	Risk SAE Status
827146	Children and Families	17/04/2024	20/06/2024	Under Review
837081	District Nursing	28/07/2024	29/08/2024	In QA
822334	Community Mental Health	07/03/2024	30/05/2024	In QA

809622	Older People's Mental Health	04/03/2024	03/05/2024	Under Review
830831	Crisis Team	08/07/2024	26/07/2024	Closed

4.13 Table 4: SAER Reviews concluded between January and December 2024.

ID	Specialty	Risk SAE - Closed	Investigation Timeframe Days	Outcome of investigation	Is this a Duty of Candour?
748646	Community Mental Health Team	09/02/2024	479	2. Issues identified but they did not contribute to the event	No
743769	District Nursing	24/01/2024	559	3. Issues identified which may have caused or contributed to the event	Yes
685415	Community Mental Health Team	04/10/2024	1060	2. Issues identified but they did not contribute to the event	No
740326	Community Mental Health Team	29/05/2024	546	2. Issues identified but they did not contribute to the event	No
753308	Community Mental Health Team	22/03/2024	395	2. Issues identified but they did not contribute to the event	No
748482	Older People's Mental Health	25/10/2024	712	3. Issues identified which may have caused or contributed to the event	Yes

Duty of Candour

4.14 Two of the closed SAERs met the threshold for organisational duty of candour. The first SAER revealed numerous contributory factors which resulted in an incident outcome of level 3. Contributory factors including failure/malfunction of equipment supplies, staff errors in judgement/knowledge/inadequate training, inadequate handover, guidance not being followed, failure to document risks and failure to escalate concerns appropriately. The learning led to a number of changes to daily practice, taking a person-centred approach. Additional training in moving and handling and stress and distress was provided for all staff and all documentation is now recorded in an electronic management information system (EMIS) meaning local variances have been removed.

The second incident related to sub optimal record keeping. The Review Team concluded, an avoidable pressure ulcer had occurred while Mr X was on the District Nurse caseload. There were however elements of good care demonstrated as evidenced from the notes written in the visit modules, where it is documented that pressure areas were reviewed and assessed on the first visit and pressure ulcer equipment was provided and contact with care at home servics to change visiting times to reduce time spent in bed. The cause of the incident is the lack of full assessments as per Pressure Ulcer Prevention policy. The SSKIN bundle is a care package designed to prevent pressure ulcers, also. It focuses on five key areas: Surface, Skin inspection, Keep moving, Incontinence/moisture, and Nutrition. By addressing these factors, healthcare professionals can reduce the risk of pressure

ulcers and improve patient outcomes. This had not been fully completed. There were some contributing factors identified including pateints non-compliance with ue of pressure relieving equipment, there were workload pressures which reduc ed availability of senior leadership available in the team. Since the incident further training has been created and delivered. A Red Day checklist tool to ensure all required documentation and processes has been completed, sample SSKINS careplans and record keeping update sessions. Staff have reflected on the incident are confident and competent in accurate grading of pressure ulcers, vigilant with their record keeping and attend all training opportunities offered to them to ensure safe effective care is provided at all times. The review team concluded this incident as a level 3 meaning the Issues identified which may have caused or contributed to the event.

- **Clinical Governance Key Performance Indicators (KPI)**

4.15 NHSGGC Management of Significant Adverse Events Policy highlights that SAE Reviews should be commissioned within 10 working days of an incident occurring (or being made aware of it); and that SAE Reviews should aim be concluded within 90 working days, with a further 40 working days to carry out Quality Assurance. None of the SAERs were completed within the policy timeframe and the average closing time was 625 days. Of the 5 incidents commissioned during this period none were commissioned within the mandated 10 working days and the average opening time was 51 days. This will be an area for focussed improvement in 2025.

Public Protection

4.16 Ensuring safe care includes meeting the needs of the most vulnerable people in communities are being met. Through the wider Public Protection agenda, the Health and Social Care Partnership work to ensure that people, particularly those at risk, are kept safe from harm and risks to individuals and groups are identified and managed appropriately. The Public Protection Chief Officers Group (PPCOG) holds responsibility for strategic leadership, scrutiny, and accountability in respect of public protection services. This incorporates a range of measures including multi-agency strategic planning and operational services providing protections to children, young people and adults at risk, with management of high risk offenders through Multi Agency Public Protection arrangements (MAPPA), Alcohol and Drugs Partnership, Violence Against Women Group, and Community Safety also make significant contributions.

4.17 PPCOG continue to strengthen their assurance and risk management processes. This includes quarterly review of multiagency, operational and strategic risk registers. The PPCOG Performance and Assurance Reporting Framework data set continues to be strengthened and developed.

4.18 NHS GGC Public Protection Unit developed a Public Protection Strategy and Quality Assurance Framework during 2023. Implementation supports enhanced oversight of corporate and local HSCP monitoring of compliance with standards and implementation of the associated action plan.

Learning Reviews

4.19 A Learning Review is multi-agency, bringing practitioners together with the review team in a structured process in order to reflect, increase understanding and identify key learning. They provide a means for public bodies and office holders with responsibilities relating to the protection of adults and children at risk of harm to learn lessons by considering the circumstances where an adult or child at risk has died or been significantly harmed. They are carried out by the Adult / Child Protection Committees under their functions of keeping procedures and practices under review, giving information and advice to public bodies and helping or encouraging improvement.

4.20 During 2024 West Dunbartonshire Adult Protection Committee commissioned two and concluded three learning reviews. West Dunbartonshire Child Protection Committee commissioned two Child Learning review and concluded two.

4.21 All Learning Reviews have associated improvement plans the progress of which is overseen by the West Dunbartonshire Adult / Child protection Committee.

5. Effective care; care at the right time, right place by right person and no unnecessary variance in quality of care and outcomes for service users'.

5.1 The Health and Social Care Standards (*2018)* set out what individuals can expect when using health, social work or social care services in Scotland. They aim to ensure better outcomes for everyone, that people are treated with respect and dignity, and that basic human rights are upheld. The Care Inspectorate, Health Improvement Scotland and other scrutiny bodies all take cognisance of these standards in relation to their work around inspection and registration of health and care services.

- **Improvement Work and Programmes**

5.2 A range of improvement activity was undertaken during 2024. Some examples of local partnership led improvement are included below.

Older Peoples Care Homes

5.3 West Dunbartonshire Local authority Care homes gained A Bronze sustainable catering award. The Food for Life Scotland (FFLS) programme, provides a framework through which local authorities and public sector sites can ensure they are serving good food. This is done by meeting a set of standards to achieve the FFLSH certification at Bronze, Silver or Gold level. Care home caterers in West Dunbartonshire have achieved a national award for serving fresh and sustainable menus, in a first for public sector food in Scotland.

West Dunbartonshire HSCP caterers at Crosslet House in Dumbarton and Queens Quay House in Clydebank gained the Food for Life Served Here (FFLSH) Bronze

award, for serving food that's good for health, the environment and the local economy. These sites serve more than 50,000 meals each year.

West Dunbartonshire HSCP Collaborative Care Home Support Team (CCHST)

5.4 Maintaining high quality care in Care Homes remains a key priority within the partnership. The care home sector continues to face challenges in terms of recruitment and retention of staff and commercial viability. Continued enhanced support for adult and older people's care homes mitigates these risks and ongoing support for improvement will continue to be delivered in line with available HSCP and NHSGGC Care Home Collaborative resources.

5.5 West Dunbartonshire HSCP Collaborative Care Home Support Team (CCHST) continues to work in collaboration with care homes, to focus on improvement, sustainability and viability. This ensures that local assurance and support arrangements link effectively with, rather than duplicate, wider regulation activity by the Care Inspectorate.

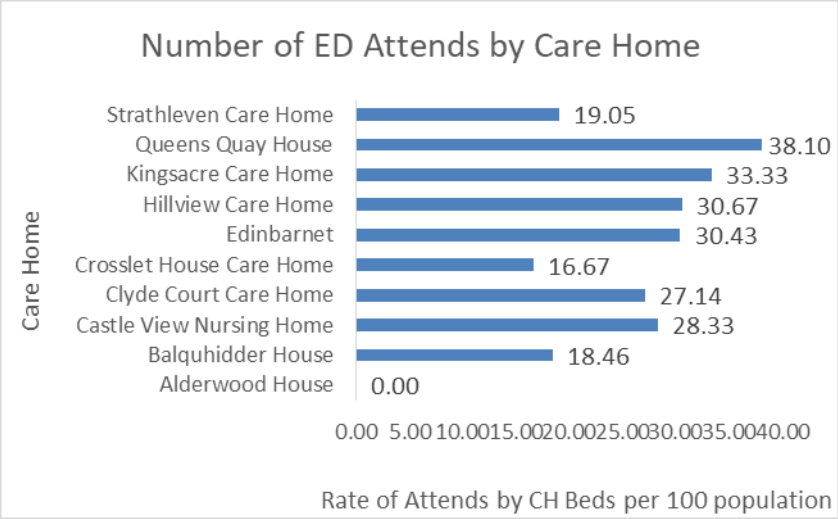
5.6 Care assurance visits are one part of the supportive framework around care homes and sit alongside HSCP commissioning relationships with individual care homes, review arrangements, and daily care home huddle reports via TURAS. These arrangements link effectively with, rather than seek to duplicate, wider regulation activity by the Care Inspectorate. The Care Assurance [CHAT] visits focus on four key themes. Theme 1 - Infection Prevention Control, Theme 2 – Resident Health Care Needs, Theme 3 – Workforce Leadership and Culture, Theme 4- Action Planning for Assurance.

Unscheduled Care - Emergency Department Attendance from Care Homes

5.7 NHSGG created a dashboard for care homes that aligns with Call before You Convey (CB4YC) activity so that efforts to understand and prevent avoidable conveyancing of residents to hospital emergency departments might be targeted.

5.8 West Dunbartonshire Care Homes had 180 attends and 97 admissions May – August 2024 a 54% conversion rate across our care homes. When this is converted to a rate per 100 beds West Dunbartonshire had no care homes in the top 20 for emergency attendances however, neither did we have any care homes in the bottom 20.

Figure 1: Rate of Emergency Department Attendances By care Home per 100 Population



5.9 There have been a number of improvement activities aimed at reducing unnecessary conveyancing and admission avoidance to date. These include,

I. Call Before You Convey aims to increase support to Care Homes to avoid unnecessary conveyances to hospital for care home residents. By providing better support Care Home residents and staff in caring for residents during a period of illness, injury or deterioration it is possible to avoid and reduce unnecessary conveyances to hospital, and inappropriate referrals to primary and secondary care, maintaining person in their home where safe to do so. This support was extended to all Care Homes in West Dunbartonshire from November 2024. A Pre-Weekend Ward Round was introduced allowing Care Homes to identify and refer anyone they felt was unwell and at risk of potential conveyance to hospital without review or intervention. The Care Home Liaison Nurse (CHLN) schedules a review to provide support and interventions aimed at maintaining the person safely in care home setting.

II. Chronic Obstructive Pulmonary Disease (COPD) review and Rescue Medication

III. District Nurse Test of Change – weekend prescribing Urinary Tract Infection (UTI), Upper respiratory Tract Infection (URTI), Cellulitis,

IV. End of Life (EOL) Care enhanced advice and support via District Nursing and CHLN.

5.10 Creation of the Care Home Dashboard will enable us to track the impact of this planned activity to reduce unnecessary conveyancing from care homes over time in order to assess the impact of these activities and focus future improvement activity.

- **Use of Clinical Quality and Clinical and Care Outcome measures**

<u>External Scrutiny - Care Inspectorate Inspection West Dunbartonshire Care Homes</u>

5.11 The Care Inspectorate is responsible for inspecting standards of care in Scotland. They use a quality framework that sets out key elements to help answer key questions about the difference care is making to people, and the quality and effectiveness of the things that contribute to that. The primary purpose of a quality framework is to support

services to self-evaluate their own performance. The same framework is then used by inspectors to provide independent assurance about the quality of care and support.

5.12 The Care Inspectorate now use Key Questions rather than Quality Themes in their inspections. Key Questions:-

KQ1 – How well we do we support people's wellbeing;

KQ2 – How good is our Leadership;

KQ3 – How good is our staff team;

KQ4 – How good is our setting;

KQ5 – How well is our care and support plan

KQ6 – Capacity for improvement

The Care Inspectorate use a six point scale: 1 – Unsatisfactory, 2 – Weak, 3 – Adequate, 4- Good, 5- Very Good, to 6 – Excellent against each quality indicator.

Table 5: Care Inspectorate Inspections - Grades Awarded 2024 [or most recent inspection]

Care Home	Date of Inspection	Inspection Grades					No of Requirements A = Achieved E = Extended O= Ongoing	No of Areas for Improvement	Grades Relative to previous Inspection
		KQ 1	KQ 2	KQ 3	KQ 4	KQ 5			
Alderwood	23.01.24	3	3	3	3	3	8 = A	2	↑
Balquhidder	07.06.22	3	3	5	N/A	N/A	0	5	↓
Castle View	21.09.23	4	4	4	N/A	4	0	2	↑
Clyde Court	30.09.24	3	3	3	4	4	1 = O	4	↔
Crosslet	18.12.23	5	5	N/A	N/A	N/A	0	4	↔
Dunn St - Respite	03.10.22	5	5	5	N/A	N/A	0	0	↑
Edinbarnet	17.10.24	4	4	5	4	4	0	10	↔

Hill View	23.10.24	2	2	2	2	2	1 = O	0	
Kingsacre	04.10.24 &20.12.24	4	5	4	4	4	1 = A	3	
Queens Quay	19.12.24	4	N/A	4	N/A	3	1 = O	3	
Strathleven	10.10.24	5	5	5	4	4	0	0	

5.13 The Care Inspectorate uses requirements and recommendations to help regulated care services improve. A requirement is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Public Services Reform (Scotland) Act 2010 regulations or orders made under the Act, or a condition of registration. Requirements are enforceable in law. A recommendation is a statement that sets out actions that a care service provider should take to improve or develop the quality of the service, but where failure to do so would not directly result in enforcement.

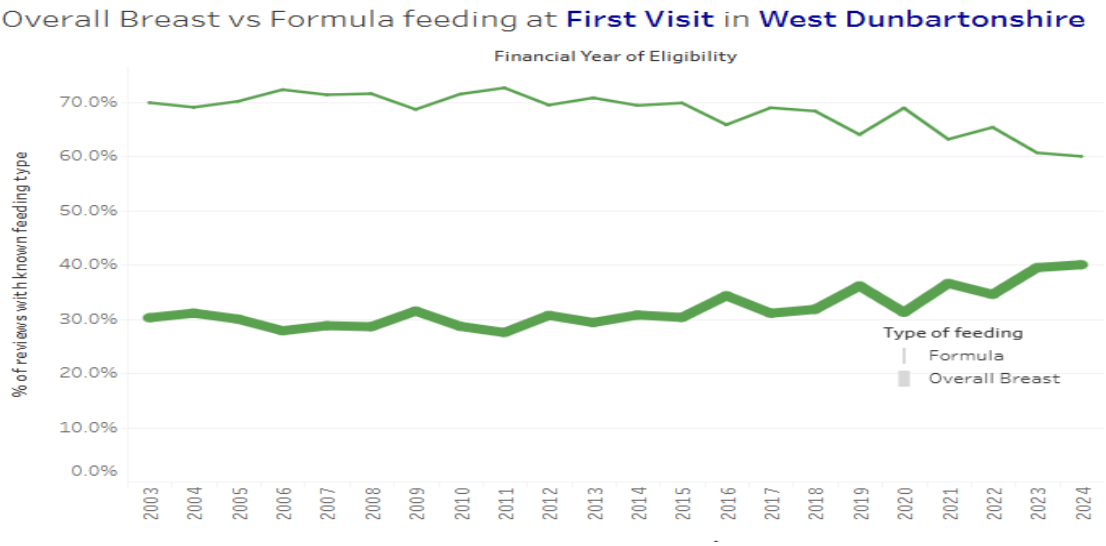
5.14 The HSCP placed a Moratorium on admissions in three care homes during 2024 due to care quality concerns. This was designed to support care homes and enable them to focus on achieving required improvements in care quality.

Children and Families - Health Visiting

5.15 Breast Feeding gives babies the best start in life reducing risks from infection, Sudden Unexpected Deaths in Infancy (SUDI), obesity and can support attachment. West Dunbartonshire is proactive in promoting, protecting and supporting breastfeeding having maintained UNICEF Gold accreditation since 2018. The Unicef Baby Friendly Gold award is the highest level of accreditation and celebrates excellent and sustained practice in the support of infant feeding and parent-infant relationships.

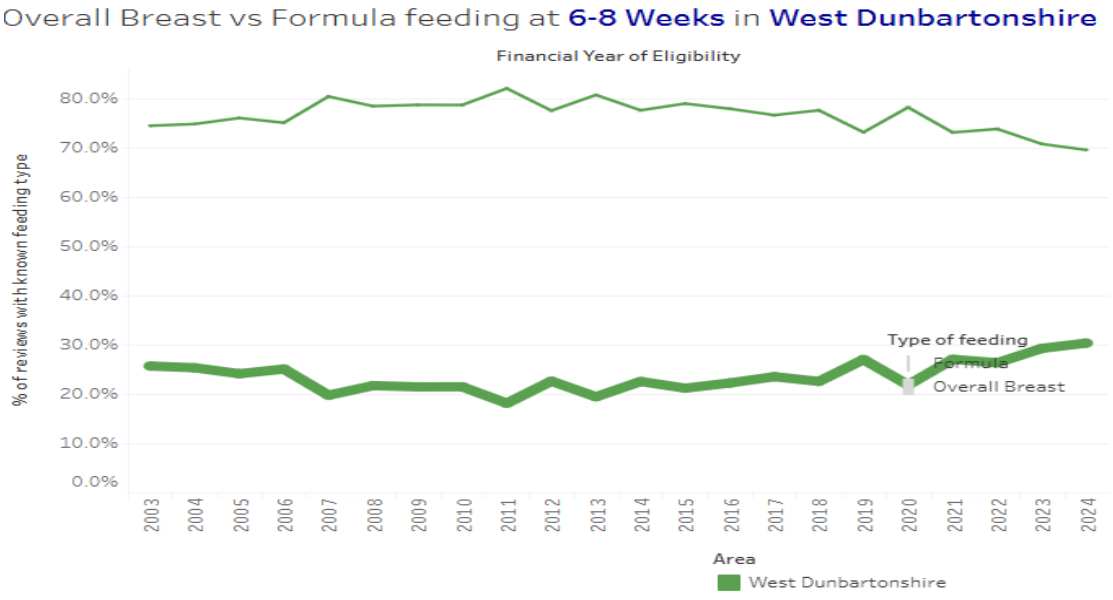
5.16 Figure 2 demonstrates the decline in bottle feeding and increase in breast feeding between 2018- 2024.

Figure 2:



5.17 Figure 3 shows that at 6-8 weeks while marginally fewer mothers are exclusively breast feeding, than 2022/23 more are offering some breast milk - with the proportion recorded as mixed increasing. We are seeing an increase in the proportion of babies who are receiving breastmilk at 6-8 weeks but a reduction in the proportion who breastfed exclusively at this point.

Figure 3



Family Nurse Partnership

5.18 Family Nurse Partnership (FNP) is a preventive licensed voluntary programme for first time mothers aged 19 years and under and currently Care Experienced first-time mothers aged up to 22 years. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two years old. It is an intensive, structured intervention for young first-time mothers and their children to enhance parenting capacity and achieve the 3 programme outcomes to improve pregnancy and birth outcomes, through improved prenatal health behaviours, child health and development, through positive, responsive caregiving and the economic stability of the family, through developing their vision and realising their plans for their future. The programme aims to modify behavioural risk and enhance protective factors through intensive home visiting using a strengths-based approach, through motivational interviewing and specialised interventions.

5.19 The Scottish Government's Vision for the Family Nurse Partnership programme in Scotland is for it to become a universal service available to all eligible young women aged 21 years and under, and all care experienced pregnant women aged 25 years and under at LMP regardless of where they live. Recruitment pathway improvement activity has been successful with notifications mainly from maternity services. To date there have been 215 clients enrolled in programme in West Dunbartonshire. High engagement rate of entitled clients = 82% and very low attrition disengaged = 3%. 83% of clients from most deprived quintiles so the service is reaching the clients with most need .as shown in Table 12.

Table 6

	West Dun Locality Data* ≤ 19yrs	All of GGC FNP Data ≤ 19yrs *	West Dun Locality Data* ≤ 20yrs Care Experienced Data	All of GGC* ≤ 20yrs Care Experienced Data
No. of Notifications to FNP	312	2775	3	23
No. of Clients Enrolled on FNP	213	1876	2	14
Average Age @ Enrolment	18	18	22	20
Age Range of Clients	15-19	12-22	20-22	20-22
SIMD Q1 & Q2	258	2215	3	12
Attrition – disengaged clients only	6	75	0	0
Total Number of Births	191	1750	0	6
Graduated Clients	119	1041	0	0

All figures shown are based on the new concurrent model since the expansion of FNP GG&C from September 2017 to 31st Dec 2024

Mental Health Services

5.20 In June 2024 The Mental Welfare Commission required the service to strengthen its statutory requirement to supervise private Guardians in line with the prescribed timescales. There were a number of outstanding reviews and existing processes were adapted to address this. Procedures were altered so that Mental Health Officers now complete the initial three month supervision visit. Fortnightly Guardianship Governance meetings have been established to review progress and strengthen CareFirst recording to support regular reporting via the data reports developed. The HSCP Adults with Incapacity (AWI) procedures and guidance have been updated and an online AWI resource page on the intranet is under development. Information that is shared with prospective Guardianship applicants has been standardised so that consistent and up to date information is given. This includes the use of QR codes and other digital means of access.

5.21 In Scotland, a Social Circumstances Report (SCR) is a document prepared by a Mental Health Officer (MHO) within 21 days of a person being detained under a Short Term Detention Certificate (STDC), or under other specified circumstances. The SCR provides details of the individual's circumstances leading to detention and aims to reflect their views on their detention. It's a crucial document for monitoring the use of compulsory powers under the Mental Health (Care and Treatment) (Scotland) Act 2003. The Team have made significant improvements have been made in this area via a review of the entire process for prompting and documenting the completion of SCRs. CareFirst activities are now used by all MHOs on a proactive basis to prompt the completion of an SCR following a relevant event. The MHO and Senior Management Team receive monthly reports on the completion of SCRs (as well as all other areas of MHO practice) and the data around this is used as a basis for discussions in team meetings and individual supervision sessions where necessary and to evidence improvement as shown below Table 7 .

Table 7: Improvement in Completion Social Circumstance Reviews

	STDC	SCR	SCR1 No report	Missing
2022-23		**25%**	**25%**	**50%**
2023-24		**28%**	**45%**	**27%**
2024 -25	**91**	**48%**	**34%**	**18%**

Alcohol and Drug Recovery Service (ADRS)

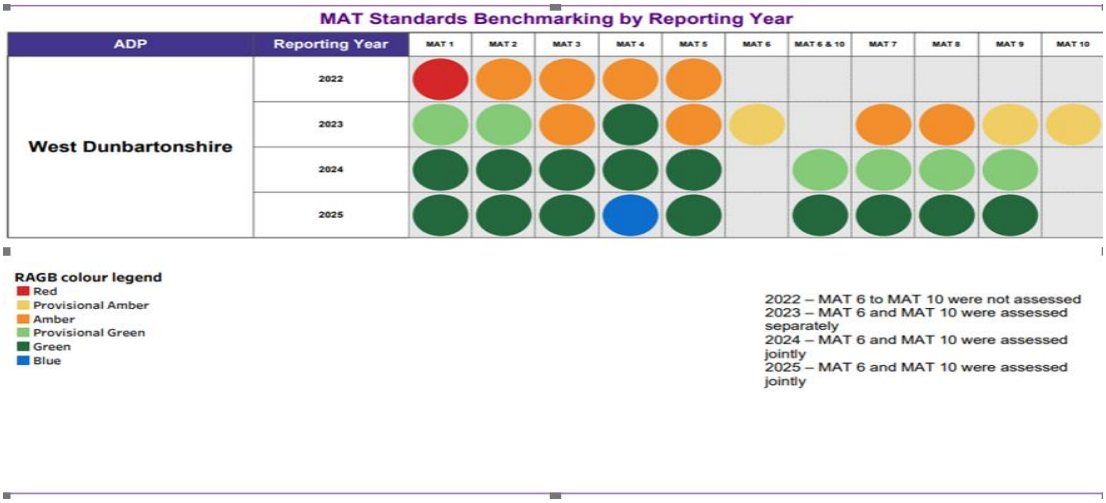
5.22 Medication Assisted Treatment Standards (MAT) were introduced in 2021 and came into force in 2022 to improve access, choice and support for those affected by drug related harms. Through effective implementation of these standards each year we can evidence that West Dunbartonshire is supporting individuals, families and communities to reduce drug harms and drug deaths. A key priority is to ensure people receive high quality treatment and care. An experiential programme was introduced alongside the implementation of the MAT Standards as a qualitative measure designed to explore how people accessing services evaluate their experience. This measure and approach was designed by lived and living experienced individuals alongside family members. The programme was to ensure that the MAT Standards were meeting the aims and objectives of those they were designed to help.

5.23 It has been evidenced that those who enter into a program of substitute prescribing have increased chances of better health outcomes. That is why this critical intervention helps to support people through problematic drug use.

5.24 Each year the MAT Implementation Support Team (MIST) sends out the benching marking report from the evidence that has been submitted through numerical data and process documentation. Once they have received this information they can then score each of the standards accordingly producing a RAG rating. The objective for all the standards is to achieve a green status and as you can see from the table below in West Dunbartonshire we have progressed each year, obtaining full implementation for 2024/25, demonstrating our commitment to delivering the highest standard in

treatment and care to all service users. MAT standards 6 and 10 are submitted to NHS Greater and Clyde and omitted from the table however, full implementation was achieved. Through each standard we incorporate a holistic approach that covers all services and organisations that are responsible for the delivery of care in a Recovery Orientated System.

Table 8: MAT Standards benchmarking by Reporting Year



*Blue - (sustained implementation) because this standard has been Green for the previous 2 consecutive years

5.25 In support of MAT Standard 9, improving joint working with ADRS and Mental health services, several steps have been taken to improve working and to improve overall mental health support available to patients of ADRS, addressing the divide identified by Mental Welfare Commissions report – Ending the exclusion. We know the impact of trauma, often leads to poor mental health and addiction. However, for the first time, we are now seeing the benefits of joint working with our patients, giving them the appropriate support to address mental health needs and reduce dependency at the same time. Having introduced this change to clinical practice we anticipate a reduction in relapse and self-harm and suicide among our patient group.

Children and Families Health Visiting – Delivery of the Universal Pathway

5.26 The Health Visitor service contributes to positive health and wellbeing outcomes for pre-school children and their families. Those outcomes are however also impacted by a myriad of other factors and it is challenging to definitively and confidently measure the specific impact of the health visiting service. The Universal Health Visiting Pathway places importance on health visitors providing support in the home. It is a key delivery mechanism for early prevention, identification and intervention. The programme provides a core home visiting programme delivered by Health Visitors. This consists of 11 home visits offered to all families; 8 within the first year of life and three further Child Health Reviews (13-15 months; 27-30 months; 4-5 years) involving formal assessment of the child's developmental progress.

5.27 Table 10 displays the % of eligible children who received each universal pathway contact and of these the % who received the visit on time. The Pathway is a key component in reducing early developmental concerns as contact with the child and family in the home supports the identification of needs and focuses on early

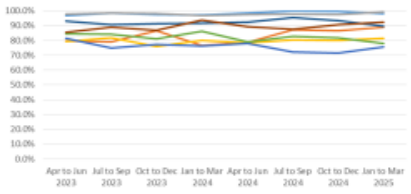
intervention and prevention. There are however opportunities to measure the full and consistent delivery of the UHVP. This can provide an indication of the extent to which pre-school children and their families are receiving support from a Health Visitor and potentially having their outcomes positively influenced as result.

Table 9: Percentage of Eligible Children Receiving universal Pathway Visits

West Duns trend - % Completed & % On time

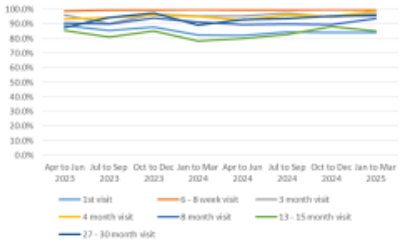
% Completion

Visit	Apr to Jun 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	Apr to Jun 2024	Jul to Sep 2024	Oct to Dec 2024	Jan to Mar 2025	Total
1st visit	96.8%	98.6%	97.6%	97.0%	98.6%	100.0%	99.5%	98.1%	98.3%
3 - 5 week visit	79.7%	78.9%	86.7%	76.5%	78.7%	87.1%	86.7%	89.1%	82.8%
6 - 8 week visit	97.9%	98.6%	98.1%	96.9%	97.3%	97.9%	97.3%	99.0%	97.9%
3 month visit	79.5%	81.9%	75.8%	79.9%	78.2%	80.3%	80.0%	81.4%	79.6%
4 month visit	81.5%	75.0%	77.4%	76.4%	78.0%	72.2%	71.6%	75.5%	75.9%
8 month visit	84.5%	84.2%	81.0%	86.2%	79.0%	82.8%	81.8%	78.0%	82.2%
13 - 15 month visit	93.1%	90.6%	91.3%	91.7%	92.2%	95.3%	93.4%	89.7%	92.2%
27 - 30 month visit	85.4%	88.9%	86.8%	93.9%	89.4%	87.5%	90.7%	92.4%	89.4%
4 - 5 year visit	90.4%	90.4%	91.8%	89.6%	75.5%	62.9%	50.6%	34.2%	73.7%



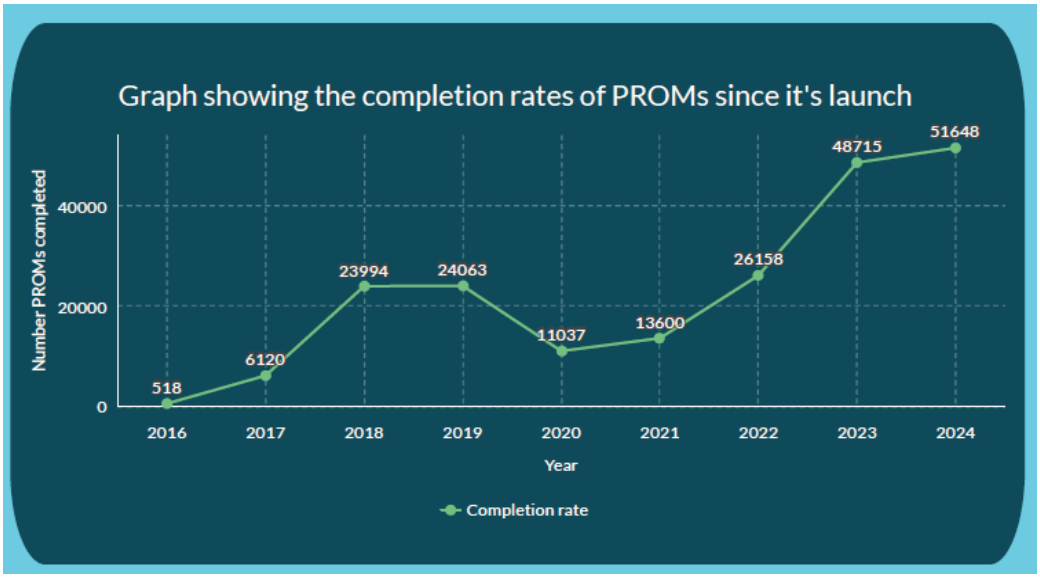
% On time

Visit	Apr to Jun 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	Apr to Jun 2024	Jul to Sep 2024	Oct to Dec 2024	Jan to Mar 2025	Total
1st visit	88.9%	85.4%	87.8%	82.6%	82.1%	84.6%	84.3%	84.1%	85.0%
6 - 8 week visit	98.9%	99.5%	99.5%	100.0%	99.4%	99.5%	100.0%	99.5%	99.5%
3 month visit	96.1%	90.3%	96.9%	95.6%	95.4%	97.5%	94.7%	97.0%	96.4%
4 month visit	93.3%	94.6%	96.0%	95.2%	92.8%	96.2%	95.0%	98.7%	95.2%
8 month visit	90.6%	90.0%	94.0%	91.4%	89.8%	89.9%	89.5%	93.8%	91.1%
13 - 15 month visit	85.7%	81.1%	85.0%	78.3%	79.9%	83.0%	88.3%	85.3%	83.3%
27 - 30 month visit	87.6%	94.4%	97.7%	89.1%	93.1%	93.7%	95.4%	95.6%	93.1%
4 - 5 year visit	79.6%	78.2%	94.5%	97.7%	93.1%	100.0%	100.0%	100.0%	91.4%

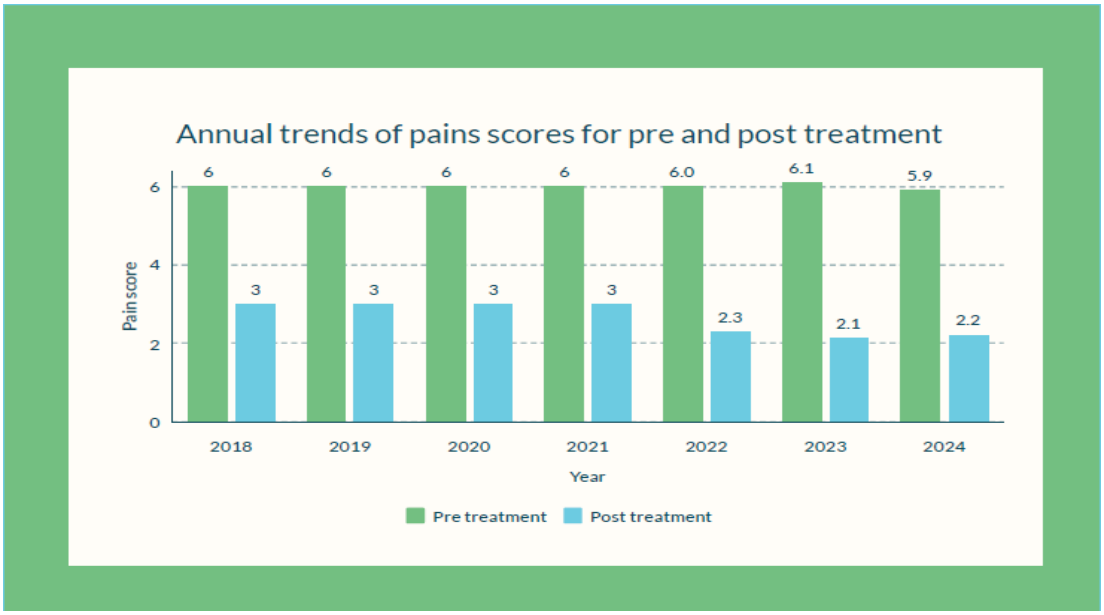


NHSGGC Musculoskeletal (MSK) Physiotherapy

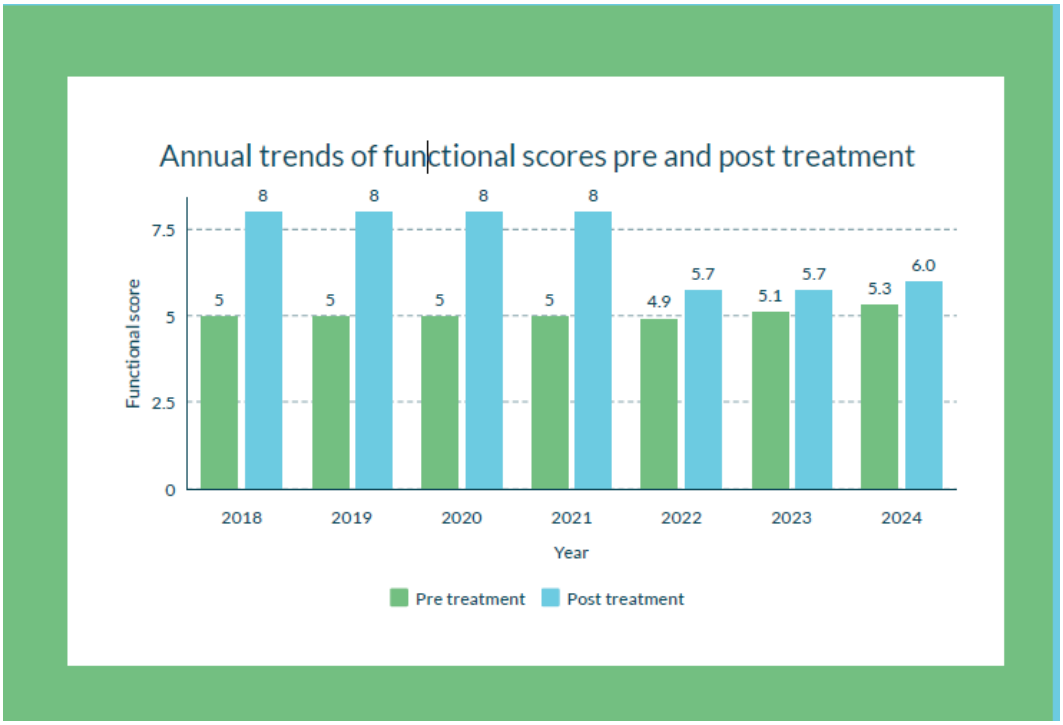
5.28 NHSGGC GGC MSK Physiotherapy Service continues to measure and achieve Impressive results with the patient recorded outcome measures (PROMs). The MSK staff have again increased the number of completed PROMs from 2023 into 2024-25 as shown in Figure 4 below.



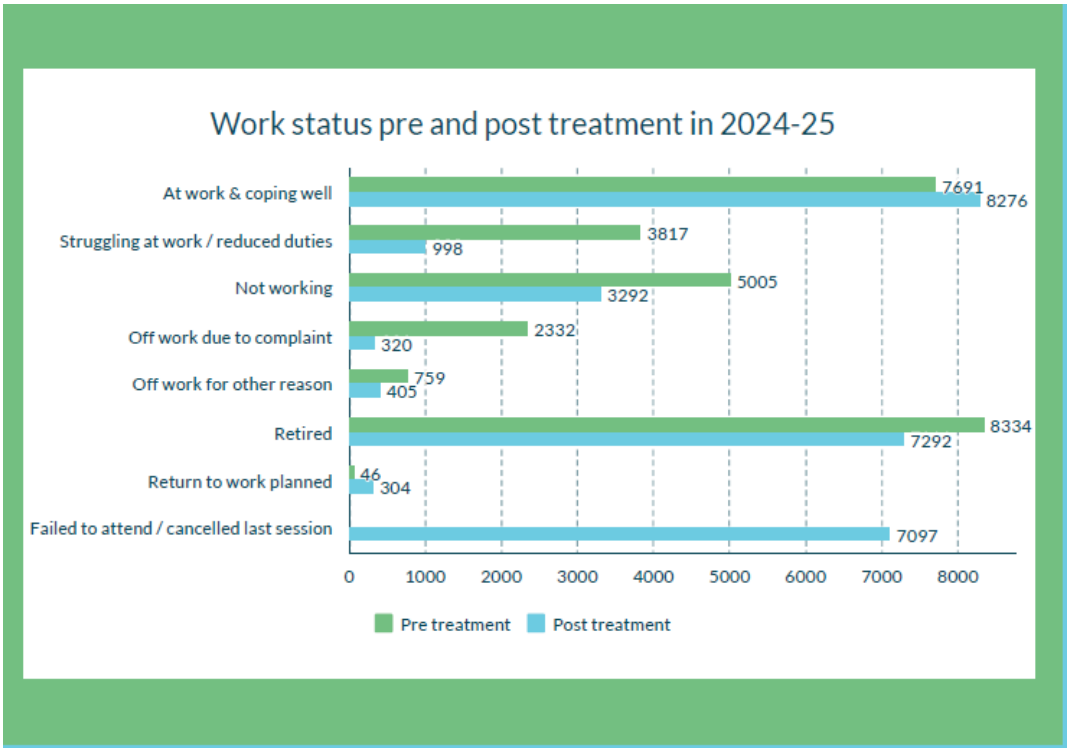
5.29 Figure 5 shows the paired pain scores collected have remained consistent since 2022 (when we saw a positive change in the data).



5.30 Figure 6 shows the consistent improvement with the paired functional scores



5.31 Figure 7 demonstrates year on year positive trends in improving work status



Health and Community Care – District Nursing Services

5.32 The majority of people would prefer to die at home. Honouring preferences is critical for the delivery of high-quality care. As a crucial starting point to enhance strategies to align care with patient and family preferences Excellence in Care
Indicators for Palliative and End of Life Care (PEOLC) have been set nationally; these are specific to people who have received District Nursing care in the last month of their life and who had an identified PEOLC need. The national target for the following aims is:

60% of people who had their preferred place of death (PPD) recorded

60% of those people with a PPD who achieved their preferred place of death (PPA)

5.33 NHSGGC HSCPs have set a more ambitious target of HSCP PPD – target: 85% by March 2025.

Table 10: Preferred place of Death Recorded

HSCP	January 2025		February 2025		March 2025	
West Dunbartonshire	95%	n =21	100%	n=22	100%	n=22

Table 11: Preferred Place of death Achieved

HSCP	January 2025		February 2025		March 2025	
West Dunbartonshire	86%	n =21	86%	n =22	94%	n =18

Primary Care

5.34 As implementation of the Primary Care Improvement Plan progress the benefits of the multidisciplinary (MDT approach mean that some presentations can be assessed, reviewed or treated efficiently and effectively by a more appropriate professional. This allows General Practitioners' time to focus on more complex presentations.

5.35 The expansion of the MDT (Vaccination Transformation Programme, Pharmacy Team, Advanced Nurse Practitioners, Advanced Physiotherapists, Community Link Workers and Wellbeing Nurses) all contribute to additional capacity in primary care services. The traditional receptionist role has evolved. They support people to get the right care from the right professional at the right time.

5.36 A significant piece of work carried out by GP practices and the Prescribing team with regard to de-prescribing of Lidocaine patches which was identified by the Health Board as a prescribing saving, due to cost and the recognition that this is a drug of Low Clinical Value. The work carried out has resulted in significant reductions in lidocaine prescribing exceeding savings targets (219%) without a significant increase in prescribing of alternative pain medication.

5.37 GP Clusters continue to work with Practice Quality Leads from each practice attending one of the 3 GP Clusters within West Dunbartonshire. Support is provided by GGC Quality Improvement Team and LIST analysts. Projects are agreed within clusters based on local population and health care needs. Some of the projects worked on in 2024-25 include:

- COPD and provision of rescue medications
- Late stage cancer diagnoses in particular lung cancer
- Improving access to Long Acting Reversible Contraception by increased training for insertion of Intrauterine devices
- Medication safety audits
- Veteran health care
- Modernising General Practice by increased use of IT

Diabetic Retinal Screening

5.38 Of the 70,897 eligible individuals, 57,982 (81.4%) were screened during 2024, exceeding the 80% uptake target. Improvements in workflow management resulted in reduced waiting times at Level 3 Grading from 54 days on 3rd January 2024 to 22 days on 10th December 2024.

5.39 The Autumn 2024 External Quality Assurance Report showed Greater Glasgow and Clyde's Level 1 & 2 graders achieved an average Sensitivity of 95.6% and Specificity of 95.9%, both well in excess of the requisite 80% target. Sensitivity refers to the test's ability to correctly identify individuals with the disease. Measures the proportion of individuals with the disease who are correctly identified as positive by the test.
A high sensitivity means that the test is good at detecting the disease and minimizing false negatives. Specificity refers to the test's ability to correctly identify individuals without the disease. Measures the proportion of individuals without the disease who are correctly identified as negative by the test. A high specificity means that the test is good at correctly identifying healthy individuals and minimizing false positives.

5.40 In response to an internal 2023/24 Public Health audit's recommendations all local polices were reviewed, revised and authorised by the steering group with clearly documented failsafe mechanisms highlighted. New policies and screening pathways were introduced to ensure appropriate management and outcomes for diabetic patients being prescribed new treatment options (GLP-1 Analog and Hybrid Closed Loop Therapy) which can exacerbate pre-existing diabetic retinopathy in the short term.

6. Person Centred Care : 'compassion, continuity, communication, co-production and shared decision making'

- **Systems and processes in place to gather patient experience and feedback**

6.1 An NHSGGC board standard is being developed for Person Centred Care which will likely have an impact on how we measure this area of work in 2025. Each Nursing family have a work plan on person centred care planning outlining their work intentions and progress for this agenda forward. Each nursing family use a different system for recording so while care planning may look different in format, they will work to the same principles for recording their person centred features of care.

Future Care Planning

6.2 Future care planning is about thinking and planning ahead for people at any age or stage of their life. It is particularly helpful when someone has one or more health conditions or disabilities that mean their health will change, is living with a serious illness, or is getting older and less well. Future care planning conversations include 'What matters to you?' and shared decision making about available options for care and treatments. A person-led, future care plan summarises what people say about themselves alongside clinical advice to guide treatment and care if they become unwell.

6.3 Non-recurring funding supported additional Band 5 bank nurse hours to review, update and transfer Future Care Plans from Care Home records onto Clinical Portal ensuring these were accessible to all practitioners involved in the residents care.

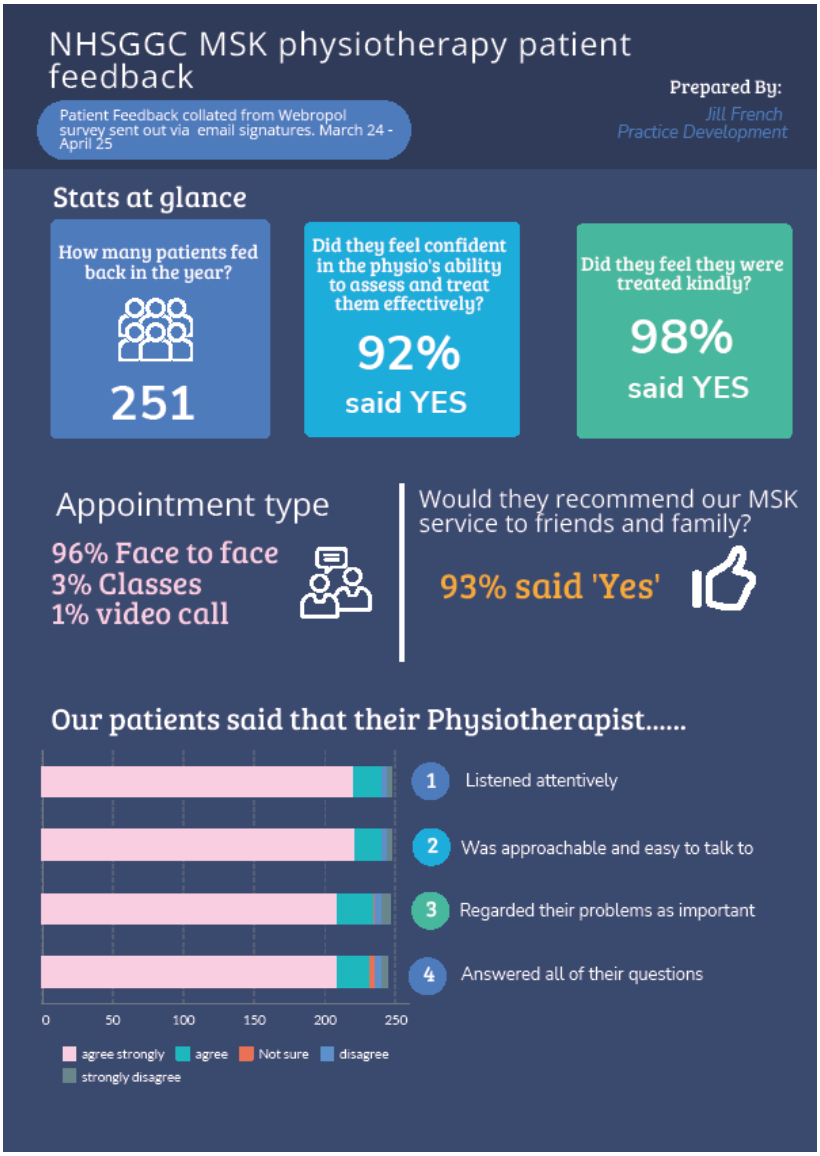
6.4 The Rockwood Clinical Frailty Scale (CFS) is a tool used to assess a person's overall health and frailty status, ranging from 1 (very fit) to 9 (terminally ill). It's a judgment-based scale that considers factors like illnesses, function, and cognition to determine a frailty score. The District Nurses service surpassed the NHSGGC target requiring 85% of patients with a frailty score of 9 on their caseload to have a FCP completed by December 2024. Moreover they are working to extend this and currently 60 % of all clients on the DN caseload have an FCP in place.

MSK Physiotherapy Service

6.5 The MSK Physiotherapy service currently generates patient feedback through the Consultation and Relational Empathy (CARE) measure, Care Opinion website and through a QR code added to staff emails that invites patients to provide feedback on their experience of MSK physiotherapy. This breadth of methods ensures that the service gets continuous feedback from patients throughout the year. They are always striving to explore new and more effective ways to generate and respond to feedback from patients.

6.6 The CARE measure is a recognised and validated tool to measure empathy and has a direct correlation to improved patients outcomes. Between May and August 2024 4000 individual CARE reports were generated. The average score for the service was 4.89 / 5. This tells us that staff build positive and empathic relationships with their patients. Staff also get the opportunity to reflect upon qualitative feedback from patients as part of the completion of the CARE measure and can use this to inform their Personal Development Plan and learning and development needs.

6.7



6.8

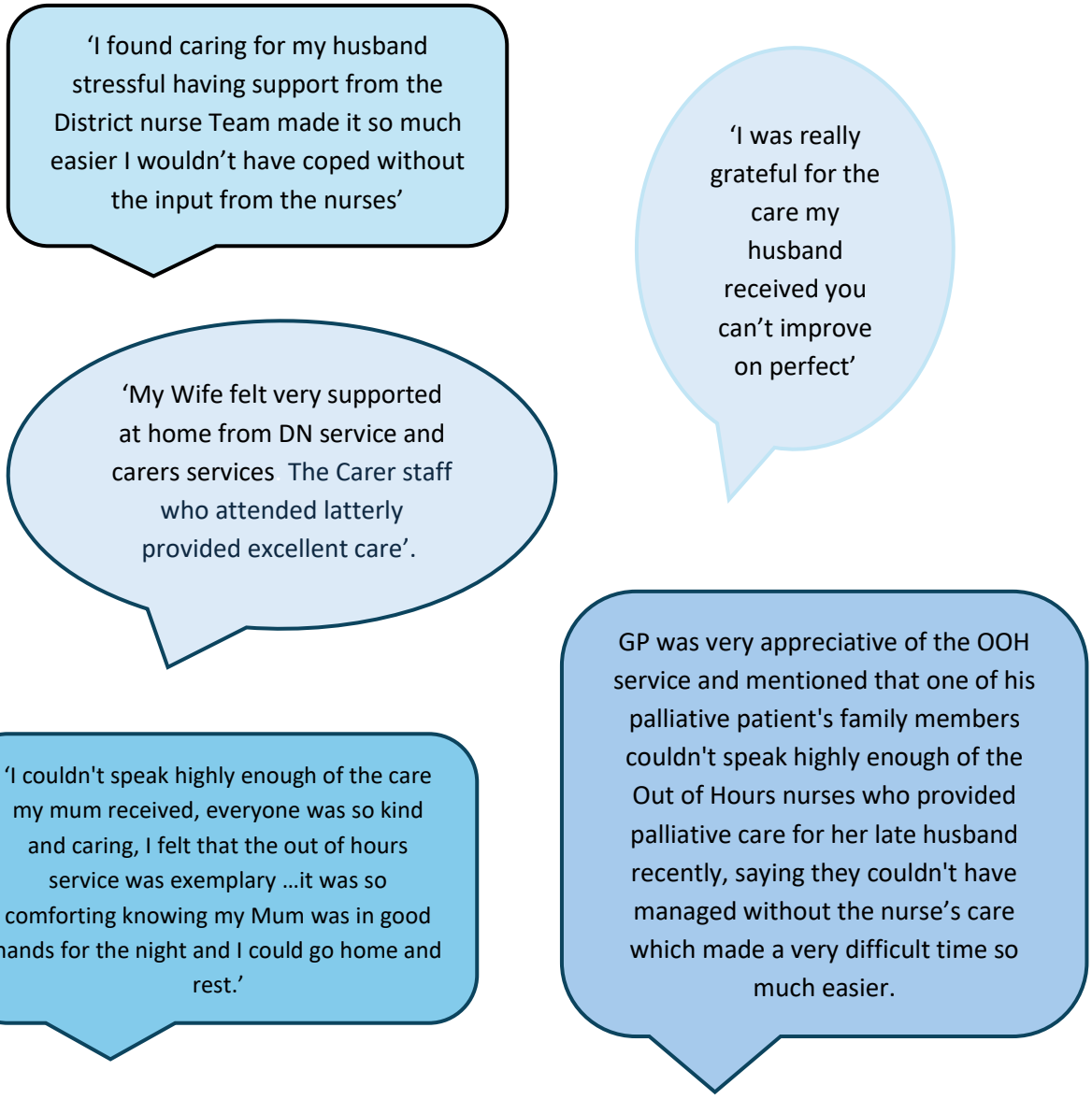
What patients said:

I can't praise the service enough, it's been excellent. I thought I would be crippled for life but I am so much better!

Had a great appointment this morning at Gartnavel. I felt listened too and I was so impressed with his knowledge and kindness. I feel like there is light at the end of the tunnel. Thank you so much NHS.

District Nurse Service - Palliative Care Survey Feedback from Families

6.9 A telephone survey is undertaken by the District Nursing Team to secure feedback from families on their experience palliative care delivered by the HSCP.



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6.10 Fruin and Katrine Wards are mental health assessment and treatment in-patient facilities in West Dunbartonshire. They received a visit from the Mental Welfare Commission (MWC) all the relatives and patients who spoke with them were very positive about their experience of care on the ward. They were told that all staff were very proactive in communicating with relatives and that service users and their families felt fully involved and informed regarding any care decisions. They heard that medical staff were accessible and responsive to requests for contact. One relative advised that, having raised a concern, they were invited to meet with the consultant, the staff grade and the senior charge nurse the next day to discuss their concern and the issue was promptly resolved. Everyone spoken to felt welcome while on the ward, and encouraged to be involved in all aspects of their loved one's care, and supported to maintain their relationship. People spoke of being able to take their loved ones out or being able to bring in a meal and have a private visiting space to enjoy dinner together occasionally. Arrangements had been made to support a

whole family visit with children and grandchildren. Relatives told the MWC that staff provided support to them as well as their family member and that they felt confident leaving the ward knowing their loved one was being well cared for. Patients advised that they were treated well. One patient reported that the ward had "saved their life" and that staff are "generous in their care." Staff were initially anxious about the introduction of person-centred visiting, however this has been fully embraced and staff were very positive about the benefits of this for everyone involved.

6.11 Care Opinion

The Patient Rights (Scotland) Act 2011 introduced the right for people to give feedback, comments, concerns, and complaints about the services they receive. As part of this Act all NHS staff have a legal duty to actively encourage, monitor, take action and share learning from the feedback they receive and use it to improve care and services. Care Opinion is an independent, not-for-profit website, where people can provide anonymous feedback to HSCP services about their experience of care. It is intended to complement HSCP processes for dealing with feedback and complaints. The HSCP are progressing with the implementation of care opinion on a phased basis. This will go live for health services in the HSCP from September 2025.

7. Exemplar Case Studies

Health and Community Care

7.1 *The adult nursing service have recently been invited to the HSCP Multi Agency Forum to enhance integrated service delivery for our most vulnerable clients. During this meeting a vulnerable adult within the community who was subject to coercive controlling behaviour from their partner and physical assault, was discussed. The Treatment Room nursing service raised an adult support and protection concern regarding a patient accessing the service. This led to enhanced multiagency working to support the vulnerable adult. The Treatment Room service became an anchor for the patient; with social work services attending the treatment room appointments to allow the patient to gain access to the safety mechanisms within the HSCP which supports vulnerable people at risk of domestic abuse such as the 'holly app' and storm warning on their address and to explore options of alternative housing and offer of wellbeing support.*

Learning Disability

7.2 *The Health and Care (Staffing) (Scotland) Act 2019 provides a statutory basis for the provision of appropriate staffing in health and care services, enabling safe and high-quality care and improved outcomes for service users. For care settings, the Act places a duty on those who provide care services to ensure both appropriate staffing and appropriate training of staff. In preparation for the implementation of the act, Housing Support Services had discussions at our team meetings to raise awareness and understanding of the duties around the new safer staffing legislation. Furthermore, all staff were supported to sign up to TURAS learning site and complete the required training (4 domains in level 1). Staff completed this between April & July*

2024. Following this, we were able to develop a staffing protocol for each service showing what staff was required/where they were required and the reasons why (for safer staffing) This equipped staff with better knowledge and understanding of the legislation and how it applies in the social care setting. This resulted in it being highlighted as an area of good practice by the Care Inspectorate during an unannounced inspection in December 2024.The inspection report commented positively on the evidence they found.

"We observed the staffing compliment was very good on both inspection days and people were coming and going out to activities as well as being supported with day to day living tasks. As a result, people were very excited and looking happy from their activities. We noted the staff rota demonstrated the reasons why extra staff had been called in or specific staff being used."

"Almost all staff had completed training on the recent and new legislation, the Health and Care (Staffing) (Scotland) Act 2019 enacted on 1 April 2024. Staff spoke very confidently and competently about their knowledge of the Act and felt very happy with the current staffing arrangements."

Appendix 1: West Dunbartonshire HSCP CCG Workplan 2024

Appendix 2: West Dunbartonshire HSCP CCG Workplan 2025

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

AUDIT AND PERFORMANCE

Report by Helen Little, MSK Physiotherapy Manager GGC

25 June 2025

Subject: Annual Report for Musculoskeletal Physiotherapy Service 2024/25.

1. Purpose

1.1 To present the Annual Report for Musculoskeletal (MSK) Physiotherapy service (Greater Glasgow and Clyde) 2024/25.

2. Recommendations

It is recommended that the Audit and Performance Committee note the:

2.1 Content of the report.

2.2 Achievements of the MSK service in regards to performance; priority project work; patient feedback and involvement; use of data and work on digital enhancement within the MSK service.

3. Background

3.1 This paper presents the Annual Report for MSK Physiotherapy Service for 2024/25 which can be found at Appendix 1 of this report. The paper is not meant to be representative of all the work that was carried out within the service but represents the key performance areas and priority project work, as well as the MSK Digital Strategy.

4. Main Issues

4.1 The paper presents an overview of service performance data from 2024/25. This includes waiting times data; impact data (including patient reported outcome measures and patient experience and impact data from Advanced Practice Physiotherapists within GP practice). The priority projects presented reflect the service priorities for that period. The Scottish Government waiting times target for AHP MSK services is that 90% of patients should be seen within 4 weeks of referral. For clarity some current MSK performance information is bulleted below:

- Demand for MSK service has risen by 6.8% (on top of the 13.3% increase in demand the previous year). Referral rate rose from 73,680 referrals in 2023/24 to 78,746 in 2024/25.
- Since April 24 the total number of patients waiting for an appointment has increased from 14,216 in April 24 to 17,514 at end of March 25 (a rise of 5,358 referrals).
- Since April 24 the maximum routine wait has increased from 13 weeks to 16 weeks.
- At present the MSK service ensures that all urgent patients are seen within the 4 week target. Work continues to address the routine waiting list as until the routine waiting times are closer to the 4 week target the proportion seen within 4 weeks will not significantly change.

4.2 The paper provides an overview of the 5 priority objectives and associated priority project work within the service. The 5 priority objectives were waiting times; vetting; internal referral; staff wellbeing and streamlining MSK pathways of care and shared decision making for patients with OA of hip/knee. A brief overview is provided for each project. There is a hyperlink to the MSK Digital Strategy which is also included as Appendix 2.

5. Options Appraisal

5.1 None required.

6. People Implications

6.1 No implications.

7. Financial and Procurement Implications

7.1 No implications.

8. Risk Analysis

8.1 Performance Management has been identified by the HSCP Board as a strategic risk. The presentation of this annual report mitigates against this risk by providing an opportunity for the Committee to review and scrutinise performance management information in relation to the MSK service. Failure to review and scrutinise performance management information creates a risk of the HSCP being unable to manage demand analysis, service planning and budget management across totality of its organisational responsibilities.

9. Equalities Impact Assessment (EIA)

9.1 An EIA is not required as the recommendations within this report do not impact on those with protected characteristics.

10. Environmental Sustainability

10.1 N/A

11. Consultation

11.1 This report has been completed in consultation with MSK Physiotherapy Extended Management Team and with support of MSK Practice Development staff.

12. Strategic Assessment

12.1 On 15th March 2023 the HSCP Board approved its Strategic Plan 2023-26 "Improving Lives Together". The Plan outlines sustained challenge and change within health and social care. These changes bring with them a host of governance implications: cultural, operational, structural, ethical and clinical. Good governance, which includes performance management, is essential to ensure the actions within the Strategic Plan are implemented effectively and efficiently in a way which promotes safe and effective care whilst achieving best value.

13. Directions

13.1 None required.

Name Dr Helen Little

Designation MSK Physiotherapy Manager Greater Glasgow and Clyde

Date : 25/6/25.

Person to Contact Dr Helen Little

Appendices: Appendix 1: Annual Report for Musculoskeletal Physiotherapy Service 2024/25.
Appendix 2: MSK Digital Strategy.

Background Papers

Introduction

Welcome to our Musculoskeletal (MSK) Physiotherapy annual report which covers the period from April 2024 to March 2025.

MSK conditions continue to have a major impact on people's lives. It is one of the leading causes of time off work and more years are lived with an MSK disability than any other condition. The MSK Physiotherapy Service continues to provide a person-centred approach where each person is individually assessed and their bespoke care is focused on symptom management, movement, exercise and supported self-management. As we help patients to recover and return to normal activities, we also encourage them to take up more active and healthy lifestyles. In addition we focus on health improvement and support patients who have wider health needs (e.g. who require support on issues such as alcohol, smoking, weight management, stress management) by signposting to appropriate services.

Our report provides a brief overview of the main areas of focus over the last year, namely:

- Service performance: data on demand/activity and waiting times.
- Impact data: Patient reported outcomes measures and patient reported experience.
- Impact data: Success of Advanced Practice Physiotherapists within Primary Care.
- Brief summary of 5 key priority projects (and work around Health Care Staffing Act).
- MSK Digital strategy.

We believe that our report provides an overview of some of the key areas of work and successes within the MSK service over the last year and that the data presented within our report reflects the amount of work that goes into ensuring that our MSK service is “Fit for the Future, fit for life”.

Section 1: A year in data: an overview

The MSK Physiotherapy service continues to have a huge focus on data, in regards to waiting times; quality assurance and to inform and drive priority project work.

MSK performance data in regards to waiting demand, capacity and waiting times is presented within Section 1.1 of the report. Data collected from patients in regard to their treatment outcome and experience of the MSK service is presented within Section 1.2 and Section 1.3 provides data on the success of Advanced Practice Physiotherapists within GP practice. Section 2 presents some of the project work carried out within 2024/25.

There has been ongoing priority project work to address waiting times (see section 1.1). The project work utilised Quality Improvement methodology and the driver diagram for the priority project work is included within section 2.1 below. Demand for service provision rose by almost 7% in 2024/25 when compared to the previous year (when demand also rose by 13.3% on previous year), which meant that maximum routine waiting times and number of patients waiting for a routine appointment rose throughout the year, even with the dedicated focus on waiting times.

Data was collected in regards to Patient Reported Outcome Measures (PROMS) and patient experience (Section 1.2). Both measures validated the quality of service provision, with PROMS demonstrating service effectiveness in reducing patients' pain, increasing patients'

function and returning patients to the workplace. The feedback on patient experience with service provision was overwhelmingly positive.

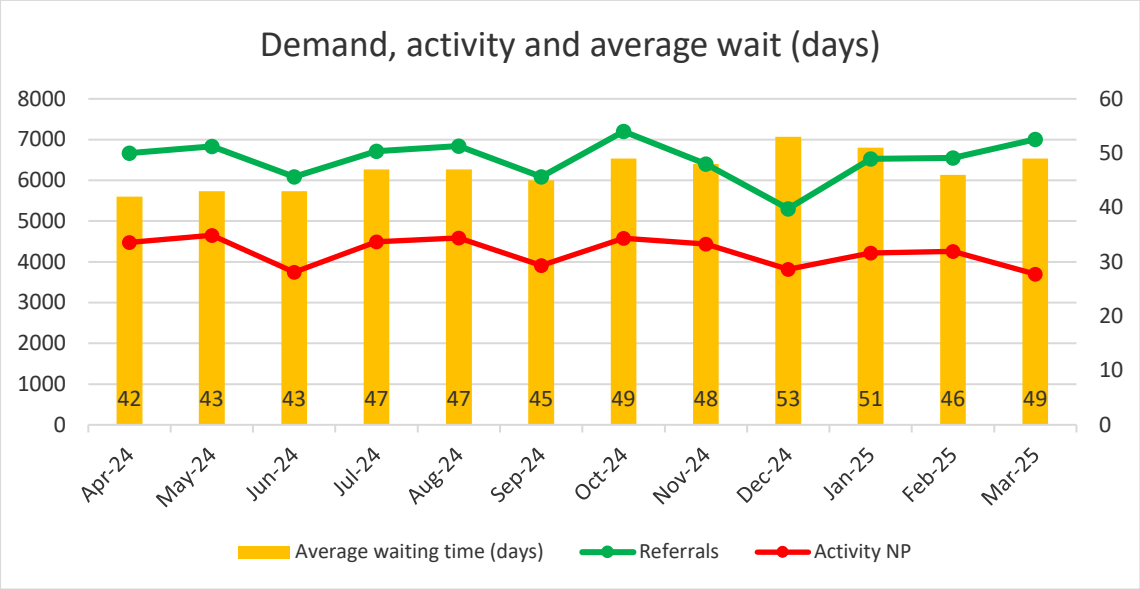
Impact data from Advanced Practice Physiotherapy (APP) staff based within GP Practice (see section 1.3). APPs demonstrated their effectiveness in supporting 78% to self manage their MSK condition. Requests for bloods, medication and imaging were low, as were onward referral rates to MSK and orthopaedics (including lower than GP practices without an APP) which shows the APPs to be a cost effective resource within a Primary Care setting. The priority projects are then summarised in section 2.0 and the Digital Strategy presented as a hyperlink (and attachment).

1.1 Referral rate; activity and average waiting times.

1.1.1 Referrals and Demand

Demand for the MSK service has risen in 2024/25 compared to the two previous years (referral rate demonstrated a further increase 6.8% this year on top of the 13.3% increase the previous year). The service received 78,746 referrals in 2024/25 (compared to 73,680 referrals in 2023/24 and 65,017 in 2022/23). The referral rate was consistently around 6-7k referrals per month (with referrals peaking at over 7k in both October and March. The service experienced the usual seasonal dip in December with 5,358 referrals). This data is presented within Graph 1 below.

Graph 1: Demand, Activity and average waiting times



Graph 1 above and Table 1 below also show maximum routine waiting times across the year. Maximum wait for a routine appointment has increased by 3 weeks over the second half of the year (from 13 week maximum wait to 16 week maximum wait for a routine appointment). Previously the service has been able to respond to rising demand by recruiting agency staff (or over recruit short term) using MSK reserves budget. However within 2024/25 there was an additional turnover savings of £375k to achieve a further 3% savings (on top of the normal 4% turnover target of £320k). This meant that the service was not in the position to recruit agency staff to address rising waiting times as reserves budget had to be utilised to achieve the increased turnover target. As well as demand increasing staff have reported on the increase in patient complexity (see section 3.0 below) with increased prevalence of socioeconomic issues; comorbidity and mental health issues. These patients require more support and time to discuss and signpost to appropriate services. There has also been an ongoing issue around both

increased use of interpreter services and inefficiencies in provision of interpreters by the interpreting service, both of which impact on service capacity detrimentally. Frequently interpreters either do not attend for appointments or cancel at the last minute which ultimately results in rebooking of the patients; additional capacity and additional workload for clinical staff. This is being highlighted via NHS Datix system and reported through Board wide group around interpreting services.

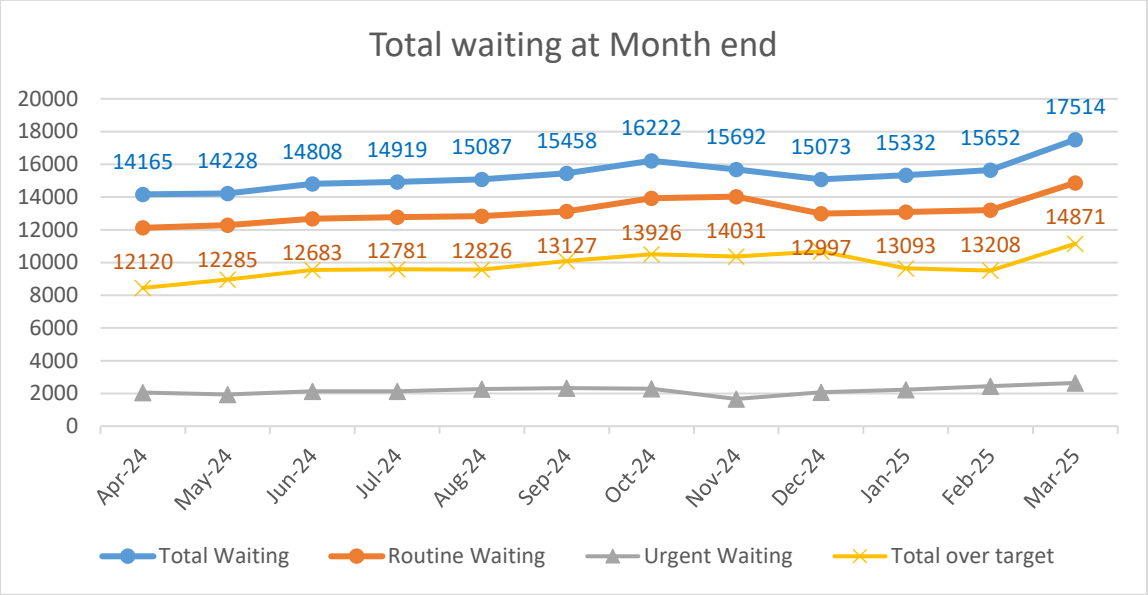
Table 1: Demand, Activity and maximum routine waiting times

Referrals
Activity NP
Waiting time in weeks

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
6671	6831	6086	6713	6845	6086	7201	6403	5305	6529	6547	7004
4478	4652	3743	4489	4588	3913	4578	4438	3816	4218	4253	3699
13	12	13	13	13	13	14	13	14	15	14	16

There has also been a rise throughout the year in the number of patients waiting on an appointment over 2024/25 (see Graph 2 below). Despite the rise in referral rate by 5,358 referrals, there were 3,298 more patients waiting for a routine appointment over the period (increasing from 14,216 in April 24 to 17,514 at end of March 25). As previously stated referral rate increased by 5,358 referrals demonstrating that the ongoing priority project work to address routine waiting times has offset some of the rise in demand. The service has also had to work to prioritise that the proportionate increase in urgent referrals are all appointed within the 4 week target (see below).

Graph 2: Monthly total number of patients waiting for an appointment



All referrals into the MSK service are clinically vetted into “urgent” and “routine” based on clinical need and then appointed into “urgent” and “routine” appointment types. The service trakcare templates are built in such a way that 40% of all New Patient appointments are maintained to prioritise “urgent” referrals and ensure that these patients are appointed within the Scottish Government AHP MSK waiting times target of 4 weeks (see below). Any urgent appointment not utilised is converted to a routine appointment to address routine waiting times and the appointments are provided to those patients who have been waiting longest.

The service continues to be able to appoint all urgent referrals within this 4 week target. Although the service achieves the Scottish Government waiting times for all urgent referrals, the target states that 90% of patients should be seen within a 4 week period. In order to achieve this target the service’s priority project work has focussed primarily on reducing routine appointment waiting times (until the routine waiting

times are closer to 4 weeks the percentage of patients seen within the target will not vary much- see Table 2 below).

Table 2: Percentage seen within Scottish Govt AHP MSK waiting times of 90% patients seen within 4 weeks.

	Apr 24	May 24	Jun 24	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
% seen 4 wks	**43%**	**40%**	**38%**	**38%**	**39%**	**37%**	**37%**	**47%**	**32%**	**40%**	**41%**	**39%**

1.1.2 Service Capacity and Activity

New patient (NP) activity levels within 2024/25 are illustrated by the red line within Graph 1). Despite all the ongoing work to improve waiting times there was a very slight decrease in new patient appointments in 2023/24 compared to the previous year (64,653 NPs in 2024/25 compared to 65,141 NPs in 2023/24).

There are several reasons for this decrease. Firstly as previously mentioned the service had reserves funding to recruit agency staff (n= 7-10 wte over various times) in 2023/24 which was not available this year due to increased turnover savings target. This significantly impacted on service capacity and meant that the service did not have the increased capacity to meet the growing demand.

Recruitment into MSK vacancies has improved compared to previous years (with more applicants for posts and therefore posts are easier to fill) but the service still has high staff turnover due to size of the service

(with most staff moving to promoted posts). Although this high turnover is essential towards financial savings there is an ongoing impact on service capacity/activity when posts are vacant for a period of time, both during the period when the post is unfilled but also due to the impact of absorption of caseload by others when a staff member leaves the service.

Sickness absence has impacted on capacity throughout 2024/25. Prior to the pandemic sickness absence rates within MSK service were rarely over the 4% target. However during 2024/25 sickness absence rates were consistently over the 4% target (see Table 3 below). There is no cover available for maternity leave. Data throughout the year demonstrates that sickness absence, maternity leave and annual leave results in up to a quarter of the workforce being absent across all months.

Table 3: Monthly % sickness absence rates 2024/25

	Apr 24	May 24	June 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 24	Feb 25	Mar 25
%	7.86	7.57	7.09	7.56	8.28	6.74	5.68	7.83	8.08	7.61	7.09	6.03

Service capacity has also been impacted by supporting orthopaedic colleagues to improve their long waits for a Spinal assessment (waiting times were 78 weeks). In the interest of patient care, the MSK service agreed to release MSK sessional commitment of 0.9wte Orthopaedic APPs for a period between Nov 24 and March 25 (but this has now extended in 2025/26). Although the Board centrally funded extra hours and overtime for MSK staff to allow backfill, there was not sufficient

uptake to compensate for the loss of the sessional commitment. The service lost approx. 250 New Patient appointments whilst supporting orthopaedic colleagues, further impacting on service capacity.

Accommodation challenges have also impacted on service capacity and the ability to provide the best rehabilitation environment for our patients in one Physiotherapy site. This has primarily been due to other services utilising MSK space during the pandemic and the area not yet being returned to MSK. There has been a delay in getting bespoke MSK rehabilitation space returned, but capital funding has been approved by the Health Board and work has commenced to relocate the occupying service and return the space to MSK.

1.1.3 Demand vs Capacity and impact on waiting times

The gap between the red and green lines on Graph 1 demonstrates that the referral rate (demand) continues to be higher than New Patient (NP) capacity. This, as well as the backlog of patients waiting for a routine appointment has meant that addressing waiting times has been an ongoing challenge. The ongoing priority project to address waiting times has really only served to offset some of the year on year increase in demand (see section 2.1).

The gap between demand and capacity is not as great as the data suggests as a variable proportion of patients referred routinely to the service do not ‘opt in’ at the time of appointment offer. However, there is still a challenge around demand continuing to exceed capacity, which limits ability to address the backlog of patients waiting for a routine appointment.

1.2 Impact data: Patient Reported Outcomes and Experience of the MSK service.

1.21 PROMS

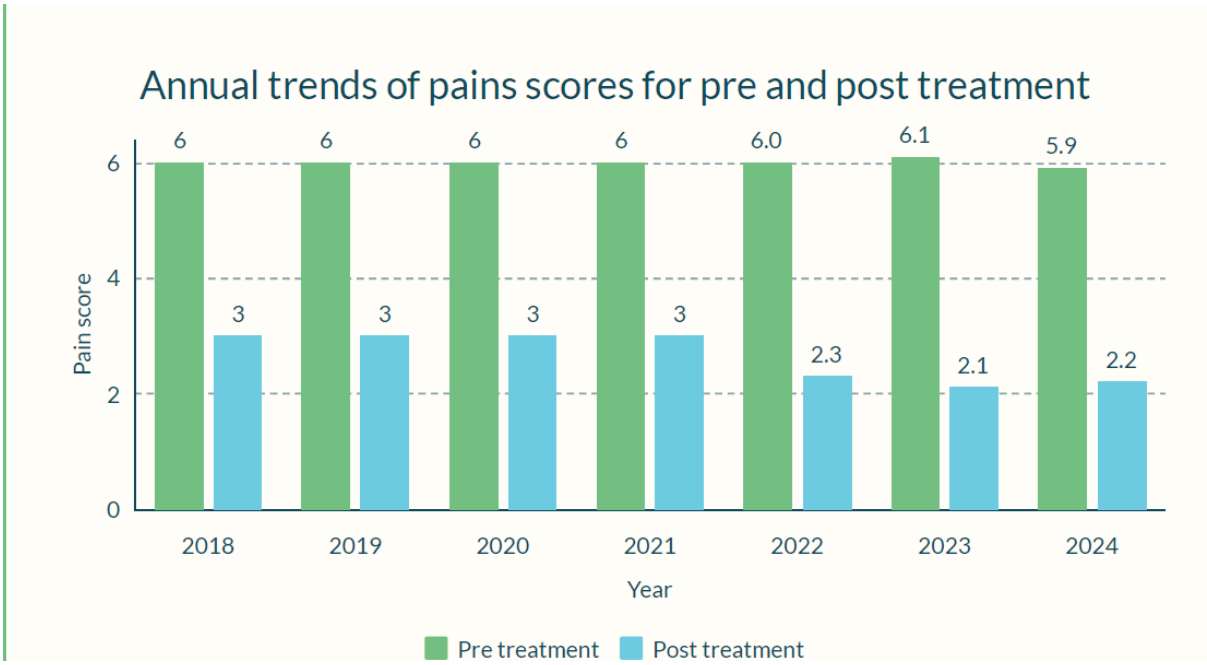
Patient Reported Outcome Measures (PROMS) using validated tools are gathered routinely after a course of treatment. The MSK service collects PROMS across the 4 quadrant areas. This is to demonstrate impact of care, quality of care and provide assurance around equity of clinical care across all areas. The results over the years have indicated real consistency within the MSK Physiotherapy service with very similar quantitative outcome data across the wide geographical area.

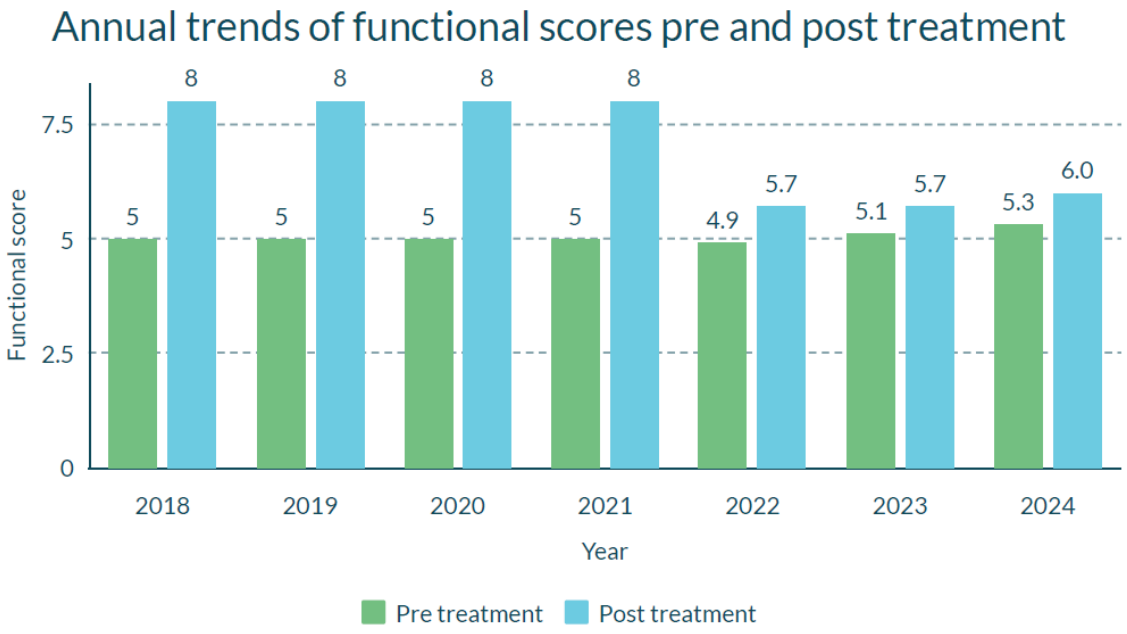
There have been historical challenges in completion rate of PROMs over the years, but this has improved since the introduction of Digital Clinical Records/Active Clinical Notes over the last 2 years, with the PROMS being embedded in the ACNs.

There was a significant increase in the completion of PROMs in 2023/24 (n = 48,715) and then marked further increase in 2024/25 (n = 51,648 completed).

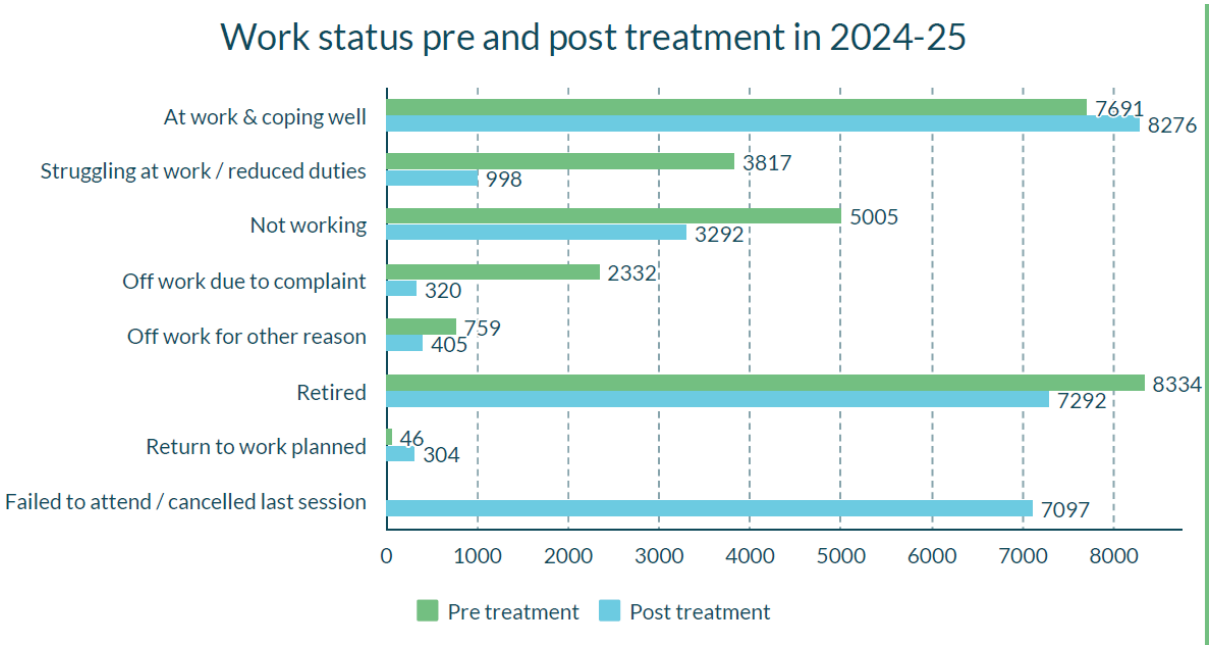
A snapshot of 2024/25 data are presented in the infographics 1 and 2 below and demonstrate the reduction of pain (from a score of 6 to 2); improvement in function(from a score of 5 to 6) and successful return to work as a result of MSK service intervention (infographic 2).

Infographic 1: Patient Reported Outcome Measures on Pain and Function over the years.





Infographic 2: Work status pre and post physiotherapy



1.22 PREMS: Patient Reported Experience of our MSK Physiotherapy Service

The MSK Physiotherapy service currently generates patient feedback through the Consultation and Relational Empathy (CARE) measure, Care Opinion website and through a QR code (emailed to patients with their exercise programme) which invites patients to provide feedback on their experience of MSK physiotherapy.

This breadth of methods ensures that our service gets continuous feedback from patients throughout the year. We are always striving to explore new and more effective ways to generate and respond to feedback from patients.

CARE measure:

The CARE measure is a recognised and validated tool to measure empathy and has a direct correlation to improved patients outcomes

(Mercer SW and Reynolds W. Empathy and quality of care. BJGP 2002, 52 (Supplement), S9-S12). Between May and August 2024 over 4000 individual CARE reports were generated. The average score for the service was 4.89 / 5. This tells us that our staff build positive and empathic relationships with their patients. Staff also get the opportunity to reflect upon qualitative feedback from patients as part of the completion of the CARE measure and can use this to inform their PDP and training and development needs.

CARE opinion:

Currently Care Opinion feedback is only available for our physios working in the acute sites but the service is aware that West Dunbartonshire HSCP are subscribing to Care Opinion in 2025/26.

Some examples of patient feedback from the Care opinion website for MSK physiotherapy:

"I have just completed my 6 weeks physiotherapy classes with L (Physio) and S (HCSW) at the New Victoria Hospital. I thoroughly enjoyed the classes. The instructions, atmosphere and venue and the satff were amazing, professional and fun. Thank you for helping me with my recovery. Excellent."

"I was referred by my GP to Physio MSK in Renfrewshire H&SC after a hip operation. On arrival I was seen by Physiotherapist M who was very professional and helpful. After my fall I had totally lost confidence and M supported me to realise I could get back on my feet again…….. Just wanted to take this opportunitity to personally thank M who put in a tremendous amount of time and patience to help me."

"Following successful treatment at the fracture clinic at GRI I was referred for Physiotherapy at Woodside H&C centre in January 2024. I was treated by physiotherapist D. His care and attention has been exemplary. His standard of care made my treatment a pleasure and I even began looking forward to my

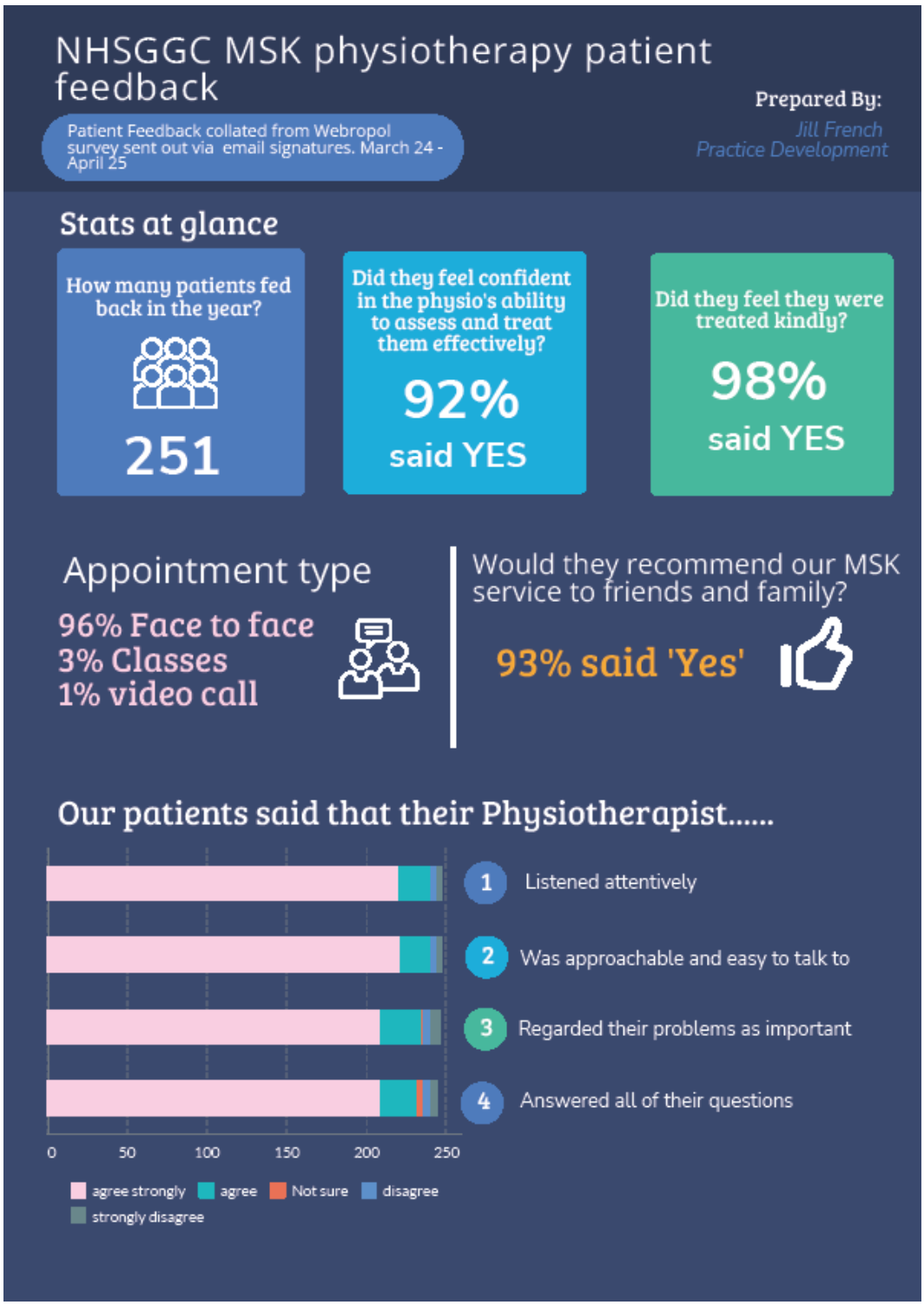
appointments. ….. I was amazed by D's holistic approach to treatment, he is an asset to his department and GGC health Board."

Feedback from webropol via email:

Patient feedback is also generated on a continuous basis through a QR code added to an email sent to patients with their exercise programme.

The service collates the results quarterly and share the feedback with staff. This provides an opportunity to share the positive comments patients have added and to reflect upon any areas for improvement. In 2024/25 the service received feedback from 251 service users via this feedback mechanism. A summary for the whole year is presented in infographic 3 below.

Infographic 3: Patient feedback on MSK service provision via webropol



Continuous Improvement

As a service we recognise that we can continue to improve the ways we collect and use patient feedback to inform the development of our service. In 2025 we plan to test out CollaboRATE as a tool to measure the extent to which our clinicians are using shared decision making during consultations.

We also aim to explore more effective ways of generating feedback from our hard to reach populations.

1.3 Impact data: Patient Reported outcome and experience for Advanced Practice Physiotherapists within GP practice

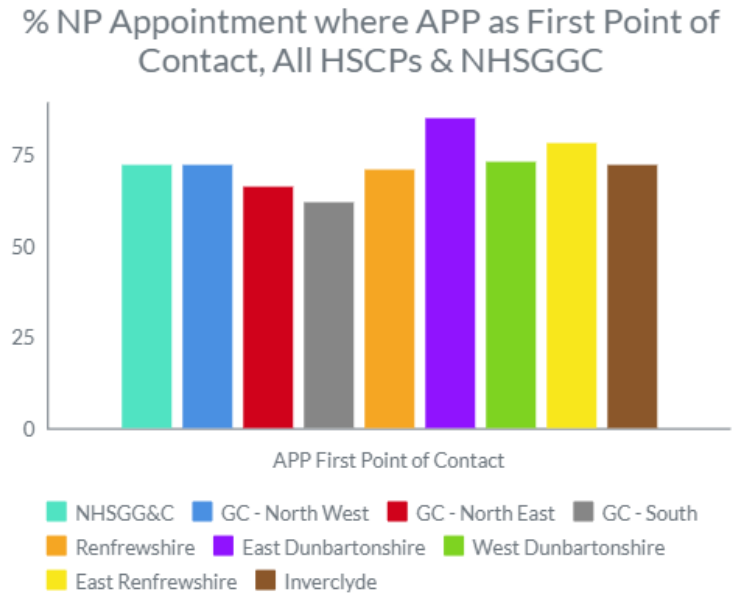
Advanced Practice Physiotherapists (APPs) were recruited to support GP practices as part of the Multidisciplinary team within the Primary Care Improvement Plan. This was with a view to releasing GP time and providing expert and timely MSK advice for patients.

There are now almost 30wte APPs in GP practices across GGC (covering 44% of the GGC population). The resource was based on the recommended national model of one whole time equivalent APP per 16 - 18,000 head of population. In 2024/25, APPs provided 63,747 patient appointments across GGC (an increase of 804 appointments from 2023/24). Impact data from the Board area can be accessed via this hyperlink GP APP Impact Data 2024-25

Impact data shows that:

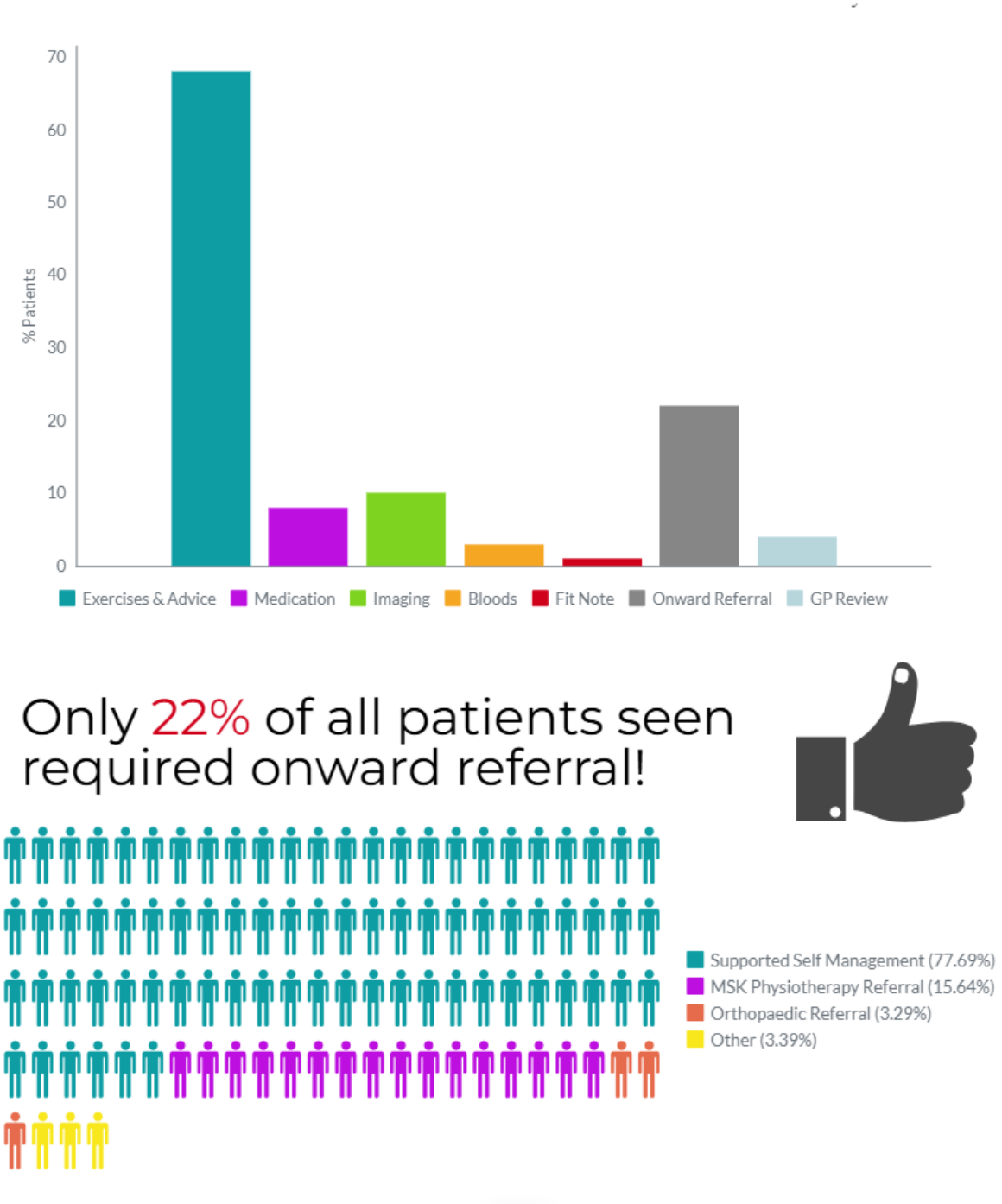
- 89% of available APP Appointment were filled, (of note this figure is unlikely to reach 100% due to last minute cancellations).
- 72% of patients had not seen a GP prior to their APP appointment, demonstrating the release of GP time spent on MSK consultations, (this has risen from 68% in 2023/24). The remaining 28% of patients were directed to the APP via the GP.

Infographic 4: Patients attending APPs as a first point of contact in Primary Care



78% of patients attending an APP were supported to ‘self-manage’ their MSK condition within primary care. Please refer to the infographics below. GP practices with APPs have demonstrated that they reduce referrals to orthopaedics by 24% when compared to GP practices without APPs.

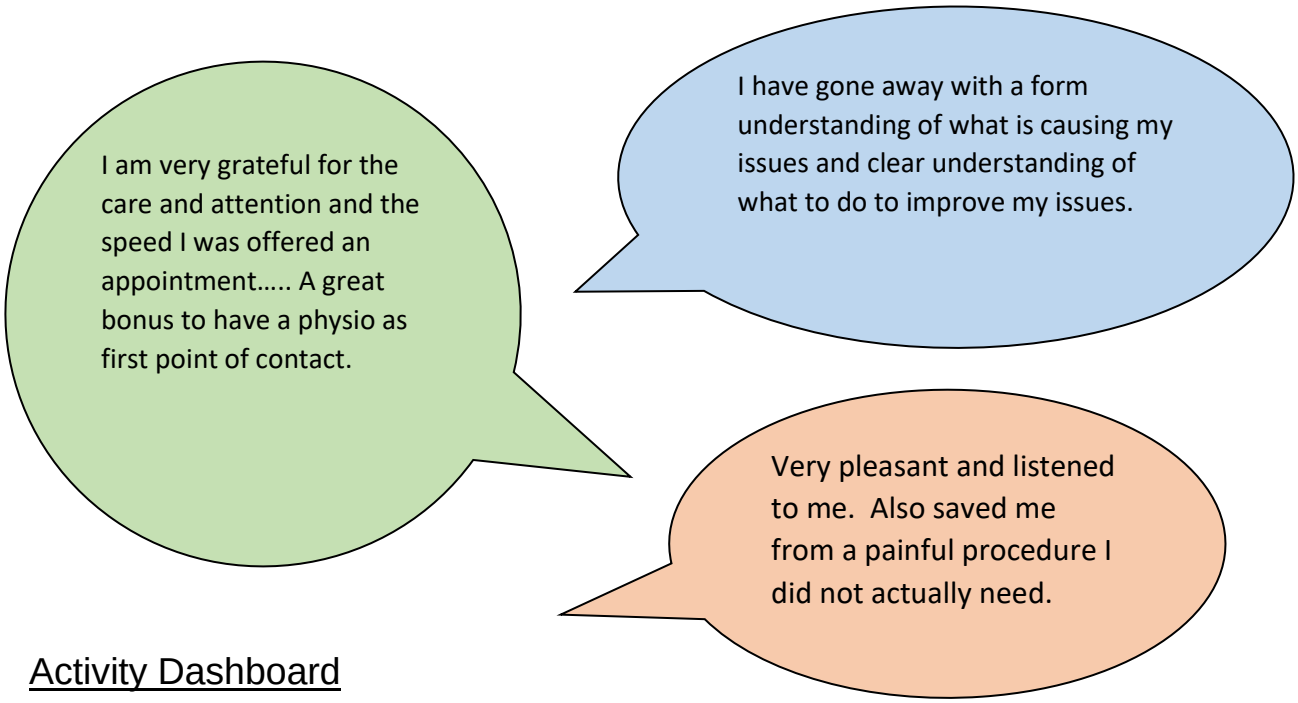
Infographic 5: What happened when patient attended GP APP?



Patient Feedback

During 2024/25 all staff within the GP APP team collected 25 Patient Reported Experience Measures (PREMS) using the Consultation and

Relational Empathy Measure (CARE), accounting for 900 PREMS. The team average score was 4.8/5, demonstrating extremely high levels of satisfaction.



Activity Dashboard

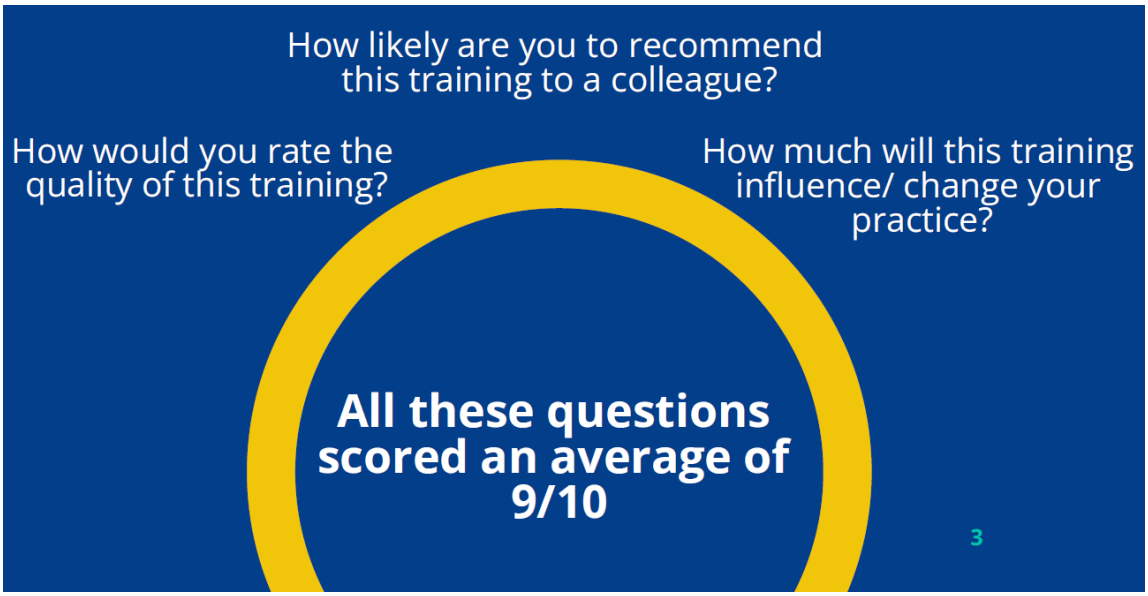
The service has worked with Public Health Scotland last year to review how APP activity is gathered & recorded. An electronic dashboard was developed (in line with National Agreed Data for APP activity in Primary Care). This has now been rolled out across GG&C for the APP team. The dashboard supports business intelligence, and data obtained is being used to improve the efficiency of how our service is used.

MSK Education

In collaboration with the core MSK Physiotherapy service APPs provide regular educational sessions to GP trainees. This aims to support learning and development and upskill other health care professionals in the management of MSK conditions. Sessions delivered provide

overview of assessment/ diagnosis of commonly seen MSK presentations, an overview of the MSK Physiotherapy service and links to useful resources that patients can be directed to which support self-management. These sessions have always been rated highly. The infographic below highlights feedback from the last session.

Infographic 6: GP trainee feedback on education sessions provided by APPs



In addition, APPs provide shadowing opportunities, 1:1 or group training on MSK issues within the practices they are aligned to.

Pathways

The GP APP team have worked in collaboration with colleagues in Primary care, MSK physiotherapy and Orthopaedics to re-vamp the lower back pain (LBP) pathway across NHS Greater Glasgow and Clyde. The new streamlined LBP pathway will support clinical decision making for patients presenting with back pain across the healthcare system. This will allow patients to get the right care, in the right place first time. It is the first step in a meaningful collaboration with multiple

care providers to support the patient journey across a single MSK pathway.

The group have developed serious pathology guidelines for Musculoskeletal conditions to aid clinical decision making and timely management of patients within primary and community services. The document, which will go live online, will have links to pathways, contact numbers and decision support tools to enable staff to safely and effectively manage patients presenting with red flag symptoms across the differing healthcare landscapes of NHS GGC.

MSK Waiting List Project

10% of a GP APP's working week is spent within the MSK service. This capacity was utilised to see a proportion of MSK's new routine patients at point of referral. Modelling Primary Care clinics the GP APPs assessed patients (within 30mins) and supported them with advice and guidance. Patients were either signposted to another service, given the opportunity to access further rehab if required (after 12 weeks), or discharged to self-manage their condition.

Patient satisfaction for this model of care was high and 83% of patients felt confident or very confident to self-manage their MSK condition following the initial appointment.

Although 57% of patient were given the opportunity to be reviewed, only 24% of these initiated a review appointment.

A full summary of the project is available here.

This project echoes findings within the literature that demonstrate improved patient satisfaction and self-efficacy with the implementation of

patient-initiated review (PIR). The project also demonstrated improved efficiency for the MSK service. In view of these findings the MSK service is exploring increasing the uptake of PIR amongst staff and service users.

2.0 Key Priority Objectives

The service had a year of success with regards to progressing 5 priority objectives. The service priority objectives are below, all of which were a continuation from work started last year:

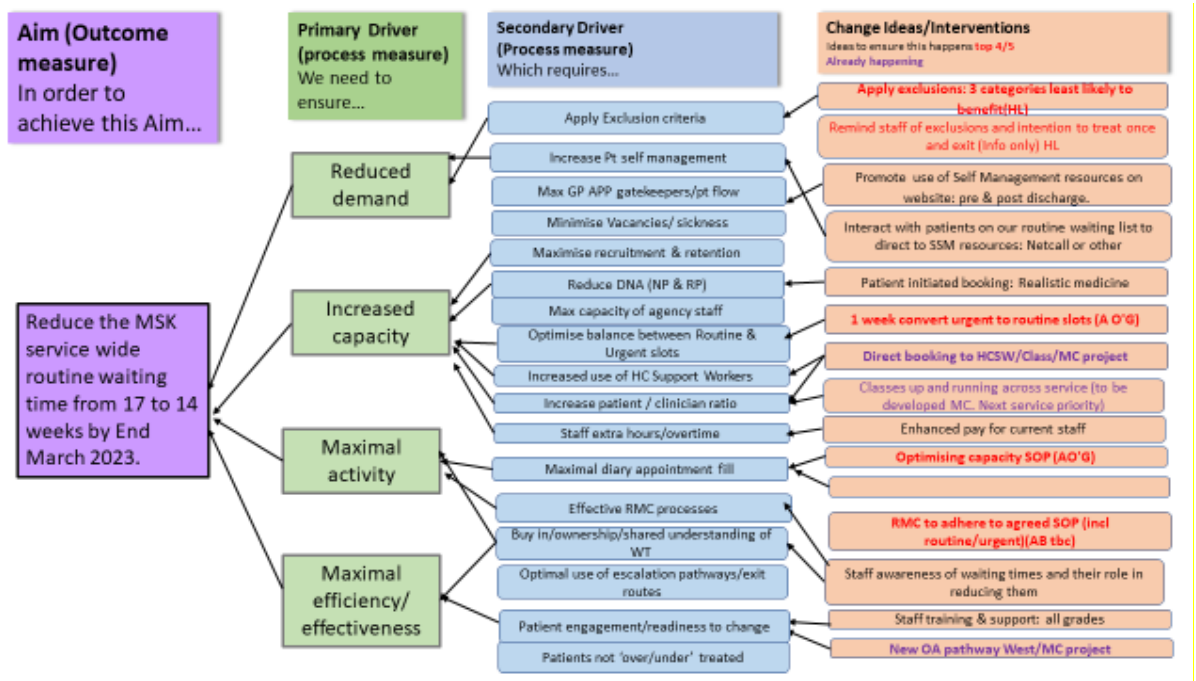
- Waiting times
- Vetting
- Internal referral
- Staff wellbeing
- Streamlining MSK Pathways of Care and shared decision making for patients with OA of Hip/Knee.

A short summary of each project is presented below.

2.1 Waiting times

The waiting times data has been presented within Section 1.1. This section presents the Priority Project work which went towards addressing the maximum routine waiting times. Quality Improvement methodology was used within the project work. The driver diagram for the project work is within Infographic 7 below.

Infographic 7: Driver diagram demonstrating Quality Improvement Approach to waiting times project.



Waiting times are multifactorial and hence the tests of change (right hand column) were multi-faceted. There were several tests of change which are listed on the right hand side of the driver diagram. A brief overview is provided on four of these tests of change. Firstly, the service continued to follow a Standard Operating Procedure to maximise efficiency. This involved local admin staff merging any two unutilised return slots in clinician's diaries and converting to new patient slots. The increase in new patient availability is measured monthly and this created additional New Patient (NP) appointments each month (ranging between 39-146 additional NPs each month).

A further test of change started in Jan 24 and was aimed at directly increasing the % seen within 4 weeks whilst still adhering to Board Access Policy. This test of change involved the Advanced Practice Physiotherapists in Primary care (in their MSK sessional commitment) seeing routine self referred patients at point of referral. This has been

reported within section 1.3 above and the findings will inform a priority project within 2025/26.

The service worked with Digital health colleagues to introduce Netcall/Patient hub in December 2024. This means that patients receive a text message at point of referral to the routine waiting list. The link within the text message connects patients to the MSK Physiotherapy website which was developed 2 years ago to provide patients with information to manage their MSK condition. The benefit of Netcall is being evaluated but the expectation is that more patients will be able to manage their condition independently and therefore not opt in/require assessment when they reach the top of the routine waiting list. The current utilisation/ “hit rate” is 62%.

The work on OA pathways is presented within Section 2.5 below.

2.2 Vetting.

The MSK Physiotherapy service agreed that one of its priority projects for 24/25 was to complete the review and rebuild our referral vetting process within TrakCare (this project commenced in 2023/24). The main drivers behind this project were to ensure patients reached the correct grade and expertise of clinician at point of access e.g. Advanced Practice Physiotherapist (APP) through to Health Care Support Worker (HCSW), thus ensuring the right care was provided by the right clinician in a more timely manner, improving the patient journey and utilising the available clinical skills more effectively and also optimising capacity across the service.

All vetting outcomes have been redesigned to allow direct booking of appropriate new patients to our APP’s and HCSW and also direct

booking to some clinicians with specialist skills e.g. booking appropriate patients requiring a corticosteroid injection to a member of staff who is trained to carry out this intervention. This will directly improve the patients' journey and resultant effective use of capacity. The vetting outcomes have also been redesigned so that the Referral Management Centre (RMC) will now automatically book urgent patients to urgent appointments and routine patients to routine appointments ensuring the urgent appointments are kept for their purpose of seeing clinically urgent patients quicker. The project has also gained staff feedback and acted on this to aim to improve the process of vetting e.g. moving admin tasks associated with vetting to admin staff to complete; streamlining our vetting guides from one per quadrant to one for the service; updating vetting time required in each quadrant with current referral rates and reviewing all staff templates to ensure equity and enhance staff wellbeing.

2.3 Internal Referrals via Trakcare system

It is necessary that patients receive the right care with the right clinician at the right time based on timely referrals and consistent standard of appropriate referral information. Electronic referral is favoured over paper referral for future access to the service. This is to increase the speed of referral to the service; to provide a full audit trail; and to have the ability to swiftly return referrals when they are inappropriate for the MSK service without any delay in patient referral management. Clinical governance issues associated with the inability to return a referral to the referrer on Trak Care has identified the need to tailor individual standard operating procedures for each service wishing to refer internally.

A patient referral may require to be returned for a variety of reasons. This could include referrals having insufficient clinical information to accurately vet a referral as urgent or routine, the condition may not be MSK in nature or the patient may not living within Greater Glasgow and Clyde Board area. As there is no established process to electronically return inappropriate referrals this presents a patient safety and clinical governance issue. The main issue with internal referral is the lack of ability to quickly, easily and safely return electronically inappropriate referrals evidenced by a clear audit trail. The bulk of referrals through internal referral will come from Orthopaedics inpatient and outpatient across the three main sectors of North, South and Clyde, however other referrers such as Major Trauma, and Orthotics have come on board and refer to MSK via this option on Trak Care. The service project is currently working around agreements with each of the Orthopaedic sectors for Orthopaedic inpatient and outpatient referral. To date Orthopaedic South and Clyde inpatients referrals are dealt with through internal referral reducing paper based referrals. Unfortunately Orthopaedic outpatient referrals from South and Clyde despite much service engagement, has yet to deliver an agreed procedure for the return of referrals. This is a significant challenge and has delivered minimal progress to getting this objective over the line. Everyone is in agreement that electronic referrals are the appropriate way forward for the obvious benefits of, speed, paper light, audit trail and clinical governance. The plan is to continue to engage with these services to complete the objective, but to do so requires a commitment to work in collaboration with MSK Physiotherapy to get the job done and deliver the best for the patient in managing referrals that require to be returned without detriment to the patients journey

2.4 Staff wellbeing

The service recognises that staff wellbeing is essential in delivering the high-quality care we aspire to. The service focusses its efforts through the well-established Wellbeing steering group. The service aim is to maintain a focus on staff wellbeing and a working culture that supports it.

Each staff group has representation on the Steering group who meet 6 times a year. Wellbeing is a standing item on local agendas and all are encouraged to bring suggestions and act locally to enhance wellbeing. The regular service Newsletter always contains up to date wellbeing resources and shares good practice related to the 5 steps to wellbeing that we use as a guide. This supports all staff to take a proactive approach to their wellbeing in line with updated HCPC standards of practice.

The annual half day Wellbeing Event was held in the QEUH Teaching and Learning Centre in November 2024 and attended by 100 staff. The keynote speaker was Corinne Hutton, founder of the charity Finding your Feet and quadruple amputee. She spoke of her bravery and resilience in overcoming the trauma she experienced as a result of suffering from acute pneumonia and sepsis.
This was followed by a range of breakout sessions which included active classes as well as a craft and games room which were all very well received.

The Wellbeing session evaluated well:

· 96% of attendees rated the event “excellent” or “very good”.

· 97% would recommend it to colleagues.

· All breakout sessions rated above 80%.

The service also continued to offer staff monthly mindfulness drop in sessions this year.

Staff wellbeing at all levels in our service is important and continues to be one of the service priorities. Based on feedback we have decided to offer staff more choice about how they use their wellbeing hours. Local wellbeing reps are exploring options that staff have suggested locally. We also wish to introduce regular measurement of wellbeing to support our QI approach.

2.5 Streamlining Osteoarthritis MSK Pathways of Care for hip and knee.

The MSK service has developed and implemented an enhanced care pathway for patients with hip and knee osteoarthritis to improve patient care. Grounded in the principles of realistic medicine, shared decision making and based on best practise guidelines. Two pilot studies were conducted in the West and South quadrants. The pathway focus is on delivering high value patient centred care through improved access and supported self-management.

Key developments included upskilling, Band 3 healthcare support workers to deliver one to one sessions supporting patients in identifying what matters most to them and guiding them through available options such as group classes, information sessions and referral to live active, weight management and 3rd sector services. This will be continued to

be monitored to make sure that these are safe and deliver positive patient experiences.

The service also adapted based on feedback from those who chose not to engage, replacing virtual sessions with FTF formats to better meet patients' preferences.

Following the success of these two pilot studies the pathway was rolled out across Greater Glasgow and Clyde in January 2025. And is now in the implementation and spread phase. Ongoing improvements are being made based on staff and patient feedback and the service plans to review early impact data in June /July 2025.

2.6 Safe Staffing Readiness

The Health and Care (Staffing) (Scotland) Act was passed by the Scottish Parliament in 2019. The work was paused to allow everyone to focus efforts on the Covid-19 pandemic. Enacted on 1 April 2024, the Act is applicable to all health and care staff in Scotland.

The act will:

- Apply nationally agreed, evidence based workload and workforce planning methodologies and tools.
- Ensure that key principles - notably consideration of professional judgement, local context and quality measures - underpin workload and workforce planning and inform staffing decisions.
- Monitor and report on how they have done this and provide assurance regarding safe and effective staffing.

Proposals are intended to:

- Strengthen and enhance arrangements already in place to support continuous improvements and transparency in workforce planning and employment practice across Scotland.
- Enable consideration of service delivery models and service redesign to ensure Scotland's health and social care services meet the needs of the people they serve.
- Provide assurance - including for patients and staff - that safe and effective staffing is in place to enable the provision of high quality care.
- Actively foster an open and honest culture where all staff feel safe to raise concerns regarding safe and effective staffing.

There are a number of objectives for 24/25 that our team have working to which will support services to have a workforce that provides safe and high-quality care to ensure the best care outcomes for people experiencing care and that their staff are fully supported to carry out their role effectively and efficiently.

This has included the development of the Real time staffing and Time to Lead Standard Operating procedures along with MSK health-care-staffing-scotland-act-2019-statutory-guidance. Full service training on the Turas modules has commenced.

We are currently waiting on the safe staffing tool to be developed centrally but will utilise Safe Care in the interim. The service is currently waiting to trial of Safe Care tool. It is anticipated the current patient reported outcome measures and patient reported experience measures that the service currently has in place will provide the evidence of the provision of high quality care moving forward

3.0 Training, Education and staff development towards best patient care

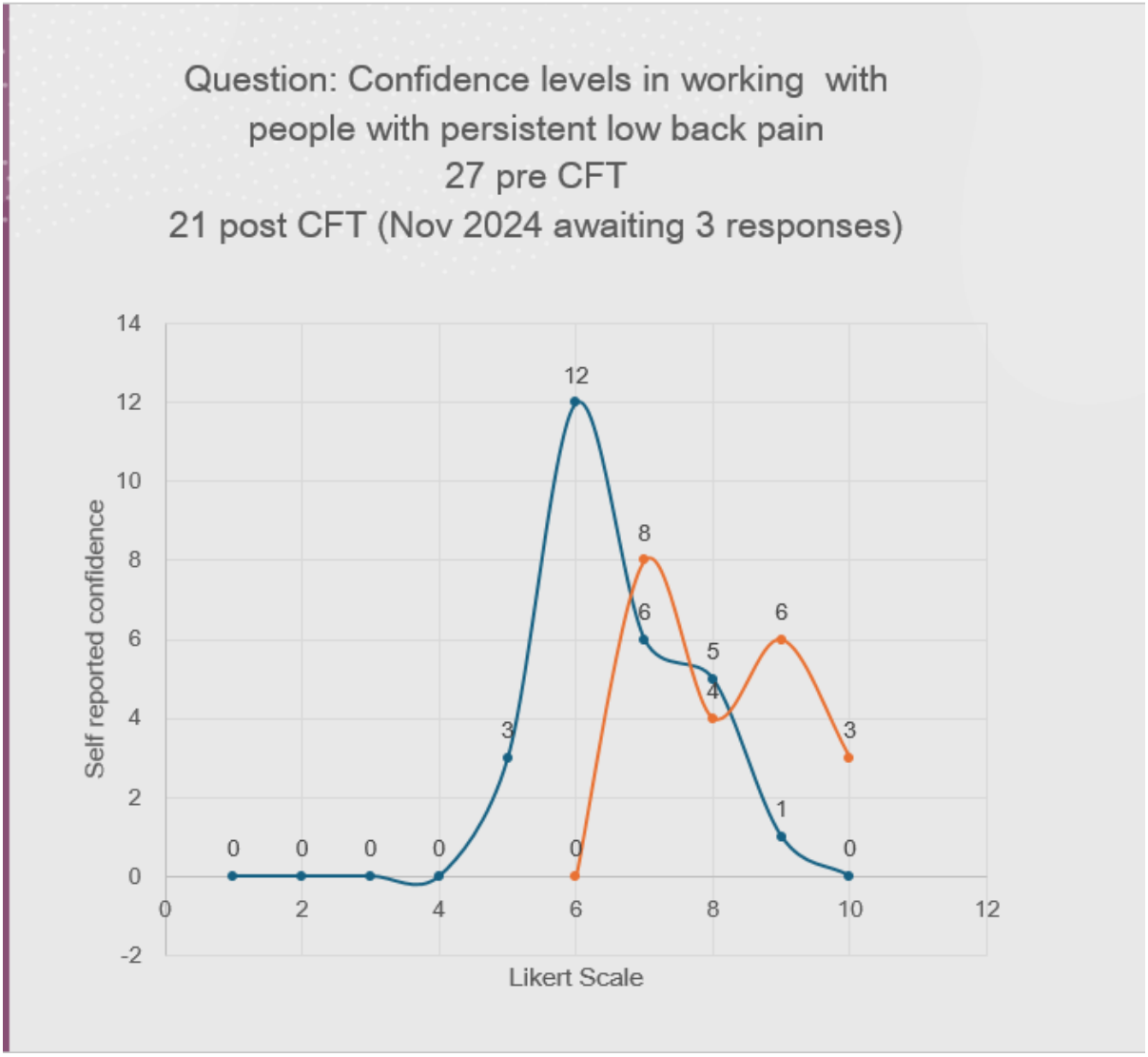
Patients are presenting with more complex and multiple co-morbidities and the service needs to ensure that staff have the skills and knowledge to effectively assess and manage this patient group. As such the service previously invested £30k in training 28 staff in Cognitive Functional Therapy (CFT).

‘Cognitive Functional Therapy (CFT) was developed as an approach to address and manage disabling Low Back Pain (LBP)**.** It can be used for many different types of back pain, as well as other disorders. The underlying motive for this approach is to analyse the behavioural psychology and beliefs seen within patterns of movement’

Over the past year, our Cognitive Functional Therapy (CFT) training initiative for MSK staff has reached its conclusion, with 28 staff members completing both workshops and 5 achieving formal competency. Reaching competency in CFT is a significant achievement, requiring a high level of commitment, clinical reasoning, and advanced communication skills. The primary driver for introducing this training was to improve staff confidence in managing a particularly complex group of patients — those with persistent low back pain, who represent a substantial proportion of our MSK referrals. As the graph below illustrates, we have seen a marked increase in clinician confidence following the training. Internationally, the evidence base for CFT continues to grow, with recent studies demonstrating sustained positive outcomes for patients even three years post-intervention — a rarity in healthcare interventions to address persistent musculoskeletal pain. A highlight of the programme was a visit from Professor Peter O’Sullivan, a leading expert in the field, who spent a day with the team delivering

training and treating patients. Professor O'Sullivan was so impressed by the MSK clinicians that he offered up this full day workshop free of charge. This was an invaluable opportunity for staff to observe expert practice in real time and further strengthen their clinical understanding. The relationships developed with the wider CFT community throughout this process has laid a strong foundation for future learning, collaboration, and development across our MSK services.

Graph 3: Confidence levels of staff working with people with persistent low back pain pre and post CFT training (confidence pre training is the blue line and post training is the orange line).



4.0 MSK Digital Strategy

The use of Digital technology has become much more of a normal part of our service delivery in recent years and is a common thread running through the majority of work plans we have progressed through this period.

Our Digital Steering Group for the service oversee our digital projects and this is recorded within the MSK Digital Strategy. This gives an overview of our current digital projects, but is also a place to articulate our future digital ambitions. Please follow this link to view the full Digital Strategy:-

MSK Digital Strategy

(If the link cannot open please refer to attached Appendix 2 document).

Conclusion

We believe that this summary report demonstrates the huge volume of quality work that has been carried out within the MSK service within the last year. We take pride in the amount of data that we collate and use towards best staff and patient care. The service continues to drive forward to ensure the best care for MSK patients.

NHS GG&C MSK Physiotherapy Service

Digital Strategy – Live Document

"Digital technology will be central to delivering the transformational change that is necessary to support integrated health and care into the future. People expect to use technology in all areas of their lives and health and care should be no exception. Digital technology provides the opportunities to support transformational change and to make care safer, sustainable and allow people to become active participants in their care." (NHS GGC Digital as Usual 2018)

Introduction

It is widely recognised that digital technology will play a crucial role in the development of future health services. Recent national and local strategies emphasise the pressing need to incorporate digital technology: NHS GGC Digital Health & Care Strategy 'Digital on Demand 2023-28', NHS GGC Digital as Usual (2018), Scotland's Digital Health & Care Strategy (2018). Digital technology can also help with supporting the aims of Ready to Act (2015) particularly with regards to access of care.
The COVID-19 pandemic has resulted in a significant change in service delivery for all aspects of healthcare including the MSK Physiotherapy Service. Many of these changes rely on digital technology to effectively continue service delivery. Therefore, it is vital that the MSK Physiotherapy service continues to incorporate and expand the use of digital technology to deliver patient-centred care.
This document outlines the Digital Strategy for our MSK Physiotherapy service, the following tables detail the seven digital priorities and within each priority, the areas for development that have been identified.

The following colour coding is being used in each table to easily identify the stage each area of development is at:-

Green = No action required / complete

Amber = Currently being worked on

Red = Decision required on how to progress

Blue = Blue sky ideas for the future

1) Receiving & Sending All Referrals Electronically

Aim to receive all referrals electronically which can be automatically added to TrakCare with minimal need for manual processing. The advantages of this is to provide a quick and easy referral pathway for all, reducing delays in care and increasing governance and audit trails of every referral received and sent to and from our service.

Area for Inclusion	Detail Current Position	Platforms Involved	Assigned to / Service Work Stream
GP SCI Referrals	Electronic referrals sent via SCI gateway with minimal processing by RMC to vetting list.	SCI Gateway TrakCare	No action required at present
Self-Referral Short Term	Electronic form has been developed and launched in December 2022. Electronic self-referrals are received into a generic email account, then processed by admin on to TrakCare. Paper referrals will still be available for patients to fill in and send to Physiotherapy departments and admin will scan to TrakCare.	Tactum Website Generic email TrakCare Paper Webropol MS Forms	No action required at present – rolled out & initial teething issues resolved, Our electronic self-referral form is currently hosted by Tactuum and will hopefully move to Show website, however changes & updates to the form is not quick or easy. We are therefore submitting an SBAR to eHealth to host this in a way we can change and update

			easily within our service eg Webropol, MS Forms etc
Within GG&C e.g. Ortho	Within GG&C e.g. Ortho – Internal referral on TrakCare (GRI Ortho only at present) has been identified as best electronic route into our service. There is no electronic route to return inappropriate referrals therefore a process needs agreed prior to a roll out plan to appropriate services being finalised. SCI referral is not going to be used for these types of referrals therefore closing down this option also needs completed.	TrakCare – Internal Referral SCI Gateway	This has been identified as priority project for the service from September 2023 – Craig Farish
Review Referral Routes to Improve & Standardise Process and Information Gained	A review of all referral routes into our service to ensure these are fit for purpose and straight forward for all referrers, but also ensure the information we receive is of a high enough standard to allow accurate decisions regarding the best pathway of care for each patient. This links to both vetting and digital innovation below.	TrakCare SCI Gateway Electronic Self-Referral Paper	Work ongoing within our Pathways Project group, also links to Vetting and Innovation below.
MSK Physiotherapy staff referring to Other specialities e.g. Ortho	Develop an agreed electronic referral route (Internal Referral) for MSK Physiotherapy staff to refer to other services e.g. Ortho.	TrakCare	This has been identified as priority project for the service from September 2023 – Craig Farish

Referring / Transferring within MSK Physiotherapy Service	Electronic referrals within our service ie patients being transferred between clinicians eg to class, gym, 2nd opinion.	TrakCare ACN	Completed through the use of agreed referral canned text on ACN.
GP APP sending SCI referrals	At present GP APP staff refer via SCI Gateway. This has been set up as being sent from one of the GP's within the practice. This results in any communication coming back to the GP rather than the APP. Previously GG&C stated APP's could not be set up individually under the HCPC number, however other health boards in Scotland have managed to do this. This is now being explored again to improve referral pathways and governance.	SCI Gateway	Fiona Rough / Lindsay Wheeler

2) Waiting List, Vetting & Appointment Type Management

We are currently using a form of a single waiting list to ensure equal waiting times across the service. Each quadrant has their own waiting list, however routine patients from all areas are appointed at the same time from the top of each list. This keeps the ability for local quadrant appointing whilst ensuring our waiting times are the same in all areas.

Vetting can be complicated by the numerous vetting options available partly due to the current 4 waiting lists, appointment type builds, and due to specialist vetting outcomes. Vetting should be reviewed in line with the service aim to improve patient pathways and waiting list management, with the aim of streamlining and simplifying vetting, which could progress to the use of artificial intelligence (AI) to achieve this and thus reducing clinical hours taken up with our current process.

Area for Inclusion	Detail Current Position	Platforms Involved	Assigned to / Service Work Stream
Vetting	Streamline, simplify and standardise vetting outcomes as much as possible across the whole service. to tie in with improving the overall patient pathway, for example:- • Option to vet to either a specialist first or anyone first with option to escalate. • Look at using support workers more for initial appointments including the possibility to vet straight to classes. • Patient Choice to allow them to choose preferred mode of contact Telephone V's Video V's F2F This will also involve a decision regarding the use of ACRT Vetting – more in-depth with clinicians making the decisions OR simplified 'tick box' AI Vetting. Links to digital innovation below & improved referrals above	TrakCare	Identified as a 2023 Priority Objective starting in September '23 – Louise Ross and Alison Baird will lead.
Interacting with patients waiting on our service	It is recognised that if advice / pre-information can be given to patients as early in their journey as possible it improves outcomes. The aim would be to find ways to easily interact with patients either at vetting or when placed on the routine WL to direct patients to generic information and exercises	TrakCare Website Netcall	Awaiting eHealth to give go ahead for SBAR submitted to trial Netcall.

	so that they can start self-management while waiting. Florence was previously piloted however involved manual input of patients details, the aim would be to find a system or platform where all routine patients are automatically sent a link e.g. email or text to direct them to our website and encourage them to access relevant SSM information.		
R5 & R4 MSK Waiting Lists	The R5 waiting list is still available to use on TrakCare. No speciality ever took ownership of this which resulted in patients being added to it in error and patients being lost resulting in significant delays in patient care. All Physiotherapy specialities now have their own speciality on TrakCare and the waiting list is clear. However final work is required to allow this speciality to be closed / hidden so that no patients can be added in error and 'lost'.	TrakCare	Both the R5 and R4MSK specialities have been marked as 'Do Not Use' while the TrakCare team find a solution to close or hide both specialities completely so they can no longer be added to. Meanwhile monitor and deal with additions - Alison Baird
Single Waiting List	We continue to use of a 'single waiting list' to ensure equitable waiting times across the service. Future service decision required regarding whether we continue to use in current build format of 4 waiting lists which still allows some local control, or may redesign to under one hospital and appointment types in the future.	TrakCare	A single / equitable waiting list has been achieved from the point of view of all patients across our service have waiting times that are same.

3) Virtual Patient Management – Modes of Contact

Due to the COVID pandemic requiring almost immediate introduction of remote consultations without any planning, work has now taken place to ensure this is still integrated into the service we provide with patient choice being the main driving factor behind what mode of contact is chosen. We want to continue to embrace the opportunities that remote consultations can give us alongside face to face consultations.

Area for Inclusion	Detail Current Position	Platforms Involved	Assigned to / Service Work Stream

Modes of Contact	Investigation conducted to optimise patient centred care through effective use of appropriate appointment types (face to face and VPM). Changes implemented including template review to ensure safety netting, patient choice and staff wellbeing. Delivering classes remotely has been trialled however not rolled out or scaled up. This needs investigated again to see if there is a need for some classes to be offered in this format.	Telephone Near Me MS Teams	'Optimising appointment type' project led by Louise Ross is complete. All new patient appointments are built as F2F with patients able to choose another mode of contact if more suitable. All return appointments built as Tel / F2F so either can be booked at any time based on clinical need and patient choice. Virtual classes were trialled but have now stopped, this will be included in the scoping for the Pathways Project to review, update and standardise classes across the service – Margot Cohen will lead.
VCreate	Investigate the functionality and potential use of VCreate to help with reviewing patient's progress visually, then interact with them remotely. This can also be used as way to visually document progress and also as a valuable teaching tool.	Vcreate	Potential future discussion as there is the possibility of using VCreate from an educational point of view e.g. trial with CFT course in 2023
EQIA	We need to ensure that what we develop is accessible to all no matter background, IT literacy etc., for example continue to offer	NA	Included in service wide EQIA led by Aileen O'Gorman & Helen Little

	paper formats or drop in's / phone in's where assistance is given to self refer.		
Accommodation	Links with forward planning for 'ideal accommodation' with adequate IT infrastructure e.g. single rooms with appropriate IT whilst keeping rehabilitation space. Ensure we keep accommodation planning on everyone's planning agenda	NA	Ongoing discussions EMT

4) Digital Innovation

Innovative solutions are required to improve the referral process for patients to ensure they reach our service and the most appropriate clinician in a smooth and easy way while being fully informed along the pathway with appropriate information.

Self-Referral Long Term	Long term a solution similar to MSK Advisor which gives patients more information and direction to correct service at the point of referral. Appropriate MSK referrals are then vetted / processed electronically and automatically to TrakCare in an accurate way – reducing the time needed for clinicians to process referrals. Paper referrals or telephone referrals (admin fill in SR over phone then add to TrakCare) may still be required to offer route for all if can't access via IT.	Referral tool similar to MSK Advisor TrakCare Paper Telephone	Current discussions ongoing to agree best way forward as a service either on our own, with other GG&C services and / or nationally
Exploration of AI or algorithm based Digital	• Work with WOS Innovation hub to explore Digital access.		Tracy Cassidy - Reviewed monthly at EMT objectives

access – **Section added from Jill French taken off service workplan – needs tidied up**	• MAP current and desired MSK pathways • Write Prior Information Notice for Procurement tender • ? SBAR to be submitted to WOS Innovation hub (all awaits outcome on e health strategy from Board)		meeting as required (to be added as agenda item)

5) Electronic Patient Records (EPR)

Our business case for EPR for the MSK service was agreed with eHealth at the end of 2018. Since then a work stream was established to work with eHealth to plan, build and then implement EPR in the form of ACN on TrakCare across the service as per our business plan. The roll out of this across the service was completed at the end of 2022 resulting in all our clinical interactions now being recorded electronically. Further developments of our EPR will continue to make sure it is fit for purpose for our service, staff and patients moving into the future.

Area for Inclusion	Detail Current Position	Platforms Involved	Assigned to / Service Work Stream
Plan, Build & Implement EPR – Active Clinical Notes (ACN) on TrakCare	Finalise the platform that will be used then finalise the building of the forms to then allow the forms to be piloted then rolled out across the service as per stages 1,2 & 3 in the business case.	TrakCare	Completed end 2022 – Marion O'Toole October 2023 Staff Feedback was sought

Hardware	Secure funding for large amount of hardware to allow EPR to be rolled out on all sites, especially on sites with cubicles that currently have no access to IT.	All required hardware	Completed 2022 – Marion O'Toole
PROMS Collection	PROMS were manually inputted on TrakCare by clinicians and automatically collected on our dashboard, with EPR this data is now automatically collected from our ACN forms (to save separate inputting) and cease use of the separate TrakCare questionnaire. A new dashboard is being built to collate and display these results to aid service monitoring and reporting.	Dashboard TrakCare	New dashboard has been finalised alongside service processes to collate and disseminate appropriate reports eg Analysis & Plan questionnaires sitting at entered - Marion O'Toole Trial producing individual reports for staff on their PROMS, possibly use within TURAS review discussions
Future Developments	Our service should always consider the impact on ACN at start of all service improvements or changes.	TrakCare	Ongoing all EMT
Patient Access to Records	There is the possibility that nationally, patients will have appropriate access to their own records e.g. 'Patient Portal'. We need to link, as appropriate, with any work streams regarding this to ensure any MSK Physiotherapy records link up appropriately.	TrakCare Netcall 'Patient Portal'	Potential future discussion

6) Data

Continue to develop the collection of the data we need to use to inform and prove our service (stop collecting data we don't need), make sure data is collected automatically to minimise manual data collection and is flexible and responsive to allow our service to ask more or different questions as required.

Area for Inclusion	Detail Current Position	Platforms Involved	Assigned to / Service Work Stream
Current Data Collection	Review our current dashboard reports to ensure our reports give us what we need quickly and easily and are easy to interpret with access to all who need it. Previously started to be looked at with the 'Measuring for Improvement' project.	Dashboard TrakCare	Digital group has summarised what we have already, what needs to be stopped and what we need that we don't already have. Wider EMT to consider with all future developments.
Future / Ideal Data Collection	Project required to build on outcome of 'Current Data Collection' above. This would aim to ensure the data we collect is what we need and when we need it and would include removing unnecessary data collection. We would look to include more specific epidemiology & demographics of patients that access our service which will help to shape our current and future service provision.	Dashboard TrakCare	Project to be assigned / agreed
Sharing Data	Share Data with staff and stakeholders as appropriate, find out what stakeholders and	Dashboard Infographics	Ongoing on an ad hoc basis – Project to be assigned / agreed

	staff want or need – this will link with 'Future Data Collection' project.	Email Websites	
PROMS	Ensure this data is further developed to make it as meaningful as possible, for example, making it more condition specific, link with proving virtual v's F2F etc. Agree whether we want to pursue individual staff reports on their PROMS for reflection and directing areas for self-development.	Dashboard TrakCare Clinical Portal	Carolyn Galloway is monitoring outcome measure data return and presenting these results. Future developments to be agreed
PREMS	Alongside PROMS we also need to ensure as a service we also collect meaningful PREMS, that can be collected, analysed and reported quickly & easily using appropriate digital platforms available.	TBC	Karen Glass – will relaunch / investigate what to use, how & when. New group meeting in September '23
GP APP Data Collection	This data was collected manually on paper which was a time consuming process to collect then present this information electronically. Work is currently underway with PHS/ISD to build an FCP dashboard, with data collected in line with National FCP agreed data. This still requires an element of manual input by staff using MS Forms for each patient, however, seems quicker, and the dashboard will provide greater degree of governance/overview. Staff will continue to	EMIS Dashboard	Fiona Rough working on this with the GP APP team.

	have to manually count numbers of appts available & filled each month. A pilot of the new data collection/dashboard is anticipated in Sept 23.		
Moving share folders to SharePoint	All share folders will be moved to SharePoint. As a service we want to do this with our own timescales to ensure the move meets our needs as a service. Local areas need to tidy up current folders so only relevant information is included so they are ready to move. Then we need to agree timescales to complete this with assistance from eHealth.	Share Folders Share Point	EMT agreed to tidy shared drives by the end of 2023 with view of moving to SharePoint

7) Staff Information & Training

Staff should be supported with developing digital skills and also be able to easily access all information they require in a timely manner to be able to do their jobs easily and effectively.

Area for Inclusion	Detail Current Position	Platforms Involved	Assigned to / Service Work Stream
Digital Literacy	"Support a modern and flexible workforce with the tools, training, and new skills they will need to operate within a modernised organisation and meet the expectations of a digitally confident workforce". However "that measurement of competency should focus on the local context of environment and professional role to have meaning" P19 GG&C AHP Learning & Development Strategic Framework New HCPC standards also required all registered Physiotherapists to be coherent in the digital you need to do your job. We need to ensure we have a digitally literate and confident workforce which could involve a specific LNA of staff to highlight training needs, incorporate digital literacy into TURAS and PDP discussions to increase awareness of staff that we want to support them in developing the digital skills they need to do their jobs. As a service we want to optimise the use of remote consultations, where indicated, by supporting staff with training and appropriate IT hardware where needed. This is to ensure remote consultations are used for staff & patients benefits.	MS teams Any as indicated	Requires a project to be assigned / agreed however with ongoing discussions within EMT and wider board AHP groups.

	Succession planning for digital leadership within the service should also be encouraged eg Digital Leadership course with projects to align to our digital strategy and then become involved in the MSK Digital Group.		
Review MSK Index	'The Right Decision Service' is an alternative to CKP (for MSK Index) which services are moving to as CKP upgrades are no longer going to be supported. Our service needs to plan moving our information to a new / supported platform	MSK Index The Right Decision Service	MSK Index is currently being moved completely to Right Decision Service
Staff Information	All information to be able to carry out their jobs, including delivering patient care, should be easy to access, timely and relevant.	Website MSK Index Email MS Teams Core Brief SharePoint Newsletter	Ongoing – all EMT
Feedback	Feedback from staff, (patients), stakeholders – timely & meaningful that is then actioned and results shared with those that require it.	Webropol MS Teams Email Infographics	To be agreed / assigned & Ongoing Ad Hoc Currently through wellbeing team for staff feedback

O365 Functionality	Increase knowledge of full functionality and how best to utilise this to improve flow of work, projects and information sharing in all aspects of the service. Disseminate and share this knowledge across the whole service. Work with IT to find solutions to any issues that o365 may be able to provide.	Microsoft 0365	To be agreed / assigned & Ongoing Ad Hoc

8) Patient Information

All information that patients require, at various points in their journey i.e. before, during and after interacting with our service, should be easy to access and appropriate.

Area for Inclusion	Detail Current Position	Platforms Involved	Assigned to / Service Work Stream
Self Management Information / Resources	Our public facing website has been extensively improved and continues to be updated so that the public can access all Self Management information alongside our service information at any time.	Word Press – website TrakCare	Website Team

Information provided while patients being seen within the service.	Continue to find easy ways to share condition and patient specific exercises and advice after assessment. SSM area on MSK Index is a great way to hold a lot of information however can be time consuming to find appropriate information, review options to streamline this as above. Possibly move towards creating more of our own advice resources e.g. videos.	MSK Index Generic emails PhysioTools Website	Ongoing as part of other work streams – monitor.
Post Discharge Information	Equip patients with the knowledge to easily access both generic information but also to access and refresh specific information previously given.	Website	Ongoing as part of other work streams – monitor.
Share Success and promote our profession and health promotion messages.	Expand ways to celebrate our service successes and developments. Move towards having more people who share positive news and information on various platforms to reach a wide audience both within and out with GG&C.	Social Media - Twitter Core Brief Website Email	Ongoing as part of other work streams – monitor.
Feedback	Feedback from patients or stakeholders – timely & meaningful that is then actioned and results shared with those that require it.	Webropol MS Teams Email Infographics	Ongoing / To be agreed / assigned

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
AUDIT AND PERFORMANCE COMMITTEE

Report by Val Tierney, Chief Nurse

25 June 2025

Subject:
West Dunbartonshire Collaborative Care Home Support Team Annual Report 2024

1. Purpose:

1.1 The purpose of this report is to update on the work of West Dunbartonshire Collaborative Care Home Support Team [CCHST], and two associated sub groups - The Care Home Practitioners Group & the Care Home Managers Group. All work is undertaken in partnership with NHGGGC Care Home Collaborative [CHC]. This covers all older peoples nursing and residential care homes in West Dunbartonshire, and one respite service for clients with learning disabilities and a care home for people with mental health disorders. The report is for information and assurance

1.2 The report provides a high level overview of the findings from the care assurance visits undertaken between January and December 2024 by members of West Dunbartonshire Collaborative Care Home Support Team. Areas of good practice are highlighted alongside areas for improvement.

1.3 The findings are triangulated with Care Inspectorate Findings, West Dunbartonshire HSCP Quality and Commissioning Quarterly monitoring reports and themes emerging from complaints, adult support and protection notifications and reviews of resident's care needs.

1.4 The report highlights support provided to West Dunbartonshire Care homes by NHSGGC CHC and WD CCHST to support improvement in care quality within care homes and reviews available data to illustrate the impact. Future priorities for improvement activity are identified.

2. Recommendations

2.1 Members of West Dunbartonshire Health and Social Care Audit Partnership Audit and Performance Committee are asked to note the content of the report.

3. Background

3.1 Care Home Oversight Teams were established in HSCPs during the pandemic as Care homes environments were susceptible to the coronavirus with elderly residents at risk of poorer outcomes due to pre-existing conditions. This work aligned to the NHSGGC Executive Nurse directors delegated responsibilities set out by Scottish Government at that time to provide nursing leadership, professional oversight, implementation of infection prevention and control measures, use of personal protective equipment [PPE] and quality of care within care homes.

3.2 The success of the Covid booster programme and high uptake means that our residents are protected and the impact of Covid 19 has been successfully reduced. Nonetheless the care home sector continues to face challenges in terms of recruitment and retention of staff and commercial viability.

3.3 In 2022 The My Health, My Care, My Home - Healthcare Framework[1] for adults living in care homes provided guiding principles and a framework which recommends that health and social care professionals continue to work together to improve the health and wellbeing of people living in care homes.

3.4 The HSCP Care Home Oversight Group evolved into the HSCP Collaborative Care Home Support Team [CCHST] which continues to work in collaboration with care homes, to focus on quality improvement, sustainability and viability. This ensures that local assurance and support arrangements link effectively with Chief Nurse and Chief Social Work Officer, rather than duplicate, wider regulation activity by the Care Inspectorate.

4. Main Issues

4.1 Maintaining high quality care in Care Homes remains a key priority within the partnership. The Collaborative Care Home Support Team [CCHST] is focusing on implementation of the Healthcare Framework for Care Homes, with multidisciplinary support to care home residents and a quality management approach based on the Health and Social Care Standards.

Care Assurance Visits

4.2 Care Assurance Visits are undertaken by the CCHST twice per year for each care home and more often if required. Visits provide the opportunity to discuss with care homes areas of strength as well as key improvement priorities. Following visits liaison with NHGGC Care Home Collaborative [CHC] supports access to support for care homes to help them secure identified improvements in care.

4.3 Learning suggests that local arrangements work best where a partnership approach fosters mutual respect, trust and equal voice. Key to the approach is a recognition of the experience of care home staff; assurance support in the context of ensuring a homely environment in which people live and work; and solution-focussed improvement support conversations with supportive follow-up.

4.4 Visits are planned in accordance with the NHSGGC Standard Operating Procedure to ensure they are approached in a consistent way that promotes partnership with care homes. Visiting teams were made up of a senior social worker and a senior nurse from the HSCP. Care Home managers are consulted around the timing of visits and are sent the tool prior to the visit to self-assess their current position against the criteria. Visiting teams utilise the previous visit report and the self-assessment to provide them with a background on the home prior to the visit. Outcomes provide the opportunity to discuss with care homes areas of strength as well as key priorities for improvement.

4.5 Care assurance visits are one part of the supportive framework around care homes and sit alongside HSCP commissioning relationships with individual care homes, review arrangements, and daily care home huddle reports via TURAS. These arrangements link effectively with, rather than seek to duplicate, wider regulation activity by the Care Inspectorate

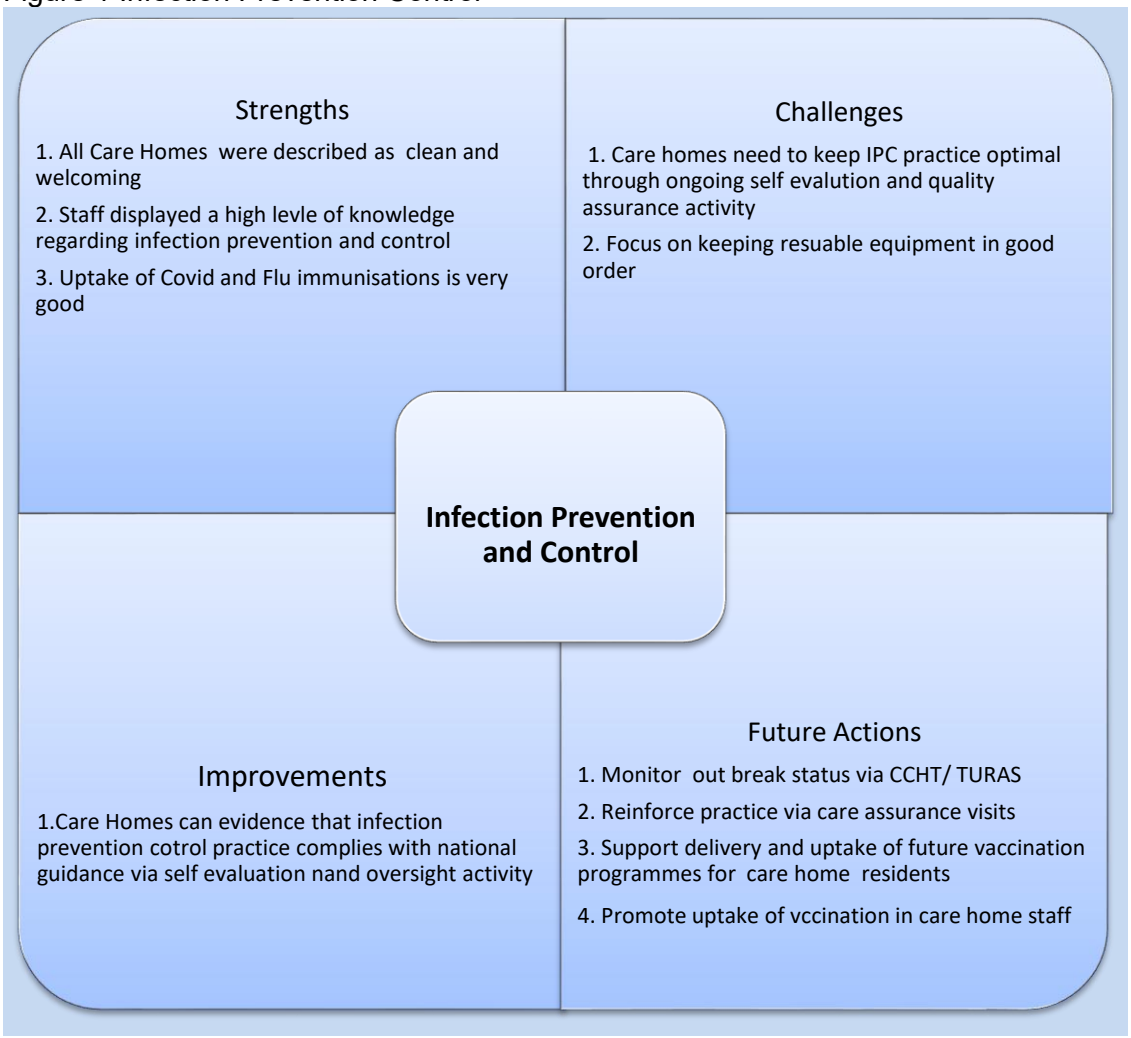
4.6 The Care Assurance [CHAT] visits focus on four key themes.

Theme 1 - Infection Prevention Control
Theme 2 – Resident Health Care Needs
Theme 3 – Workforce Leadership and Culture
Theme 4- Action Planning for Assurance

The key areas of strength and improvements required and achieved are summarised below as representative of the levels of care and practice that were observed. Theme 4- Action Planning for Assurance and Continuous Improvement is captured within each respective theme.

4.7 Theme 1 - Infection Prevention Control;
Environment, Cleaning, PPE, Handwashing Laundry and Waste Management

Figure 1 Infection Prevention Control



All homes have completed a significant amount of education and training around infection prevention and control. The majority of homes remained compliant with IPC mandatory training, but it is evident that ongoing self – evaluation and education is required to ensure practice remains optimal and that systems and resources are in place to facilitate consistent implementation and compliance monitoring of IPC as specified in the national care home infection prevention control manual[2] in all care areas.

4.8 Theme 2 – Resident Health Care Needs:
Personal planning, Future Care Plans [Anticipatory Care Planning], Right Care, Right Place, Food, Fluid & Nutrition Continence Promotion, Falls prevention, Medicines Management, Pressure Care

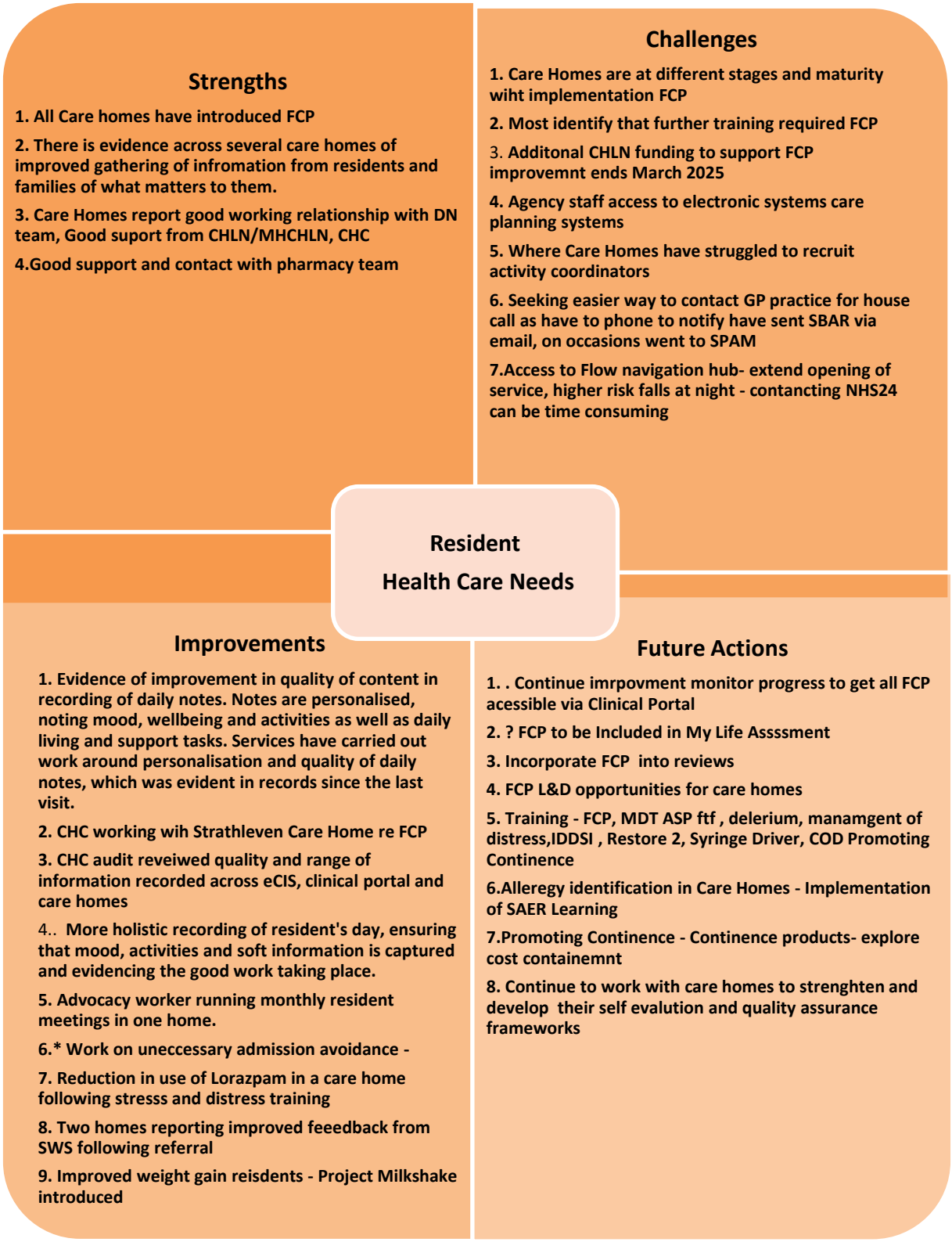
This focusses on person centred and high quality nursing and social care being delivered across care homes. An appreciative enquiry approach is adopted to glean information based on discussions and the sharing of information by care homes to evidence their practice. It does not involve a care plan audit rather the intention is to understand the process of care planning within the home and a selection of resident care plans are discussed to determine how staff are facilitating person centred care

Positive and caring interactions were observed between staff and residents, and staff were observed to be kind and caring. Activities were observed to be in progress in some of the homes which residents were clearly enjoying and care plans were observed which articulated 1-1 interests and preferences. Good assessment processes were noted in relation to pressure area care and all homes reported timely access to pressure relieving equipment.

Most care plans were person centred and up to date with evidence of robust processes to support regular review, a small minority were noted to be task oriented and required further development. Most care homes were using or transferring to electronic recording systems which supported identification of the need for review. Where electronic systems were in place they were noted to provide clear and easily navigated care plans.

One area that warrants further exploration is equitable access to support and care assurance visits for all care homes regardless of the client group they serve. Some support services have been developed with a remit specifically for older peoples care homes this has been problematic on occasion when endeavouring to find the appropriate support for care homes for adults with mental health or learning disabilities as their primary focus. NHSGGC CHC are testing CHAT tools for future use.

Theme 2 Resident Care Needs



Emergency Departments Attendance

4.9 NHSGG created a dashboard for care homes that aligns with Call before You Convey [CB4YC] activity so that efforts to understand and prevent avoidable conveyancing of residents to hospital emergency departments might be targeted.

4.10 For example WDHSCP had a 54% conversion rate in May to August 24 across our care homes. The only HSCPS with better conversion rates being East Renfrewshire and East Dunbartonshire at 59%. When this is converted to a rate per 100 beds West Dunbartonshire had no care homes in the top 20 for emergency attendances however, neither did we have any care homes in the bottom 20.

4.11 West Dunbartonshire Care Homes had 180 attends and 97 admissions May – August 2024. Creation of the Care Home Dashboard will enable us to track the impact of planned activity, to reduce unnecessary conveyancing from care homes going forward

Table 1: No. of Care Home ED Attendances vs Admission May – Aug 2024

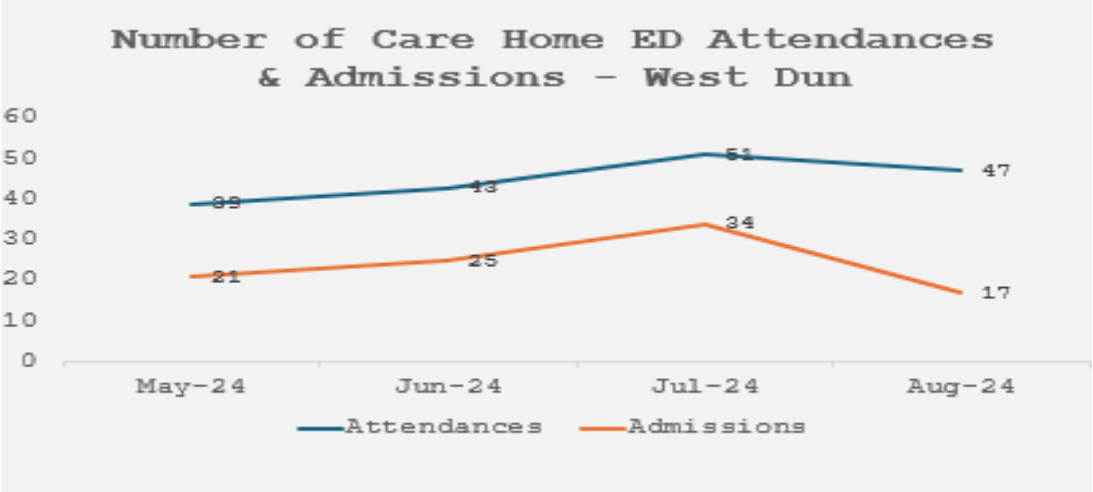
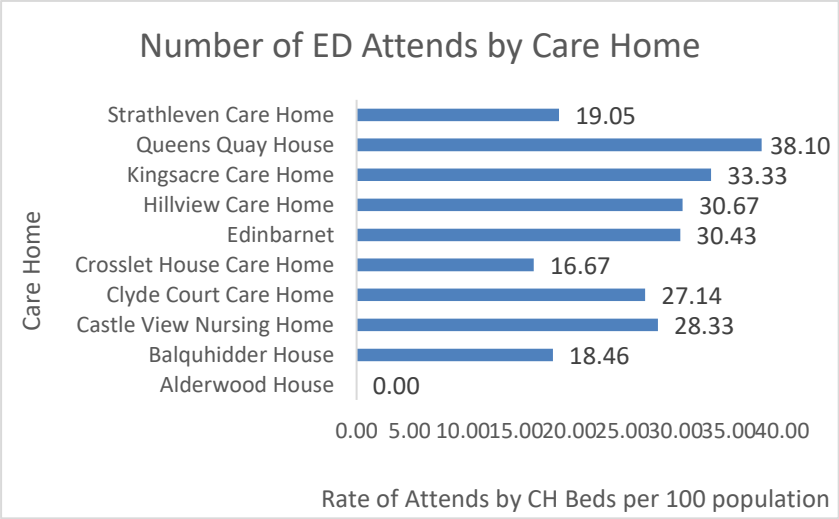


Table 2:
Rate of Emergency Department Attendances By care Home per 100 Population



4.12 Peak attendance days were Monday, Wednesday and Thursday over this period for West Dunbartonshire. The highest reason for attendance was recorded as 'not known' followed by head injury. This suggests that improvements in recording and further efforts to understand the factors leading to unnecessary conveyancing are required in order to further support care homes more effectively in this area.

4.13 There have been a number of improvement activities aimed at reducing unnecessary conveyancing and admission avoidance to date. These include,

I. Call Before You Convey,
II. Chronic Obstructive Pulmonary Disease [COPD] review and Rescue Medication
III. District Nurse Test of Change – weekend prescribing Urinary Tract Infection [UTI], Upper respiratory Tract Infection [URTI], Cellulitis,
IV. End of Life [EOL] Care
V. Care Home Liaison Nurse [CHLN] Future Care Planning [FCP] & Pre Weekend Ward Round in Care Homes [CHLN activity funded until end March 2025 with non-recurring Care home Collaborative monies.]

Optimising the impact of these activities will deliver further improvements.

West Dunbartonshire Call Before You Convey

4.14 This aims to increase support to Care Homes to avoid unnecessary conveyances to hospital for care home residents. The aim is to better support Care Home residents and staff in caring for residents during a period of illness, injury or deterioration. To avoid and reduce unnecessary conveyances to hospital, and inappropriate referrals to primary and secondary care where possible, maintaining person in their home where safe to do so.

4.15 No Senior Clinical Decision maker resource was available in West Dunbartonshire HSCP, however our established Care Home Liaison Nurse [CHLN] resource was available to offer additional support, enabled through the use of CHC funding which is currently non- recurring and ends 31st March 2025.

4.16 The increase of 15 hours Band 6 CHLN per week supported delivery of the Call before You Convey service to all care homes in West Dunbartonshire where previously CHLN service was only for Nursing Care Home residents, meaning three additional care homes are now supported plus support to residential areas in nursing care homes. From the beginning of November 2024 until end of January 2025 there were 51 referrals via the Call before You Convey work stream. Interventions included worsening advice and monitoring instructions, diagnosis and medication prescriptions via nurse clinical assessor/prescriber, onward referrals where appropriate and updating of Future Care Plans [FCP's] Do not attempt Cardio Pulmonary resuscitation paperwork [DNA CPR], and Adult with incapacity [AWI] information where appropriate.

4.17 A system was put in place from November 2024 allowing Care Homes to identify and refer anyone they felt was unwell and at risk of potential conveyance to hospital without review or intervention. CHLN would then call and/or visit to review, and

provide support and interventions aimed at maintaining the person safely in care home setting during period of illness, injury or deterioration.

NHSGGC Flow Navigation Centre – Falls

4.18 Care homes identified during CHAT visits that a limitation of this service is the fact that it is not available after 22:00hrs. Several care homes felt it would be useful if these hours were extended, citing the fact that many falls occurred overnight and that access to NHS 24 often proved time consuming.

Future Care Planning

4.19 The CHC non-recurring funding also supported additional Band 5 bank nurse hours to review, update and transfer Future Care Plans from Care Home records onto Clinical Portal ensuring these were accessible to all practitioners involved in the residents care.

4.20 Theme 3 – Workforce Leadership and Culture; Staffing Resource and Staff Wellbeing

This section looks at the workforce, culture and leadership within the care home. Stable and effective leadership and wider support from the organisation can be directly correlated with the care that the residents receive, how staff feel and the overall culture of the care home. Three care homes experience a change in manager during 2024. [Alderwood – April 2024, Kingsacre – September 2024, Queens Quay – July 2024].

The wellbeing of staff cannot be separated from safe care and positive outcomes for people who use services. Managers and Staff reported that they felt supported by their management teams and were happy in their roles. Recruitment of staff is an ongoing issue for many of the homes as per the national picture despite innovative approaches including overseas recruitment. Staff wellbeing remains a key priority.

Health and Care (Staffing) (Scotland) Act 2019

4.21 The Health Care Staffing places a duty on care service providers to ensure appropriate staffing and training of staff. It is designed to ensure Staff feel able to raise issues about the safety of people using services, mistakes or areas of concern vital to their wellbeing. This involves creating a culture of transparency, continuous improvement, open communication and clarity to staff that there is a culture of improvement rather than blaming individuals.

The Role of the Care Inspectorate

4.22 The Care Inspectorate regulates and inspects care services to make sure they meet the right standards. It also works with providers to help them improve their service and make sure everyone gets safe, high-quality care that meets their needs.

The Care Inspectorate now use Key Questions rather than Quality Themes in their inspections.

KQ1 – How well we do we support people's wellbeing;
KQ2 – How good is our Leadership;
KQ3 – How good is our staff team;
KQ4 – How good is our setting;
KQ5 – How well is our care and support plan
KQ6 – Capacity for improvement

They use the six point scale of 1 – Unsatisfactory, 2 – Weak, 3 – Adequate, 4- Good, 5- Very Good, to 6 – Excellent in grades awarded against each quality indicator.

Table 3: Care Inspectorate Inspections - Grades Awarded 2024 [or most recent inspection]

Care Home	Date of Inspection	Inspection Grades					No of Requirements A = Achieved E = Extended O= Ongoing	No of Areas for Improvement	Grades Relative to previous Inspection
		KQ 1	KQ 2	KQ 3	KQ 4	KQ 5			
Alderwood	23.01.24	3	3	3	3	3	8 = A	2	↑
Balquhidder	07.06.22	3	3	5	N/A	N/A	0	5	↓
Castle View	21.09.23	4	4	4	N/A	4	0	2	↑
Clyde Court	30.09.24	3	3	3	4	4	1 = O	4	↔
Crosslet	18.12.23	5	5	N/A	N/A	N/A	0	4	↔
Dunn St - Respite	03.10.22	5	5	5	N/A	N/A	0	0	↑
Edinbarnet	17.10.24	4	4	5	4	4	0	10	↔
Hill View	23.10.24	2	2	2	2	2	1 = O	0	↓
Kingsacre	04.10.24 &20.12.24	4	5	4	4	4	1 = A	3	↑
Queens Quay	19.12.24	4	N/A	4	N/A	3	1 = O	3	↔
Strathleven	10.10.24	5	5	5	4	4	0	0	↑

4.23 The Care Inspectorate uses requirements and recommendations to help regulated care services improve. A requirement is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Public Services Reform (Scotland) Act 2010, its regulations, or orders made under the Act, or a condition of registration. Requirements are enforceable in law. A recommendation is a statement that sets out actions that a care service provider should take to improve or develop the quality of the service, but where failure to do so would not directly result in enforcement.

4.24 The HSCP placed a Moratorium on admissions in three care homes during 2024 due to care quality concerns. This was designed to support care homes and enable them to focus on achieving required improvements in care quality.

Moratorium Care Home	Date Placed	Date Removed
Alderwood	25.10.23	01.03.24
Hillview	10.04.24	29.08.24
Hillview	30.10.24	Ongoing

West Dunbartonshire Commissioning Quarterly Reviews

4.25 The Quality Monitoring processes and paperwork are currently under review following feedback from Providers.

Adult Support and Protection – Thematic Review Care Homes

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4.26 Adult Support and Protection: January – December 2024

ASP Category	CARE HOMES Number of Beds)										Total
	Alderwood (32)	Balquhidder (65)	Castle View (60)	Clyde Court (69)	Crosslet (56)	Edinbarnet (45)	Hill View (150)	Kingsacre (66)	Queens Quay (84)	Strathleven (21)	
Self	8		1	2					1		**12**
Resident/Resident	17	5	4	10	7	2	35	17	1		**98**
Fall			5	1			5				**11**
Unwitnessed Fall	4	2	9	3			12	4		1	**35**
Left Care Home				2			2	1	2		**7**

Neglect/Phy Harm	2	2	2	12		7	9	4			**38**
Med Error		3	1	6					1		**11**
Financial Abuse		1	1	1	1		6	2			**12**
Wound Man		1		3			4	2			**10**
General	6	8	5	5		1	4	3			**32**
Total	**37**	**22**	**28**	**45**	**8**	**10**	**77**	**33**	**5**	**1**	**266**
Numb ASP Proceeding to Investigations			**3**	**4**	**1**		**6**	**2**			**16**

4.27 Adult Support and Protection (Scotland) Act 2007 introduced committees to oversee and coordinate the protection of adults at risk of harm. These committees are multi-agency, involving senior staff from the council, NHS, and Police Scotland, and are chaired by independent convenors. Their primary role is to monitor, review, and improve adult protection practices, ensuring effective collaboration and communication between different agencies.

An ASP referral, or Adult Support and Protection referral, is a process in Scotland used to report concerns about the safety or well-being of an adult who may be at risk of harm. This referral initiates an inquiry by the local authority to assess whether the adult requires protection under the Adult Support and Protection (Scotland) Act 2007.

The proportion Adult support and Protection (ASP) referrals that proceed to investigation is low. Care Homes have been requesting support with learning and education regarding Adult support and referrals for a number of years. West Dunbartonshire Adult Protection Committee (APC) have to date been unable to offer this support. However a dip sample was undertaken by the West Dunbartonshire Lead Officer for ASP that identified over reporting was an issue confirming the need for learning and education to support appropriate reporting. Training will be delivered during 2025 and further evaluation of ASP referrals will be undertaken in 2026 to evaluate the impact.

Care Home Residents reviews

4.28 Work led by the Head of Mental Health, Learning Disabilities and Addictions is ongoing across the HSCP to strengthen oversight, reporting and timely completion of resident's reviews within care homes in line with best practice and statutory duties. This will inform the CCHST of any merging themes that may require support from a care quality perspective.

Operation Koper

4.29 This is the criminal investigation into the deaths of care home residents and staff from Covid-19. All information has been provided in line with Crown Office Procurator Fiscal Service [COPFS] requests to assist with inquiries.

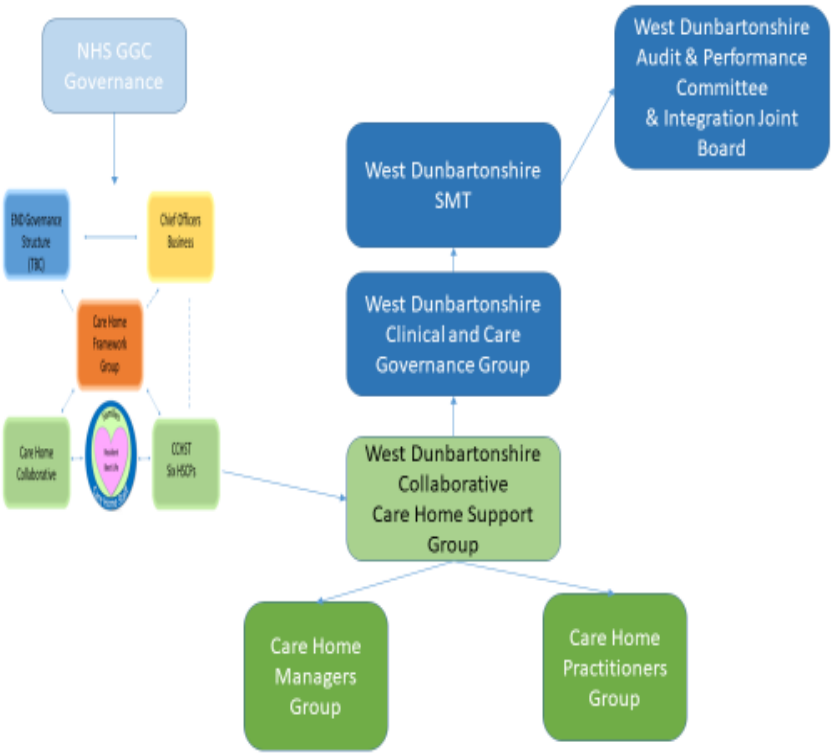
Governance and Reporting

4.30 West Dunbartonshire CCHST reports quarterly to West Dunbartonshire Clinical and Care Governance Group.

4.31 West Dunbartonshire HSCP Commissioning and Quality team provide reports to West Dunbartonshire HSCP Audit and Performance Committee following notification of Inspections by the Care Inspectorate.

4.32 The CCHST reports monthly to NHSGGC Care Home Collaborative and Quarterly to NHSGGC framework Group. Examples of reporting templates are contained in Appendix 3 & 4 respectively.

4.33 West Dunbartonshire CCHST Governance and Reporting Structures



5. Options Appraisal

5.1 Not applicable

6. People Implications

6.1 Not applicable

7. Financial and Procurement Implications

7.1 Action planning and implementation will be contingent on available funding and resources to support ongoing activity

7.2 Funding is available to support the delivery of WDHSCP Call before You Convey and Future Care Planning Efforts between November 2024 and end of March 2025 on a non-recurring basis via NHSGCC CHC funds. Sustainability of this service is contingent on further funding being identified.

8. Risk Analysis

8.1 The ongoing pressures experienced across the care home sector, in relation to recruitment, retention and financial viability present a credible risk to care quality within care homes. Continued enhanced support for adult and older people's care homes to support the sector mitigates these risks and ongoing support for improvement mitigates this risk and will continue to be delivered in line with available HSCP resources.

8.2 Funding is available to support the delivery of WDHSCP Call before You Convey and Future Care Planning Efforts between November 2024 and end of March 2025 on a non-recurring basis via NHSGCC CHC funds. Sustainability of this service is contingent on further funding being identified to ensure that the potential to sustain and further reduce unnecessary conveyancing of resident to hospital is optimised.

9. Equalities Impact Assessment (EIA)

9.1 This report does not introduce a new policy, function or strategy or recommend a Change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required

10. Environmental Sustainability

10.1 Not applicable

11. Consultation

11.1 This report has been prepared by the Chief Nurse in consultation with all members of the Collaborative Care Home Support Team and NHSGGC Care Home Collaborative representatives. The findings at each care assurance visit are agreed with the care home prior to sign off.

12. Strategic Assessment

12.1 The report evidences West Dunbartonshire Collaborative Care Home Support Team and NHSGGC Care Home Collaborative contribution to the achievement of National Wellbeing Outcomes and the priorities within West Dunbartonshire HSCP Strategic Plan

13. Directions

13.1 No directions required to council or health board.

Name: Val Tierney

Designation:	Chief Nurse
Date	28.03.2025

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1. My Health, My Care, My Home - healthcare framework for adults living in care homes My Health, My Care, My Home - healthcare framework for adults living in care homes - gov.scot

2. National Infection Prevention and Control Manual - Care Home Infection Prevention and Control Manual https://www.nipcm.hps.scot.nhs.uk/care-home-infection-prevention-and-control-manual-ch-ipcm/

Appendix 1 CARE HOME ASSURANCE VISIT SCHEDULE OCT/NOV 2024 WEST DUN HSCP

CARE HOME	DATE/TIME	DATE CONFIRMED BY CH
Clyde Court	Thursday 17th October 13:00	Confirmed by CHM 18/9/24
Hillview	Friday 18th October 13:00	Confirmed by CHM 01/10/24
Castleview	Monday 21 October 13:00	Confirmed by CHM 18/9/24
Strathleven	Monday 28th October 13:00	Confirmed by CHM 17/9/24
Balquidder	Tuesday 29th October 13:00	Confirmed by CHM 19/9/24
Alderwood	Monday 4th November 13:00	Confirmed by CHM 18/9/24
Kingsacre	Tuesday 5th November 10:00	Confirmed by CHM 01/10/24
Queens Quay	Monday 11th November 13:00	Confirmed by CHM 18/9/24
Dunn Street Respite	Thursday 14th November 13:00	Confirmed by CHM 18/9/24
Crosslet	Wednesday 27th November 13:00	Confirmed by CHM 18/9/24

Appendix 2. Support Provided to West Dunbartonshire Care Homes by NHSGGC CHC

1. Care Home Collaborative Contacts January 2024 – December 2024

Date	Care Home	Contact Request	Action	Status
31/01/24	Hillview	TVN support	Training provided	Closed
13/03/24	Edinbarnet	Dementia training	Directed to upcoming events	Closed
10/04/24	Hillview	Request for support	Support provided	Closed
17/04/24	Kingsacre	Palliative training	Training provided	Closed
30/04/24	Hillview	Palliative care advice	Advice provided	Closed
14/05/24	Balquhidder	Support for patient on renal dialysis	Support provided	Closed
21/05/24	HSCP	SPAR training for DN team	Training provided	Closed
05/06/24	Kingsacre	Palliative Care training	No response from care home	Closed
12/06/24	HSCP	FFP3 fit testing	Signposted to other resources	Closed
20/06/24	Clyde Court	Care home support	Training provided	Closed
04/07/24	Kingsacre	IPC advice	IPC visit taken place	Closed
16/08/24	Castleview	Multiple training requests	Training provided	Closed
15/10/24	HSCP	Stress and distress behaviour support	Discussions ongoing	In progress

15/11/24	Dunn St	Support to introduce PU risk assessment	In progress	In progress	
13/12/24	Hillview	PUP training	In progress	In progress	
			Total	**15**	

2. Training

Date	Care Home	Training	Nos of staff attended
09/01/24	Clyde Court	RESTORE2	6
09/01/24	Alderwood	Record Keeping	7
23/01/24	Balquhidder Kingsacre Hillview Castleview	RESTORE2	3 3 2 2
06/02/24	Alderwood	Record keeping	3
14/02/24	Strathleven	RESTORE2 Mini	4
20/02/24	Hillview	Palliative Care for Carers	12
21/02/24	Strathleven	RESTORE2 Mini	5
22/02/24	Crosslet Hillview Balquhidder	Strength & Balance	9 1 2
23/02/24	Crosslet	IPC	8
08/03/24	Alderwood	PUP	2
20/03/24	Hillview	SPAR	3

21/03/24	Crosslet Mugdock House	Meaningful Activity	2 4
17/04/24	Alderwood	CAPA/SB Duet	3
18/04/24	Hillview	MUST/MUST Step 5	7
07/05/24	Balquhidder	Stoma Care	10
08/05/24	Clyde Court	Essentials in Dementia	4
09/05/24	Castleview Edinbarnet Balquhidder Crosslet Strathleven Queens Quay	Care Home Development Day	4 2 3 6 2 1
09/05/24 10/05/24 13/05/24	Hillview	Record Keeping	9 8 6
14/05/24	Strathleven	SPAR	4
14/05/24	Hillview	Record Keeping	4
14/05/24	Edinbarnet	Delirium	1
15/05/24	Kingsacre Etive	Palliative Performance Scale Training	1 1
15/05/24	Strathleven	SPAR	5
16/05/24 20/05/24 22/05/24	Hillview	Record Keeping	8 3 8
30/05/24	Unknown	IDDSI events	7
04/06/24	Balquhidder	Renal diet	29
05/06/24	Hillview	Record keeping	9
06/06/24	Balquhidder	Renal diet	29
07/06/24	Hillview	Strength & Balance	6

07/06/24	Hillview	PUP	4
13/06/24	Balquhidder	Wound Care Study Day	1
17/06/24	Crosslet	MUST/MUST Step 5	9
18/06/24	Hillview	PUP	5
25/06/24	Strathleven	SPAR	14
01/07/24	Balquhidder	Stoma care	8
31/07/24	Hillview	IPC	23
07/08/24	Hillview	IPC	8
08/08/24	Crosslet Strathleven Edinbarnet Balquhidder	Meaningful Activity	1 1 1 3
27/08/24	Crosslet	RESTORE2 Mini	16
03/09/24	Clyde Court	Medication Error	6
	HSCP		3
18/09/24	Balquhidder	Renal Session	10
25/09/24	Balquhidder	Care Home Training Day	1
08/10/24	Edinbarnet	Project Milkshake Launch	1
	Queens Quay		5
	Strathleven		3
09/10/24	Crosslet	RESTORE2 (soft signs)	8
09/10/24	Hillview	Essentials in Dementia	3
10/10/24	Crosslet	RESTORE2 (soft signs)	7
05/11/24	Queens Quay	Soft Signs and Escalating Concerns	13
12/11/24	Crosslet	Airflow Mattress	16
13/11/24	Queens Quay	RESTORE2	8

	15/11/24	Hillview	Strength and Balance	6
	26/11/24	Crosslet	Airflow Mattress	8
	16/12/24	Edinbarnet	MUST Webinar	1
			Total	**453**

3. Care Home Visits and Type

Date	Care Home	Staff attending	Purpose
10/01/24	Hillview	Palliative care nurse specialist, QI advisor & care support worker (CSW)	SPAR audit & review
11/01/24	Crosslet	Dietitians & CSW	Data collection
18/01/24 23/01/24 30/01/24	Hillview	CSW Palliative care nurse specialist & CSWs	Completing obs SPAR support
06/02/24	Crosslet	Dietitians & CSW	Data collection (Project Milkshake)
06/02/24	Hillview	Palliative care nurse specialist, HUB5 RN, QI advisor & CSWs	Data collection (SPAR)
08/02/24	Crosslet	Dietitians & CSW	Data collection (Project Milkshake)
13/02/24	Hillview	Palliative care nurse specialist, HUB5 RN & CSW	SPAR project
14/02/24	Crosslet	Dietitians	Reviewing project milkshake data
19/02/24	Hillview	Dietitian	Clinical cover
04/03/24 06/03/24	Crosslet	Dietitians CSW	Data collection (project milkshake) Intergenerational project
07/03/24	Alderwood	Palliative care nurse specialist	Ongoing support discussion

12/03/24	Crosslet	CSW	Nutrition & hydration week
14/03/24 19/03/24 26/03/24 02/04/24 10/04/24 11/04/24	Hillview	Palliative care nurse specialist & HUB5 RNs HUB5 RNs & CSW Dietitians	SPAR audit Data collection Student dietitians catering task
11/04/24	Crosslet	Dietitians	Project milkshake
16/04/24 23/04/24	Hillview	HUB5 RNs & CSW Palliative care nurse specialist, HUB5 RNs & CSW	Data collection SPAR staff survey
29/04/24	Crosslet	CAPA lead & CSWs	Strength and balance discussion
02/05/24	Hillview	TV nurse specialist	Manager meeting
15/05/24	Crosslet	Dietitians	Project Milkshake
21/05/24	Hillview	Dietitians & CSW	MUST audit
21/05/24	Crosslet	CSW	Strength and balance
22/05/24	Hillview	TV nurse specialist	Red Day review tool
22/05/24	Strathleven	Palliative care nurse specialist	SPAR launch
23/05/24	Crosslet	CSW	Strength & balance
30/05/24	Balquhidder	HUB5 nurse lead & CSW	Renal/dialysis meeting with home
06/06/24	Crosslet	Dietitians	Project Milkshake
02/07/24	Strathleven	HUB5 RN & QI advisor	RESTORE2 mini feedback
09/07/24	Hillview	CSWs	Strength and balance
11/07/24	Crosslet	Dietitian and CSW	Project Milkshake

22/07/24 26/07/24 29/07/24 05/08/24 12/08/24	Hillview	CSWs	Strength and Balance
22/08/24 22/08/24	Crosslet	Dietitian and CSW CAPA lead and CSWs	Project Milkshake Strength and balance
26/08/24	Hillview	CSWs	Strength and balance
29/08/24 04/09/24 11/09/24		Palliative care nurse specialist, QI advisor and CSW	SPAR project
28/08/24	Crosslet	HUB5 nurse lead and RN	Continence containment discussion
18/09/24	Castleview	Palliative care nurse specialist	Contact follow up
26/09/24	Hillview	CSWs	Strength and balance
04/10/24	Crosslet	CSW	Strength and balance
04/11/24	Strathleven	TV nurse specialist and HUB5 RN	CPURA
06/11/24 19/11/24 20/11/24	Hillview	CSWs Dietitian CSWs	Strength and balance Clinical cover Strength and balance

	21/11/24 25/11/24 04/12/24	Crosslet	CSWs Dietitian and CSW	Strength and balance Project Milkshake
	08/12/24	Hillview	CSWs	Strength and balance
	09/12/24	Crosslet	CSWs	Manager meeting
	11/12/24	Dunn StrSeet	TV nurse specialist and CSW	CPURA
	11/12/24	Strathleven	TV nurse specialist and HUB5 RN	CPURA
	17/12/24 18/12/24	Crosslet	CSWs CAPA lead and CSWs	Strength and balance Focus group
			Total	**65**

Appendix 3: Collaborative Care Home Support Teams (CCHST) Monthly Care Home Report

Date report completed	
HSCP	West Dunbartonshire
Contact	Val.Tierney@nhs.net
Reporting period (Month/Year)	
Total No of Care Homes included in this report	11 (9 Older People – [2 LA residential , I private residential, 6 nursing], 1 LD, 1mental health)

This monthly return is designed to capture assurance activity in respect of care homes. It should reflect CCHSTs judgement on the basis of the assurance including Care Assurance Visits, local HSCP intelligence and Care Inspectorate data. For each Care Home that is Red or Amber in relation to quality of care there should be an associated SBAR completed and returned with this report.

This report should be submitted to the ggc.chccontact@nhs.scot by the last working day of the month.

Key

Green	no concerns
Amber	concerns emerging, but assurance gained that collaborative and proactive work can manage this
Red	live issues now, deep concerns with home's ability to cope or sustain best practice

Outbreaks	Red	Amber	Green
Regarding the amount of any outbreak including : COVID-19, other respiratory or GI infections or infection outbreak, suspected or confirmed			

Staffing	Red	Amber	Green
Regarding the staffing position in each care home			

When deciding, please consider the overall number of staff and the skills that are required for effective running of the care home			

Overall	Red	Amber	Green
Based on the previous questions and, your judgement about overall performance*, how many care homes would you classify as Red/Amber/Green? *Performance factors including viability, financial and any other factors.			

Please list any care homes that are closed to admissions and / or are restricting admissions

Please include SBAR below of any home that has returned to green in the last calendar month. The SBAR must contain the actions taken to return the home to green.

Appendix 4

Care Home Framework Group **Collaborative Care Home Support Team (CCHST) update** **HSCP REPORT TEMPLATE**	
HSCP	West Dunbartonshire
Report Author:	Val Tierney Chief Nurse
Date:	
Reporting Period:	

The information provided in this template will describe the key activities of the local CCHST. In addition the focused work locally towards delivery of the recommendations within the My Health, My Care, My Home – healthcare framework for adults living in care homes.

It will contribute to the bi-annual update of the Care Home Framework Group to the NHSGGC Transforming and Guiding Council and the HSCPS Chief Officers. As well as the Board Clinical governance and the NHSGGC Clinical and Care Governance Committee.

SECTION 1: CCHST Key headlines • Are there any key updates / highlights/ exceptions that you would like to highlight or escalate?

SECTION 2: Care Assurance Visits • Provide an update of activity since the last report to the Care Home Framework group		
Number of Care Homes in HSCP	11 – [3 residential, 6 nursing, 1 Learning Disability respite Facility , 1 Mental Health]	
Number of Care Assurance Visits undertaken in reporting period		
Total number of Care Assurance Visits undertaken in the current year		
Number of Care Homes in reporting period	Red	Amber
Operation Koper Activity		
Any additional information:		

SECTION 3a: Local enhanced support, education and training by HSCP CCHST - Provide a short brief of enhanced support/ training and detail the progress, impact, and recommendations. - Share any key learning points
Local enhanced support to homes with quality of care issues

SECTION 3a: Local enhanced support, education and training by HSCP CCHST

- Provide a short brief of enhanced support/ training and detail the progress, impact, and recommendations.
- Share any key learning points

SECTION 3b: Care Home Collaborative activity within the HSCP

The CHC team will prepopulate the information below prior to sending template for completion

Reporting period		
Any additional information		

SECTION 4: Improvement and Impact

- Focus on recommendations within the multidisciplinary teams of the Healthcare Framework and SG key measures

Scottish Government measures 2024/5

Right Care, Right Place, Right Time	- No of Care Home resident's presentations at ED and reasons for presentation. - No of homes within HSCP using RESTORE 2 to identify deterioration - Call before Convey data
Infection Prevention and Control	Outbreaks within homes, any key themes / learning emerging
Care Inspectorate Grades	Any themes emerging, good practice / areas for improvement

SECTION 4: Improvement and Impact

- Focus on recommendations within the multidisciplinary teams of the Healthcare Framework and SG key measures

Care Assurance Visits	Any themes emerging, good practice / areas for improvement
Palliative and End of Life Care	- % of residents with a future care plan in place - % of residents who achieve their preferred place of death? Is this data available locally?

SECTION 5: Risks to quality of care

- Are there any significant concerns or risks to quality of care to be highlighted?

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

25 June 2025

Subject: Regulated Services Update Report

1. Purpose

1.1 To provide the HSCP Board Audit and Performance Committee with an update on Care Inspectorate inspection reports for externally commissioned registered services located within West Dunbartonshire and internally provided services by West Dunbartonshire Council (the Council) whose service delivery is caried out by the HSCP. The reporting period covered in this report is for the period 1 January – 31 March 2025, services which were inspected and/or services which had inspection reports published during this period are reported upon.

1.2 Given the public nature of the publication of Care Inspectorate inspection reports, this report includes details of internal services inspected up to an including the 29 May 2025. This is to ensure members of the Audit and Performance Committee are kept fully informed in relation to services provided by the HSCP on behalf the Council.

1.3 Where any regulated service receives a score of 2 – Weak, or less, an additional report will be provided as an appendix to this report.

2. Recommendations

2.1 The HSCP Board Audit and Performance Committee is asked to note the content of this report and its appendices.

2.2 The HSCP Board Audit and Performance Committee is asked to consider the format of this report to ensure it provides sufficient clarity and transparency of information relating to regulated services externally commissioned by the HSCP and regulated services provided by the HSCP on behalf of the Council.

2.3 The HSCP Board Audit and Performance Committee is asked to consider dedicating an informal session with the HSCP regarding Commissioning and the Care Inspectorate to further develop the Committee's knowledge.

3. Background

3.1 The Care Inspectorate now use Key Questions rather than Quality Themes in

their inspections. They still use the six-point scale detailed below:

Grade	Description
1 - Unsatisfactory	**Major Weaknesses – Urgent Remedial Action Required**
2 – Weak	**Important Weaknesses – Priority Action Required**
3 – Adequate	**Strengths Just Outweigh Weaknesses**
4 – Good	**Important Strengths, With Some Areas For Improvement**
5 – Very Good	**Major Strengths**
6 – Excellent	**Outstanding or Sector Leading**

3.2 During the COVID-19 pandemic the Care Inspectorate amended the focus of their inspections. They focused only on how well Care Home residents were supported during the COVID-19 pandemic rather than the full range of Key Questions.

3.3 They amended their quality framework for Care Homes to include a new Key Question; How good is our care and support during the COVID-19 pandemic?' This Key Question has three quality indicators:

- People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic;
- Infection control practices support a safe environment for both people experiencing care and staff; and
- Staffing arrangements are responsive to the changing needs of people experiencing care.

3.4 The Care Inspectorate have resumed looking at the Key Questions which now include elements from the Covid Key Question in their inspections.

3.5 The commissioned service providers which were inspected during the period 1 January – 31 March 2025 and reported within this period are:

<u>Externally Commissioned Regulated Services:</u>

- Castle View Nursing Home – Adults and Older People Care Home
- Clyde Court Care Home – Adults and Older People Care Home
- Alderwood Care Home - Adults and Older People
- Balquhidder House – Older People Care Home
- Quarriers, Dunn Street – Adult Residential Respite Service
- Key, Dunbartonshire – Housing Support Service
- Hearts at Home Social Care Limited – Support Service

- Cornerstone, West Dunbartonshire Community Support – Housing Support Service

Internally Provided Regulated Services:

- West Dunbartonshire Council Learning Disability Service – Adults
- West Dunbartonshire Council Home Care Service
- West Dunbartonshire Council's Children Home – Craigellachie
- Clydebank Day Service and Opportunities – Adults and Older People
- Queens Quay – Adults and Older People Care Home

3.6 A copy of each inspection report has been published and can be accessed on the Care Inspectorate website: www.careinspectorate.com

3.7 The structure of the Care Inspectorate website means that we cannot include links to each report.

3.8 The following appendices accompany this report:

- Appendix 1 – Hill View Care Home Update Report
- Appendix 2 – Cornerstone Baxter View Update Report
- Appendix 3 – West Dunbartonshire Council Home Care Service Update Report
- Appendix 4 – Craigellachie Children's House Update Report

4. Main Issues

Castle View Nursing Home – 200 Castlegreen Street, Dumbarton G82 1JU

4.1 Castle View Nursing Home is owned by HC-One Limited. Castle View Nursing Home is registered with the Care Inspectorate to provide nursing care for a maximum of 60 people including 10 people under the age of 65 with physical disabilities. At the time of inspection there were 56 people living in Castle View Nursing Home.

4.2 The service was inspected between 4 – 6 February 2025, and the report issued in March 2025. The table below summarises the grades awarded to Castle View over their last three inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
06.02.25	5	n/a	4	4	n/a
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
	4	4	4	n/a	4

21.09.23					
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
27.06.23	3	3	3	3	3

4.3 This inspection focused on 3 Key Questions –resulting in an increase in the grade for KQ1 from 4 – Good to 5 – Very Good, grade for KQ4 increased from 3 – Adequate to 4 – Good and KQ 3 remained as previous inspection.

4.4 Key messages highlighted by inspectors were:

- The service had good relationships with external health care professionals
- People's needs were being met to a very good standard
- Staffing levels were good and sufficient to meet people's needs
- Some supervisory competency assessments should be more fully and consistency completed
- Improvements to the quality of the environment need to continue to ensure all areas of the home are of a high quality and facilities and home areas are easy to negotiate

<u>Clyde Court Care Home – South Avenue, Clydebank Business Park, Clydebank G81 2RW</u>

4.5 Clyde Court is owned by Maven Healthcare Limited. Clyde Court is registered with the Care Inspectorate for a maximum of 70 people – including three named persons under the age of 65. At the time of inspection there were 56 people living in Clyde Court Care Home.

4.6 This service was inspected on 13 February 2025, and the report issued in March 2025. The table below summarises the grades awarded to Clyde Court over their last three inspections:

Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
13.02.25	3	n/a	3	n/a	n/a
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
30.09.24	3	3	3	4	4
Inspection date	**How well do we support people's**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support**

	wellbeing				planned
16.07.24	3	n/a	n/a	n/a	n/a

4.7 This inspection focused on two Key Questions – grades remained the same from previous inspection. In this inspection report there was one requirement highlighted for remedial action by the service with a timescale of 23 May 2025:

- By 23 May 2025, the provider must provide a varied programme of meaningful activities. To do this, you the provider, must at a minimum provide:

  a) an activity plan developed from people's interests and hobbies
  b) a range of meaningful activities for people living in the service
  c) opportunities for people to be out in the community

4.8 Key messages highlighted by inspectors were:

- Staffing levels have improved with the new digital system
- Medication management have improved with the new digital system
- Recruitment for an activity worker was ongoing
- Activities continue to need improvement
- Survey feedback from people experiencing care, relatives and staff had taken place

4.9 The provider put a robust action plan in place to ensure that the requirement highlighted will be met once the service is reinspected.

4.10 Management and staff continue to work to improve the service in collaboration with the HSCP and associated agencies.

<u>Alderwood House – 2 Gooseholm Road, Dumbarton G82 2AY</u>

4.11 Alderwood House is owned by Alderwood House Limited which is part of the Meallmore group. Alderwood House is registered with the Care Inspectorate for a maximum 32 adults between 18 – 64 years with non-acute mental health diagnosis including three named individuals over the age of 65 years.

4.12 This service was inspected between 27 February – 4 March 2025, and the report issued in April 2025. The table below summarises the grades awarded to Alderwood House over their last three inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
05.03.25	4	4	4	4	4
23.01.24	3	3	3	3	3
13.11.24	2	2	2	2	2

4.13 This inspection focused on all five Key Questions – resulting in an increase to all previous grades of 3 'Adequate' to 4 'Good'. In this inspection report there were no requirements highlighted for remedial action.

4.14 Key messages highlighted by inspectors were:

- People were happy with the care and support they received in the service
- External professionals were happy with the staff, management and quality of care and support
- Some staff and external professionals felt communication could be better
- Meeting records within the service should be more structured and detailed
- The service should continue to support recovery, promote independence and upskill staff as needs dictate

4.15 Management and staff continue to work to improve the service in collaboration with the HSCP and associated agencies.

<u>Balquhidder House - 1 Charleton Way, Alexandria G83 0TD</u>

4.16 Balquhidder House is owned by Balquhidder Care Ltd which is part of the Handsale Group. Balquhidder House is registered with the Care Inspectorate for a maximum of 65 older people. At the time of inspection there were 63 people living in Balquhidder House.

4.17 This service was inspected between 10 – 12 March 2025, and the report issued in May 2025. The table below summarises the grades awarded to Balquhidder House over their last three inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
19.03.25	4	3	3	4	3
07.06.22	3	3	5	n/a	n/a
07.08.19	5	n/a	n/a	n/a	5

4.18 This inspection focused on all five Key Questions – resulting in an increase to grade for KQ1 from 3 – Adequate to 4 – Good, there was a decrease for KQ3 from 5 – Very Good to 3 – Adequate. In this inspection report there were no requirements highlighted for remedial action by the service.

4.19 Key messages highlighted by inspectors were:

- External professionals spoke positively about their working relationships with the home
- People and relatives we spoke to, appeared happy with the care and support provided
- Most staff felt happy and supported within their roles
- The home should make improvements to their records such as health charts and medication recordings
- Audits were not picking up on areas within the care plan that were not reflective of people's wishes and preferences around their care and support

4.20 Management and staff continue to work to improve the service in collaboration with the HSCP and associated agencies.

<u>Quarriers Dunn Street Adult Residential Respite Service – 10 Dunn Street, Duntocher, Clydebank G81 6JE</u>

4.21 The property which Dunn Street is operated from is leased by Quarriers. Dunn Street is registered with the Care Inspectorate to accommodate a maximum of 6 adults from the ages of 16 – 70 with a recognised learning disability in respite/short break placements. T At the time of inspection there were 5 people being supported at Dunn Street.

4.22 This service was inspected between 19 – 20 February 2025, and the report issued in March 2025. The table below summarises the grades awarded to Dunn Street over their last 3 inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
20.02.25	5	n/a	5	n/a	n/a
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
03.10.22	5	5	5	n/a	n/a
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
23.08.19	5	n/a	n/a	n/a	4

4.23 This inspection focused on two Key Questions – with the service retaining grades of 5 – Very Good in both areas. In this inspection report there were no requirements highlighted for remedial action by the service.

4.24 Key messages highlighted by inspectors were:

- People were respected and listened to because their wishes and preferences were used to shape how they were supported during their stay
- People who used the respite service and staff benefited from a warm atmosphere because there were good working relationships
- People were very happy with the care and support provided by Dunn Street
- Management demonstrated a clear understanding about what was working well and what improvements were needed
- Staff arrangements allowed for more than basic care needs to be met and supported people to get the most out of life and have a holiday experience

<u>Key – Dunbartonshire</u>

4.25 Key – Dunbartonshire, is owned by Key Housing Association Ltd. Key – Dunbartonshire is registered with the Care Inspectorate to provide a housing support service to adults with disabilities in their home and in the community. At the time of inspection Key – Dunbartonshire was supporting 175 people in their own homes or supported group accommodation across East and West Dunbartonshire.

4.26 This service was inspected between 4 – 6 March 2025, report issued in April 2025. The table below summarises the grades awarded to Key – Dunbartonshire over their last three inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
06.03.25	5	5	5	n/a	5
Inspection date	**Care and Support**	**Staffing**	**Management and Leadership**		
02.012.19	5	n/a	5		
Inspection date	**Care and Support**	**Staffing**	**Management and Leadership**		
02.02.18	5	4	5		

4.27 This inspection focused on four Key Questions – with the service retaining grades of 5 – Very Good in all areas. In this inspection report there were no requirements highlighted for remedial action by the service.

4.28 Key messages highlighted by inspectors were:

- There is a high level of satisfaction among service users
- Families have confidence in the service to keep their loved ones safe and active
- Associated professionals value the service's approach to joint working
- The service requires to do more to ensure regular reviews of care take place

Hearts at Home Social Care Ltd

4.29 Hearts at Home is owned by Hearts at Home Social Care Limited. Hearts at Home is registered with the Care Inspectorate to support services to children and adults with physical disabilities, learning disabilities and older people living in their own home. At the time of inspection Hearts at Home was supporting 11 people in their own homes and community.

4.30 This service was inspected between 10 – 12 March 2025, report issued in April 2025. Hearts at Home registered with the Care Inspectorate in November 2020 and have only been inspected once since the date of registration. The table below summarises the grades awarded to Hearts at Home in initial inspection:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
12.03.25	5	4	4	n/a	4

4.31 This inspection focused on four Key Questions – with the service receiving grades of 5 – Very Good for KQ1 and grades of 4 – Good for KQ 2, 3 and 5. In this inspection report there were no requirements highlighted for remedial action by the service.

4.32 Key messages highlighted by inspectors were:

- People were respected and listened to because their wishes and preferences were used to shape how they were supported at home
- Staff treated people with dignity and were respectful when working in people's own homes
- Overall, people were very happy with the care and support provided by Hearts at Home
- Some improvement was needed around quality assurance to ensure that people continued to have very good outcomes
- Personal plans had a good level of detail to guide staff around how best to care and support for each person

Cornerstone West Dunbartonshire Community Support

4.33 Cornerstone West Dunbartonshire Community Support is owned by Cornerstone. Cornerstone's service is based on four key outcome areas – increased social inclusion, improved health, improved independence and responsibility and improved wellbeing. Cornerstone staff work closely with the individuals, and their families, to support these goals. Please note this service is registered separately from Baxter View and is subject to a different management team.

4.34 This service was inspected between 26 and 27 March 2025, report issued in May 2025. Cornerstone registered the Community Support Service in April 2024 and has been inspected twice date of registration. The table below summarises the grades awarded to Cornerstone West Dunbartonshire Community Support over their last 2 inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
27.03.25	n/a	n/a	4	n/a	4

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
15.01.25	4	3	4	n/a	3

4.35 This inspection focused on two Key Questions – with the service retaining grades of 4 – Good for KQ3 and an increase in grade of 3 – Adequate to 4 – Good for KQ 5. In this inspection report there were no requirements highlighted for remedial action by the service.

4.36 Key messages highlighted by inspectors were:

- The service had made progress with the updating of care plans
- Care plan reviews were taking place regularly
- Care plan reviews were taking place regularly
- Staff supervisions had improved to ensure staff practice was monitored and developed
- Quality assurance of the overall service was still in the process of being improved
- Staff recruitment and arrangements continued to be difficult, but work was progressing

Internal Regulated Services

West Dunbartonshire Council Learning Disability Service

4.37 West Dunbartonshire Council Learning Disability Service is registered with the Care Inspectorate to provide a service to adults with learning disabilities living in their own homes. The service provides housing support and care at home to people living in their own tenancies across three properties.

4.38 The service was inspected on 21 January 2025, and the report issued in March 2025. The table below summarises the grades awarded to West Dunbartonshire Learning Disability Service over their last three inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
21.01.25	4	4	n/a	n/a	n/a
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
12.12.24	3	3	5	n/a	5

Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
22.11.19	n/a	n/a	5	n/a	5

4.39 This inspection focused two Key Questions –resulting in an increase to the grade for both area from 2 – Adequate to 4 – Good. In this inspection report there were no requirements highlighted for remedial action.

4.40 Key messages highlighted by inspectors were:

- Staff were aware of their role and responsibilities in relation to Infection Prevention and Control (IPC)
- Staff had applied for refresher training for infection prevention and control (IPC)
- Peoples homes were free of malodours and clean
- Most of the contaminated objects had been removed from bathrooms and ensuites
- Quality assurance processes had improved

West Dunbartonshire Council Home Care Service

4.41 West Dunbartonshire Council Home Care Services provides care at home support to people living in their own homes. The service operates throughout the West Dunbartonshire local authority area from two office bases, in Clydebank and Dumbarton.

4.42 The service was inspected on an unannounced basis on the 14, 15, 16 and 17 of January 2025, which looked at progress toward the requirements made in March 2024. A further unannounced inspection took place between 1 and 11 April 2025.

4.43 At the time of the inspection, the service was supporting around 1,253 people.

4.44 The inspection was carried out by four inspectors from the Care Inspectorate, with the support of an inspection volunteer.

4.45 A summary of the findings from the Care Inspectorate can be found in Appendix 3 – West Dunbartonshire Council Home Care Service Update.

Craigellachie Children's House

4.46 Craigellachie Children's House is a residential care home for children and young people provided by the HSCP on behalf of the Council. The Care Inspectorate carried out an unannounced inspection on 17 and 18 September 2024. However, the report was not published until December 2024, therefore to ensure transparency we have included this inspection

within this period of reporting.

4.47 At the time of inspection Craigellachie Children's House had been experiencing significant challenges for several months including staff absence, and young people who required a high level of care and support who presented at times with highly challenging behaviour.

4.48 To support the staff team, stabilise the service and enable the improvements required by the Care Inspectorate, the Head of Service took the decision to limit the services registration from seven children and young people to six. This occupancy level is in line with other children's residential services.

4.49 A summary of the findings from the Care Inspectorate and subsequent improvement activity by the service can be found in Appendix 4 – Craigellachie Children's House Update Report.

<u>Clydebank Day Service and Opportunities – Queens Quay House, Queens Quay Main Avenue, Clydebank G81 1BS</u>

4.50 Clydebank Day Service and Opportunities is registered with the Care Inspectorate to provide support to adults aged 50 years and over. The service provides daytime assistance, social activities and meals/snacks. At the time of inspection there were 91 people using this service.

4.51 This service was inspected between 15 – 17 April 2025, and the report was issued in May 2025. The service was registered with the Care Inspectorate in December 2020 and has only been inspected once since the date of registration. The table below summarises the grades awarded to Clydebank Day Service and Opportunities initial inspection:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
18.04.25	5	5	5	5	5

4.52 This inspection focused on all 5 Key Questions with the service being awarded grades of 5 – Very Good for all areas. In this inspection report there are no requirements highlighted for remedial action by the service.

4.53 Key messages highlighted by inspectors were:

- People's wellbeing is promoted through personalised and respectful care
- Leadership drives continuous improvement and fosters collaboration
- Staff work well together, and their commitment ensures high standards of care
- Facilities are of high quality and enhance people's experiences

- Assessment and planning are tailored to individual goals and outcomes

Queens Quay House – Queens Quay Main Avenue, Clydebank G81 1BS

4.54 Queens Quay House is registered with the Care Inspectorate to provide a care service for a maximum of 84 older people aged 60 and over. At the time of inspection there were 81 people living at Queens Quay House.

4.55 This service was inspected on 30 April, and the report was issued in May 2025. The table below summarises the grades awarded to Queens Quay House over their last 3 inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
30.04.25	n/a	n/a	n/a	n/a	4
19.12.24	4	n/a	4	n/a	3
09.01.24	4	n/a	n/a	n/a	n/a

4.56 This inspection focused on 1 Key Question – resulting in an increase to the previous grades of 3 – Adequate to 4 - Good. In this inspection report there were no requirements highlighted for remedial action.

4.57 Key messages highlighted by inspectors were:

- All staff, including agency staff, now have access to the provider's electronic care planning system
- Weekly activity planners were in place and opportunities for people had increased as there were now two dedicated activity staff
- The service is now submitting notifications to Care Inspectorate as expected
- Plans were in place to ensure staff were fully aware of their roles and responsibilities under their professional registration with the Scottish Social Services Council. However, more time was needed to work through these.

5. Options Appraisal

5.1 Not required for this report.

6. People Implications

6.1 There are no personnel issues associated with this report.

7. Financial and Procurement Implications

7.1 In relation to externally commissioned regulated services only, the National Care Home Contract (NCHC) provides additional quality payments. Care homes qualify if they are receiving grades 5 - Very Good or 6 - Excellent for Key Question one 'how well do we support people's wellbeing'. There is a second additional quality payment if the home is awarded the high grade in Key Question one and a 5 - Very Good or 6 - Excellent in any of the other four key questions.

7.2 If Care Homes fail to retain the grades detailed at 7.1, the HSCP will be entitled to remove the enhanced payments.

7.3 Castle View Nursing Home inspection has financial implications for the HSCP. As detailed at point 4.2, Castle View Nursing Home qualify to receive the single enhanced weekly rate of £2.00 per resident per week for Nursing Homes from the date of their inspection. The enhanced weekly rate increases do not apply to residents who only receive a Free Personal and/or Nursing Care payment from the HSCP.

7.4 Balquhidder House inspection has financial implications for the HSCP. As detailed at point 4.17, Balquhidder House will have the double enhanced weekly rate of £2.50 per resident per week removed from date of their inspection.

8. Risk Analysis

8.1 Grades awarded to a registered care service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within timescales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any registered service would be of concern to the Audit and Performance Committee, particularly in relation to the continued placement of vulnerable people in such services.

8.2 Where an externally commissioned regulated service receives a grade of two or less, no new referrals are permitted to be made to the service until such times as the Care Inspectorate has re-assessed their grades to be a minimum of a three and the HSCP is satisfied that the provider has demonstrated sustained levels of improvement. This is the formal position for services under the national care home contract as the same position has been adopted for all externally commissioned regulated services.

8.3 For internally provided regulated services that receive a grade of two or less, it is at the discretion of the HSCP should new referrals be made to

that service.

9. Equalities Impact Assessment (EIA)

9.1 There are no Equalities Impact Assessments associated with this report.

10. Environmental Sustainability

10.1 Not required for this report.

11. Consultation

11.1 Not required for this report.

12. Strategic Assessment

12.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan for 2023 – 26 priorities are:

- Caring Communities
- Safe and thriving communities
- Equal Communities
- Healthy Communities

12.2 The strategic priorities above emphasise the importance of quality assurance amongst providers of care and the HSCP's commitment to work with providers within an agreed assurance framework.

13. Directions

13.1 Not required for this report.

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Appendices:
Appendix 1 – Hill View Care Home Update Report
Appendix 2 – Cornerstone Baxter View Update Report
Appendix 3 – West Dunbartonshire Council Home Care Service

Appendix 4 – Craigellachie Children's House Update Report

Background Papers: All inspection reports can be accessed from https://www.careinspectorate.com

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

25 June 2025

Subject: Appendix 1 – Hill View Care Home Update Report

1. Purpose

1.1 To provide the HSCP Board Audit and Performance Committee with an update on Care Inspectorate reporting for Hill View Care Home, which is a residential care home service, which supports adults and older people, located within West Dunbartonshire.

2. Background

2.1 Hill View Care Home is owned by Advinia Care Homes Limited. It is registered with the Care Inspectorate for a maximum of 150 residents – including eight under the age of 65 with physical disabilities. At the time of writing this report there were 113 residents being supported in Hill View Care Home.

3. Main Issues

3.1 Following a complaint made to the Care Inspectorate, an unannounced inspection took place in October 2024 to investigate the complaint covering the following areas:

- Staffing levels are not always adequate to meet people's needs and requests for care.
- People's choices and preferences were not always respected. This had a negative impact on their wellbeing.
- People were left in wheelchairs for prolonged periods. This placed them at risk of harm.

3.2 The table below highlights the Care Inspectorate outcome of each complaint:

Complaint No.	Complaint	Outcome
1	Staffing levels are not always adequate to meet people's needs and requests for care.	Complaint Upheld
2	People's choices and preferences were not always respected. This had a negative impact on their wellbeing.	Complaint Upheld

3	People were left in wheelchairs for prolonged periods. This placed them at risk of harm.	Complaint Upheld

3.3 Following this visit the Care Inspectorate assessed the service with the following grades:

How well do we support people's wellbeing?	2 – Weak
How good is our leadership?	2 – Weak
How good is our staff team?	2 – Weak
How good is our setting?	2 - Weak
How well is our care and support planned?	2 – Weak

3.4 The service had two requirements to meet by 29 November 2024, at the visit in December 2024 it was assessed that the requirements were not met and the timescale was extended to 28 January 2025.

3.5 At a further visit on 29 January 2025 it was assessed that both requirements had been met. During this visit Inspectors highlighted a further two requirements with a timescale of 17 March and 1 June 2025:

Requirement No.	Requirement Detail	Outcome
1.	The provider must ensure that people experience care in an environment that is clean, safe and that minimises the risk of infections. In particular you must demonstrate: • There are adequate number of domestic staff deployed in all areas to maintain a clean and safe environment; • Members of staff are familiar with, an implement, current best practice guidance on how to prevent and control infection in a care home setting. • Regular quality assurance checks of the environment, including food storage and serving areas, are undertaken in order to ensure that the cleanliness of the environment is	MET – within timescale

	maintained and that a record of such checks is available **Deadline – 17 March 2025**	
2.	The provider must ensure people can be confident that staff who support and care for them have been appropriately and safely recruited. In order to do this, the provider must: • They follow its own organisational recruitment policy and procedures; • There is a robust recruitment system in place which tracks recruitment tasks, including pre-employment checks; • Staff involved in recruitment have been sufficiently trained; • The manager has oversight of recruitment processes and that records are in place, this includes professional registration information when required; • Right to Work checks are evidenced. **Deadline – 1 June 2025**	To be assessed at next inspection.

3.6 The HSCP and colleagues from NHSGGC Care Home Collaborative Team have provided significant amounts of support in areas such as Care Planning/Recording, Tissue Viability/Pressure Sore Management, Strength and Balance Training, this training is enabling staff to provide weekly sessions in all five units.

3.7 Staff from the Contracts, Commissioning and Quality team and nursing/social work officers from the HSCP are in regular contact with Hill View staff to offer continued support and guidance.

3.8 Following the Care Inspectorate visits in December, January and March the grades for the service are now:

How well do we support people's wellbeing?	3 - Adequate
How good is our leadership?	2 – Weak – to be assessed at next Inspection
How good is our staff team?	2 – Weak - to be assessed at next Inspection
How good is our setting?	3 – Adequate
How well is our care and support planned?	3 - Adequate

3.9 The table below summarises the grades awarded to Hill View over their last 3 inspections:

Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
20.03.25	3	n/a	n/a	n/a	n/a
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
18.02.25	3	n/a	2	3	3
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
03.02.25	3	n/a	2	n/a	n/a

3.10 The HSCP placed a moratorium on the service on 30 October 2024, following the improvements implemented within the service the HSCP and the provider agreed to a phased removal of the moratorium. With effect from 14 April 2025 the service would accept two admissions, to two different units on a weekly basis for a period of six weeks, only admissions and referrals from the HSCP would be accepted during this time. At the end of this period the Contracts, Commissioning and Quality team would meet with the provider to assess how the service has coped with the new admissions and agree the next steps for the service.

3.11 The provider put a robust action plan in place to ensure that the requirement highlighted will be met within the allocated timescales.

3.12 Management and staff continue to work to improve the service in collaboration with the HSCP and associated agencies.

4. Options Appraisal

4.1 Not required for this report.

5. People Implications

5.1 There are no personnel issues associated with this report.

6. Financial and Procurement Implications

6.1 There are no financial or procurement implications with this report.

7. Risk Analysis

7.1 Grades awarded to a registered care service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within timescales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any registered service would be of concern to the Audit and Performance Committee, particularly in relation to the continued placement of vulnerable people in such establishments.

7.2 Where a registered service receives a grade two (Weak), no new placements are permitted until such times as the Care Inspectorate has re-assessed their grades to be a minimum of a three and the HSCP is satisfied that the provider has demonstrated sustained levels of improvement.

7.3 Currently there are 37 vacancies in Hillview Care Home. It should be noted that if the moratorium remains in place this may have an impact on staffing levels and the financial stability of the service.

8. Equalities Impact Assessment (EIA)

8.1 There are no Equalities Impact Assessments associated with this report.

9. Environmental Sustainability

9.1 Not required for this request.

10. Consultation

10.1 None required for this report.

11. Strategic Assessment

11.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan for 2023 – 26 priorities are:

- Caring Communities.
- Safe and thriving communities.
- Equal Communities.
- Healthy Communities.

11.2 The strategic priorities above emphasise the importance of quality assurance amongst providers of care and the HSCP's commitment to work with providers within an agreed assurance framework.

12. Directions

12.1 Not required for this report.

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Appendices: None

Background Papers: All the inspection reports can be accessed from https://www.careinspectorate.com/

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

25 June 2025

Subject: Appendix 2 – Cornerstone Baxter View Update Report

1. Purpose

1.1 To provide the Audit and Performance Committee with an update on Care Inspectorate reporting for Cornerstone - Baxter View during Quarter 4.

1.2 The service is a housing support and care at home service, which supports adults aged 18 - 65 years old with a learning disability and complex needs, located within West Dunbartonshire.

2. Background

2.1 Baxter View is owned by Cornerstone. Baxter View is a purpose-built facility consisting of eight independent flats, of which seven are occupied. Baxter View is registered with the Care Inspectorate to provide housing support and care at home to tenants aged over 18 years with learning disabilities, autism or acquired brain injury living in their own homes.

2.2 The service has been operational since 2014. Cornerstone is a national organisation, which is a registered Scottish charity.

2.3 Cornerstone's Baxter View service continues to be under Large Scale Investigation, led by the Chief Social Work Officer.

2.4 Upon conclusion of the Large Scale Investigation, a report will be brought to the Board Audit and Performance Committee.

3. Main Issues

3.1 The service had outstanding actions within its Improvement Notice which had been in place since 26 August 2024.

3.2 The Care Inspectorate carried out unannounced inspections relating to the Improvement Notice on the following dates:

- 26 and 27 November 2024
- 7 and 8 January 2025
- 4 March 2025

3.3 Some minor progress had been made between the inspections in November 2024 and January 2025, however there had been substantive improvements made during the period January 2025 to March 2025.

3.4 These improvements were enough to ensure that the provider had met the terms of its Improvement Notice. The service was re-graded by the Care Inspectorate to:

How well do we support people's Wellbeing?	3 - Adequate
How good is our leadership?	3 – Adequate
How good is our staff team?	3 – Adequate
How well is our care and support planned?	3 – Adequate

3.5 The table below highlights the grades achieved over the last three inspections:

Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
05.03.25	3	3	3	n/a	3
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
26.08.24	1	1	1	n/a	1
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
16.11.23	2	2	2	n/a	2

3.6 **T**he following additional supports have been provided to Cornerstone to help them with their improvement journey:

- Additional Adult Support and Protection Training.
- Support from Pharmacy colleagues including training, advice and guidance.
- Positive Behaviour Support (PBS) Training.
- Additional support from the HSCP's psychologists.
- Weekly support meetings between HSCP Operational Team and Baxter View Management Team.
- Enhanced visits from HSCP Social Work Teams.

3.7 The service continues to be under special measures, however, the frequency of these meetings has reduced from weekly to monthly between the provider and the HSCP. This decision was taken following the inspection feedback from the Care Inspectorate.

3.8 The HSCP SMT is kept informed of the progress of the service along with any key risks to the continued operation of the service.

3.9 The Large Scale Investigation scrutinises key areas along with any incidents that take place at the service, requiring actions and assurances from the provider where appropriate. This includes making recommendations to move people's care from the service should there be substantive risks to individuals (where it is appropriate to do so).

3.10 The service has continued to make improvements, and this has seen a substantial reduction in Adult and Support Protection referrals being made.

3.11 Despite the improvements made by the service, the emphasis is on sustained improvement and as such a moratorium will continue in place until such time as the HSCP are satisfied that sufficient and sustained improvements have been made.

3.12 The HSCP continues to work with colleagues in legal and Procurement and Cornerstone to address the contract issues.

4. Options Appraisal

4.1 Not required for this report.

5. People Implications

5.1 There are no personnel issues associated with this report.

6. Financial and Procurement Implications

6.1 There are no financial or procurement implications with this report.

7. Risk Analysis

7.1 Grades awarded to a registered care service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within timescales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any registered service would be of concern to the Audit and Performance Committee, particularly in relation to the continued placement of vulnerable people in such establishments.

7.2 Where a registered service receives a grade two, no new placements are permitted until such times as the Care Inspectorate has re-assessed their

grades to be a minimum of a three and the HSCP is satisfied that the provider has demonstrated sustained levels of improvement.

7.3 From reviewing the staffing reports from Cornerstone, we are aware that they are using a high amount of recruitment agency workers within the service. This is likely to be a significant cost borne solely by Cornerstone, however, for the purposes of this report we are highlighting a financial risk in relation to the on -going sustainability of the service if recruitment agency use continues.

7.4 Baxter View is now operating with one void due to an individual transitioning to a new service, which had been pre-planned.

8. Equalities Impact Assessment (EIA)

8.1 There are no Equalities Impact Assessments associated with this report.

9. Environmental Sustainability

9.1 Not required for this request.

10. Consultation

10.1 None required for this report.

11. Strategic Assessment

11.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan for 2023 – 26 priorities are:

- Caring Communities.
- Safe and thriving communities.
- Equal Communities.
- Healthy Communities.

11.2 The strategic priorities above emphasise the importance of quality assurance amongst providers of care and the HSCP's commitment to work with providers within an agreed assurance framework.

12. Directions

12.1 Not required for this report.

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Background Papers: All the inspection reports can be accessed from https://www.careinspectorate.com/

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

25 June 2025

Subject: Appendix 3 – West Dunbartonshire Home Care Service

1. Purpose

1.1 To provide the HSCP Board Audit and Performance Committee with an update on Care Inspectorate reporting for the West Dunbartonshire Council Home Care Service. The service provides care at home support to people living in their own homes.

2. Background

2.1 West Dunbartonshire Council Home Care Services is delivered by the HSCP on behalf of West Dunbartonshire Council. The service operates throughout the West Dunbartonshire local authority area from two office bases, in Clydebank and Dumbarton. At the time of the inspection, the service was supporting around 1,253 people.

3. Main Issues

3.1 The service was previously inspected on the 25, 26, and 27 March 2024 where the Care Inspectorate assessed the service with the following grades:

How well do we support people's Wellbeing?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	2 - Weak
How well is our care and support planned?	2 - Weak

3.2 Following this inspection the Care Inspectorate made several requirements which the service worked towards remediating.

3.3 A further unannounced inspection took place on the 14, 15, 16 and 17 of January 2025, which looked at progress toward the requirements. The Care Inspectorate advised that the service had made progress, however there were still outstanding areas that required improvement.

3.4 The Care Inspectorate conducted a further unannounced inspection between 1 April and 11 April 2025. The Care Inspectorate assessed the service with the following grades, which reflected the improvements made by the service:

How well do we support people's wellbeing?	2 – Weak
How good is our leadership?	3 – Adequate
How good is our staff team?	2 – Weak
How well is our care and support planned?	3 – Adequate

3.5 At this inspection the Care Inspectorate made the following requirements:

No.	Requirement	Timescale for Completion
1.	The provider must ensure that people's health, welfare and safety is supported by the effective delivery of visit schedules. To do this the provider must at a minimum: (a) Plan visit schedules in advance and review these regularly to ensure they reflect people's care and support needs. (b) Any changes to agreed schedules are to be communicated with people receiving care or their representative.	5 December 2025
2.	The provider must ensure that care plans are in place and contain sufficient detail to allow staff to provide effective support for people's health, welfare and safety needs. Reviews of care plans must take place at least every six-months, or when a significant change occurs.	5 December 2025

3.6 Key messages highlighted by inspectors were:

- Outcomes for people were being met when supported by regular staff but less so when supported by staff who were not familiar with their needs, routines and preferences.
- The service must improve how visit schedules support people to meet their health and wellbeing outcomes.
- The effectiveness of the care being provided was being impacted by identified gaps in staffing levels at certain times of the day.
- Quality assurance processes had been developed but require to be fully embedded into practice.
- Staff training was in place for core areas.
- The quality of some care plans had improved. Further work is required to ensure all care plans are in place and have been reviewed and updated.

3.7 The Service has a SMART action plan in place which is aligned to the requirements noted in section 3.5. Progress is reported to the HSCP SMT on a regular basis.

3.8 The table below summarises the grades awarded to West Dunbartonshire Council's Home Care service over their last 3 inspections:

Inspection date	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned
11.04.25	2	3	2	n/a	3
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
08.04.24	2	2	2	n/a	2
Inspection date	**How well do we support people's wellbeing**	**How good is our leadership**	**How good is our staff team**	**How good is our setting**	**How well is our care and support planned**
27.03.23	3	3	3	n/a	3

4. Options Appraisal

4.1 Not required for this report.

5. People Implications

5.1 There are no personnel issues associated with this report.

6. Financial and Procurement Implications

6.1 There are no financial or procurement implications with this report.

7. Risk Analysis

7.1 Grades awarded to a registered care service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within timescales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any registered service would be of concern to the Audit and Performance Committee, particularly in relation to the continued placement of vulnerable people in such establishments.

8. Equalities Impact Assessment (EIA)

8.1 There are no Equalities Impact Assessments associated with this report.

9. Environmental Sustainability

9.1 Not required for this request.

10. Consultation

10.1 None required for this report.

11. Strategic Assessment

11.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan for 2023 – 26 priorities are:

- Caring Communities.
- Safe and thriving communities.
- Equal Communities.
- Healthy Communities.

11.2 The strategic priorities above emphasise the importance of quality assurance amongst providers of care and the HSCP's commitment to work with providers within an agreed assurance framework.

12. Directions

12.1 Not required for this report.

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Appendices: None

Background Papers: All inspection reports can be accessed from https://www.careinspectorate.com/

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

25 June 2025

Subject: Appendix 4 – Craigellachie Children's House Update Report

1. Purpose

1.1 To provide the HSCP Board Audit and Performance Committee with an update on Care Inspectorate reporting for the Craigellachie Children's House, which is provided by the HSCP on behalf of West Dunbartonshire Council. The service is a residential care home for children and young people.

2. Background

2.1 Craigellachie is a substantial villa, located in a residential area of Clydebank. The inspection was an unannounced inspection which took place on 17 and 18 September 2024.

2.2 At the time of inspection Craigellachie Children's House had been experiencing significant challenges for several months including staff absence, and young people who required a high level of care and support who presented at times highly challenging behaviour.

2.3 Systems and practices that had been established were compromised and the team needed to have a period of reset following this inspection. A decision was taken by Head of Service to limit the registration of the service to 6 young people in line with West Dunbartonshire Council's two other Children's residential services as part of a range of measures to ensure stability and to support the required improvement.

2.4 There is no proposal that the house would return to accommodating seven young people and a variation will be progressed to limit the registration with the Care Inspectorate to six young people.

2.5 A new external residential manager had been appointed just prior to the inspection who was starting to make a positive impact in supporting the manager of the service and staff team to refocus their approach and enabling child centred care and working more effectively with other teams and services.

2.6 West Dunbartonshire Council as the provider of the service is a Corporate Parent, with statutory responsibilities to look after and accommodate children. This may mean we have the duty to care for children and young people on an

emergency basis, or with highly complex needs, and is one of West Dunbartonshires highest safeguarding priorities.

3. Main Issues

3.1 The Care Inspectorate inspection year 2024-2025 were inspecting against a focus area which looks at how regulated services use legislation and guidance to promote children's right to continuing care and how children and young people are being helped to understand what their right to continuing care means for them (KQ6).

3.2 The service was previously inspected on the 29 September 2022. Only one KQ was assessed which was KQ 6 – How well do we support children and young people's rights and wellbeing? This is the same KQ that was assessed at this inspection, which has reduced from 4 – Good, to 3 - Adequate.

3.3 The table below summarises the grades awarded to Craigellachie over their last three inspections:

Inspection date	How well do we support children and young people's wellbeing	How good is our leadership	How good is our staff team	How good is our setting	How well is our care and support planned	How well do we support children and young people's rights and wellbeing?
23.09.24	n/a	n/a	n/a	n/a	n/a	3 Adequate
29.09.22	n/a	n/a	n/a	n/a	n/a	4 Good
15.11.19	n/a	n/a	n/a	n/a	4 Good	4 Good

3.4 The table below summarises the grades awarded to Craigellachie in relation to each of the themes within the KQ that was assessed over their last three inspections:

<u>KQ – How well do we support children and young people's rights and wellbeing?</u>

Inspection date	Children and young people are safe, feel loved and get the most out of life	Leaders and staff have the capacity and resources to meet and champion children and young people's needs and rights	Children and young people's health benefits from their care and support they experience	Children and young people experience compassion, dignity and respect	Children and young people get the most out of life
23.09.24	3 Adequate	3 Adequate	n/a	n/a	n/a

29.09.22	4 Good	n/a	n/a	n/a	n/a
15.11.19	n/a	n/a	4 Good	4 Good	4 Good

3.5 The service was given one requirement in relation to the inspection, please see table below for details:

No.	Requirement	Timescale for Completion
1.	You must ensure that there is effective recording, oversight and analysis of incidents. a) you undertake a review of previous significant incidents, involving the wider team as necessary b) learning from the review of these incidents is clearly communicated with the whole care team and any identified changes to service delivery or practice is recorded and monitored c) the agreed process of current and future incident reporting is consistently implemented; roles and responsibilities clarified and includes how people have been supported post incident. d) when learning from incidents informs how people need to be supported, this is documented in support plans. e) you implement a robust, recorded process of oversight and analysis of incidents that confirms the Care Inspectorate have been notified when necessary.	31 May 2025

3.6 The Care Inspectorate identified young people had nurturing and trusting relationships and practice was extended to building connections with families supporting young people to stay safely connected and repair relationships with those who mattered, this was identified as an area of strength. The inspection identified the impact of repeated incidents on the environment and whilst staff were working to address this, the number of places and the living space in its current layout and condition was not conducive to the safe and therapeutic care that the team were trying to provide.

3.7 Inspectors identified that although leaders in Craigellachie were committed to the young people in their care, the vision for the service lacked clarity and energy and was not sufficiently resourced and focused on the needs and rights of young people. The recently appointed manager had assertively reviewed and addressed the matching risks within the service and Inspectors agreed that whilst this resulted in transitions for some young people, this was necessary to effectively and safely meet young people's needs.

3.8 The inspection found that although the team at Craigellachie had a good level of skill and were mostly experienced, the potential positive impact this had on young people was compromised by staff absence. Although additional staffing was put in place, this impacted on the consistency and continuity of young people's care.

3.9 At the last inspection the Care Inspectorate identified a need for the service to implement a recognised model of supervision that supported staff to provide the best quality therapeutic care. The organisation had reviewed their supervision policy and leaders in the service had been trained to deliver supervision, but recent demands had reduced the opportunity for supervision.

3.10 There were some systems in place to monitor aspects of service delivery, but these mainly focused on the setting. Quality assurance was not robust enough to evaluate the experiences of young people, particularly after incidents. Whilst the team had the capacity to individually reflect on practice, leaders' analysis of incidents, care plans and risk assessments was not sufficient to drive a proactive culture of outcome focused care.

3.11 Other key messages highlighted by inspectors included:

- Staff prioritised young people's safety but at times they did not have the resources to keep them safe.
- Learning from incidents needed to improve.
- Staff were skilled at developing positive relationships with young people and building meaningful connections with families was a strength.
- Quality assurance was not robust enough to learn from people's experiences or drive safe aspirational care.

3.12 The Care Inspectorate issued the service with the following Areas for Improvement:

No.	Area For Improvement
1	To promote children and young people's safety and wellbeing, the provider should ensure that the environment is conducive to safe, therapeutic care. This should include but is not limited to, reviewing the current layout and purpose of the building to ensure young people can be safely observed and supported and where spaces are shared, ensuring personal information and items that can cause harm are safely stored.
2	To support children and young people's wellbeing, learning and

	development, the provider should ensure that the culture of the service promotes predictability and supports young people to achieve their potential. This should include but is not limited to implementing high quality, individualised support plans that underpin outcome focussed care.
3	To support young people's development and promote positive outcomes, the provider should ensure a mechanism for assessing staffing arrangements, based on the needs of young people, is in place.
4	To support positive outcomes for all children and young people, and ensure care is safe and effective the provider should ensure people's experiences are evaluated. This should include but is not limited to ensuring a robust quality assurance framework is fully implemented including evaluation of support plans and risk assessments. and recording and analysis of incidents as specified in requirement one.
5	Continued from previous inspection - two of the three previous areas for improvement have been successfully met even through a particularly challenging time for the staff team. This identified area of improvement has continued to allow systems and consistency of recorded supervision to be further embedded. This previous area for Improvement is continued.

3.13 In the event that Areas for Improvement are not met by the next inspection the Care Inspectorate have the option to either extend the Area for Improvement or escalate it to a Requirement with a fixed timescale for completion.

3.14 The key areas for improvement identified require a consistent and available staff team whose interventions and support to young people are relationship and rights based to effectively meet the needs and potential for children in their care.

3.15 A service action plan has been developed to ensure the required focus is progressed and targeted to drive the required improvements in the service, this includes the following:

- Full redecoration and repair of Craigellachie is completed
- Building works carried out to remove the office space from within the House to promote a more inclusive and de-institutionalised culture
- Training sessions for staff aligned to The Promise from our Promise participation Lead have taken place.
- Review of recording systems and sign off of any incidents involving young people or staff and consideration of learning with the staff team.
- Planned refreshed Child Protection training for all staff by the Child Protection Lead Officer.
- Updated Dyadic Developmental Psychotherapy (DDP) training for all staff implemented, promoting trauma informed responses to children and young people. (Note: Dyadic Developmental Psychotherapy (DDP) is an evidence-based, attachment-focused therapy. It is designed primarily to help children who have experienced early trauma, neglect, or disruptions in attachment).

- Staffing assessments guidance updated in line with Safe Staffing.
- Staffing assessment, young people assessment and house assessment to inform the rota.
- Developed use of a core group of sessional staff to provide continuity of support at times of staff absence.
- Promoting Positive Behaviour (PPB) training for all staff including sessional.
- Awaiting licence for sessional staff to access emails.
- Care first training for staff including sessional planned to ensure strong and consistent record keeping.
- Supervision training for manager and seniors fully implemented.
- Implementation of supervision documents and agreements with staff aligned to policy.
- Central Information folder in place to ensure staff are updated and aware of relevant policy and procedures.
- Planned training for PPB incident recording and reflection.
- Quality assurance framework to be strengthened to ensure evaluation of support plan and incidents.
- Area Resource Group (ARG) in place to consider all requested admission to care and ensure appropriate placement aligned to identified need
- Peer audit of children and young people record's in place across West Dunbarton's three children's residential homes to promote learning and consistency of approach.
- Consistent robust and strengthened approaches to managing absence and vacancies with the service.
- Requirement for staff to attend planned team meetings to support team communication.
- Development of children and young people's chronologies within the service to support analysis of risk

4. Options Appraisal

4.1 Not required for this report.

5. People Implications

5.1 There are no personnel issues associated with this report.

6. Financial and Procurement Implications

6.1 There are no financial or procurement implications with this report.

7. Risk Analysis

7.1 Risks in relation to quality of support for children and young people are identified within the inspection findings. The importance of a skilled and consistent staffing team with clear communication, underpinned by trauma informed practice with opportunities for reflective learning in the support and management of young people's behaviour is key. The associated

improvement actions will strengthen the skill and resilience of staff to ensure consistent high-quality care and reduction of risk.

7.2 The House manager is being supported to ensure effective and strong leadership is in place to deliver the vision and developing culture of truly child centred practice and change in key areas.

8. Equalities Impact Assessment (EIA)

8.1 There are no Equalities Impact Assessments associated with this report.

9. Environmental Sustainability

9.1 Not required for this request.

10. Consultation

10.1 Consultation with staff and young people is ongoing as part of improvement within the service.

11. Strategic Assessment

11.1 The West Dunbartonshire Health and Social Care Partnership Board's Strategic Plan for 2023 – 26 priorities are:

- Caring Communities.
- Safe and thriving communities.
- Equal Communities.
- Healthy Communities.

11.2 The strategic priorities above emphasise the importance of quality assurance amongst providers of care and the HSCP's commitment to work with providers within an agreed assurance framework.

11.3 Children and Families 5-year Strategic Plan What Would It Take? was approved by the HSCP Board in April 2024. The strategy is underpinned by West Dunbartonshire implementation of The Promise and the required improvement activity and focus aligns with the service strategic approach to service delivery.

12. Directions

12.1 Not required for this report.

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Date: 25/06/2025

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Appendices: None

Background Papers: All inspection reports can be accessed from https://www.careinspectorate.com/

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Service Strategy and Transformation

25 June 2025

Subject: Strategic Risk Register Six Month Review

1. Purpose

1.1 The purpose of this report is to present the Strategic Risk Register to the West Dunbartonshire Health and Social Care Board Audit and Performance Committee.

2. Recommendations

It is recommended that the Audit and Performance Committee:

2.1 Comment on the Strategic Risk Register (Appendix 1), prior to its submission to the HSCP Board for approval on 19 August 2025.

2.2 Consider if there are any strategic risks the HSCP Board may wish to consider promoting to either NHS Greater Glasgow and Clyde and West Dunbartonshire Council for inclusion in their respective strategic risk registers.

3. Background

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) states that an Integration Joint Board (IJB) must have effective governance arrangements in place, which includes systems for managing strategic risks.

3.2 The Integration Scheme confirms that a key element of the required risk management process is the preparation, scrutiny, approval and then annual review of the strategic risk register for the Health and Social Care Partnership.

3.3 The Chief Officer is responsible for ensuring that suitable and effective arrangements are in place to manage both strategic and operational risks relating to the Health and Social Care Partnership.

3.4 The HSCP Board's Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group which confirms the responsibility of the Chief Officer to develop a West Dunbartonshire Health and Social are Partnership Risk Management policy and strategy. The current

Risk Management Policy and Strategy was approved by the HSCP Board on the 20 September 2021.

3.5 On the 18 February 2025 the HSCP Board Audit and Performance Committee requested some improvements in respect of how the risk register was presented to Committee. Elements of this request have been built into this report and will continue to develop.

4. Main Issues

4.1 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that beneficial and defensible decisions are made.

4.2 The attached Strategic Risk Register (Appendix 1) has been prepared in accordance with the Risk Management Policy and Strategy, approved by the HSCP Board on the 20 September 2021. Similarly, in accordance with that Policy and Strategy, standard procedures are applied across all areas of activity within the Health and Social Care Partnership in order to achieve consistent and effective implementation of good risk management.

4.3 Strategic risks represent the potential for the HSCP Board to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk. These are distinct from operational risks, which represent the potential for impact (opportunity or threat) within or arising from the activities of an individual service area or team operating within the scope of the Health and Social Care Partnership's activities.

4.4 The Chief Officer has responsibility for managing operational risks as those are more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Operational risk registers are maintained by Heads of Service on behalf of the Chief Officer; and are the "building blocks" for the Strategic Risk Register.

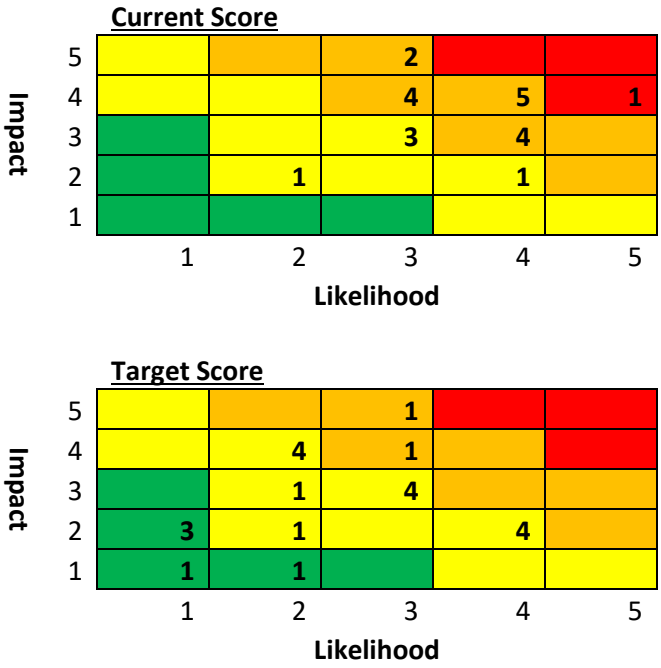
4.5 Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the HSCP Board.

4.6 Existing Strategic Risks on the risk register were reviewed by the Senior Management Team and appropriate Risk Owners.

4.7 Following the review, 10 new risks were identified and recorded in the Strategic Risk Register. The new risks have been evaluated as follows: High – seven, Medium – three.

4.8 Following the review, 12 risks were reviewed and identified as suitable for closure within the Strategic Risk Register, to move to operational registers or to be replaced by an updated risk.

4.9 Following the review, the number of open strategic risks identified by current risk level are as follows: Very High - one, High - 15, Medium - five. Overall target risk levels are as follow: High – two, Medium – 14, Low – five. These 21 open risks can be exemplified as follows:



5. Options Appraisal

5.1 Not required for this report.

6. People Implications

6.1 Key people implications associated with the identified strategic risks are addressed within the mitigating actions of the Strategic Risk Register.

6.2 The Risk Management Policy and supporting strategy affirms that risk management needs to be integrated into daily activities, with everyone involved in identifying current and potential risks where they work.

6.2 Individuals have a responsibility to make every effort to be aware of situations which place them, or others at risk, report identified hazards and implement safe working practices developed within their service areas.

7. Financial and Procurement Implications

7.1 Key financial implications associated with the identified strategic risks are addressed within the mitigating actions of the Strategic Risk Register.

7.2 The Risk Management Policy and supporting strategy affirms that financial decisions in respect of these risk management arrangements rest with the Chief Financial Officer.

8. Risk Analysis

8.1 Failure to comply with the legislative requirement in respect of risk management would place the HSCP Board in breach of its statutory duties.

8.2 The Strategic Risk Register has been reviewed by the appropriate risk owner which has included the addition of new risks, updates to existing risks including risk levels and closure of risks that no longer apply.

9. Equalities Impact Assessment (EIA)

9.1 An equality impact assessment is not required as the recommendations within this report will not have a differential impact on any of the protected characteristics.

10. Environmental Sustainability

10.1 Not required for this report.

11. Consultation

11.1 The Strategic Risk Register has been reviewed and confirmed by the Health and Social Care Partnership Senior Management Team.

11.2 Relevant Monitoring Officers, including internal auditors, have been consulted in the preparation of this report.

12. Strategic Assessment

12.1 Effective risk management will support local and strategic priorities and national health and wellbeing outcomes. It will prevent or mitigate the effects of loss or harm; and will increase success in delivery of the HSCP Strategic Plan, improving lives with the people of West Dunbartonshire.

13 Directions

Not required for this report.

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Appendices: Strategic Risk Register (Appendix 1)

Appendix 1

Ref No	Description	Cause	Risk level (initial)	Controls currently in place	Risk level (current)	Risk level (Target)	Status
1	Risk Owner: Margaret-Jane Cardno Failure to deliver contract monitoring and management of commissioned services; creates a risk to the financial management of the HSCP and there is a risk to delivery of high quality services and the delivery of quality assurance across all areas of service delivery. This includes potential failure of commissioned services in meet their legislative duties in relation to the Health and Care (Staffing) (Scotland) Act 2019.	Poor commissioning can have several underlying causes. 1.Insufficient Needs Assessment: Issue: Inadequate understanding of the health and care needs of the population. 2.Lack of Strategic Planning: Issue: Commissioning without a clear long-term vision or strategic direction. 3.Inadequate Stakeholder Engagement: Issue: Failing to involve key stakeholders (such as patients, carers, and community representatives) in decision-making. 4.Financial Constraints: Issue: Budget limitations and financial pressures. 5.Fragmented Systems and Silos: Issue: Lack of coordination between health and social care providers. 6.Inadequate Performance Monitoring: Issue: Insufficient monitoring of service quality and outcomes. 7.Short-Term Focus: Issue: Prioritizing immediate needs over long-term sustainability. 8. Lack of understanding of legislative requirements.	4x4 High = 16	1.Commissioning Work Plan agreed and monitored by Head of Service for Strategy and Transformation. 2.Commissioning Reviews linked to medium term financial plan. 3.Development and monitoring of Contract Risk Register. 4.Contracts Risk Register reported to HSCP Board. 5.Commissioning Team represented at an appropriate level across the HSCP. 6.Establish provider networks/forums across all HSCP areas. Engagement of stakeholders throughout the commissioning process to ensures inclusivity and responsiveness. 7.Develop and implement IRISS Change Makers Project. 8.Develop a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. 9.Trend analysis and reporting by exception programmed into HSCP Board reports. This enables the HSCP to regularly assess performance, collect feedback, and adjust commissioning strategies accordingly. 10.Strategic Plan "Improving Lives Together" approved by IJB. The development of this robust strategic plan ensures alignment with local and national priorities. 11.Care Pay and Care Finance roll out. 12.Balance financial constraints with the need for effective and sustainable services. 13.Promote integrated working, breaking down silos, and fostering collaboration. 14.Balance short-term goals with a forward-looking perspective. 15.Rigorous assessment processes, involving community engagement and data analysis, are essential. 16. In November 2023, West Dunbartonshire HSCP Workforce Planning Group extended the terms of reference to include Health Care Staffing Oversight and Implementation which includes commissioned services.	3x3 Medium = 9	2x2 Medium = 4	Closed
2	Risk Owner: Margaret-Jane Cardno Failure to manage contracting arrangements; there is a risk that the HSCP has commissioned services which may be out-with contract or contracts are not fit for purpose.	Poor contract management can have several underlying causes such as: 1.Inadequate Record-Keeping Techniques. 2.Too Many Manual Processes. 3.Misalignment between Legal Teams and Stakeholders. 4.Misunderstandings about contract terms and expectations. 5.Inefficient collaboration and decision-making. 6.Limited Expertise. 7.Insufficient knowledge or expertise in contract management practices. 8.Lack of training for contract managers. 9.Inability to identify and address potential risks. 10.Inadequate Technology.	4x4 High = 16	1.Commissioning Work Plan agreed and monitored by Head of Service for Strategy and Transformation. 2.Commissioning Reviews linked to medium term financial plan. 3.Development and monitoring of Contract Risk Register. 4.Contracts Risk Register reported to HSCP Board. 5.Commissioning Team represented at an appropriate level across the HSCP. 6.Establish provider networks/forums across all HSCP areas. 7.Develop and implement IRISS Change Makers Project. 8.Develop a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. 9.Trend analysis and reporting by exception programmed into HSCP Board reports. 10.Roll out of Care Pay and Care Finance.	3x4 High = 12	2x2 Medium = 4	Closed
3	Risk Owner: Margaret-Jane Cardno Failure to manage contracting arrangements; there is a risk that the HSCP is unable to demonstrate Best Value. This includes potential failure of contracted services in meeting their legislative duties in relation to the Health and Care (Staffing) (Scotland) Act 2019.	Poor contract management can have several underlying causes such as: 1.Inadequate Record-Keeping Techniques. 2.Too Many Manual Processes. 3.Misalignment between Legal Teams and Stakeholders. 4.Misunderstandings about contract terms and expectations. 5.Inefficient collaboration and decision-making. 6.Limited Expertise. 7.Insufficient knowledge or expertise in contract management practices. 8.Lack of training for contract managers. 9.Inability to identify and address potential risks. 10.Inadequate Technology. 11. Lack of understanding of legislative requirements.	4x4 High = 16	1.Commissioning Work Plan agreed and monitored by Head of Service for Strategy and Transformation. 2.Commissioning Reviews linked to medium term financial plan. 3.Development and monitoring of Contract Risk Register. 4.Contracts Risk Register reported to HSCP Board. 5.Commissioning Team represented at an appropriate level across the HSCP. 6.Establish provider networks/forums across all HSCP areas. 7.Develop and implement IRISS Change Makers Project. 8.Develop a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. 9.Trend analysis and reporting by exception programmed into HSCP Board reports. 10.Roll out of Care Pay and Care Finance. 11. In November 2023, West Dunbartonshire HSCP Workforce Planning Group extended the terms of reference to include Health Care Staffing Oversight and Implementation.	3x4 High = 12	2x2 Medium = 4	Closed
4	Risk Owner: Margaret-Jane Cardno Failure to adhere to Financial Regulations and Standing Financial Instructions when commissioning services from external providers.	Failure to adhere to financial regulations can have significant consequences for individuals, the HSCP, and the overall stability of the financial system. Underlying causes can be: 1.A poor understanding of legal obligations and contractual agreements. 2.Ignorance or Lack of Awareness. 3.Intentional Non-Compliance: 4.Financial Reporting Irregularities. 5.Culture and Incentives: Organizational culture that prioritizes efficiency or short term interventions over compliance. 6.Complexity and Opaqueness.	4x4 High = 16	1.Restructure and implementation of a Transactional Team. 2.Training on financial regulation and standing orders. 3.Care Pay and Care Finance roll out. 4.Review of Scheme of Delegation. 5.Implementation of Strategic Plan "Improving Lives Together"	3x3 Medium = 9	1x1 Low = 1	Closed

5	Risk Owner: Margaret-Jane Cardno Failure to maintain a secure information management network; there is a risk for the HSCP that the confidentiality of information is not protected from unauthorised disclosures or losses.	Maintaining a secure information management network is crucial for the HSCP and its parent bodies. Some common systemic causes are: 1.Misconfigurations of network devices. 2.Network disruptions. 3.Line Damage. 4.Human damage. 5.Sudden Hardware Failure. 6.Poor Visibility and Fundamentals in Cybersecurity. 7.Failure to implement basic security practices. 8.Outdated Software.	3x3 Medium = 9	1.Data breach management policy in place for both NHS and WDC data. This includes internal e-form reporting procedure for staff. Data breach registers for both partner organisations are kept and analysed for trends and where relevant mitigation put in place. 2.Breaches are reported to ICO and data subjects where required. 3.Ongoing monitoring and management required including relevant training. 4.Records management plan in place and lodged with National Records of Scotland. 5.Cyber security recognised as a strategic risk by both parent bodies.	2x2 Medium = 4	1x1 Low = 1	Closed
6	Risk Owner: Margaret-Jane Cardno Failure to maintain a secure information management network; there is a risk for the HSCP if this is unmanaged of breaches as a result of a GDPR breach; power/system failure; cyber-attack; lack of shared IT/recording platforms; as such being unable to manage and deliver services. Inability to provide service.	Maintaining a secure information management network is crucial for the HSCP and its parent bodies. Some common systemic causes are: 1.Misconfigurations of network devices. 2.Network disruptions. 3.Line Damage. 4.Human damage. 5.Sudden Hardware Failure. 6.Poor Visibility and Fundamentals in Cybersecurity. 7.Failure to implement basic security practices. 8.Outdated Software.	3x3 Medium = 9	1.Data breach management policy in place for both NHS and WDC data. This includes internal e-form reporting procedure for staff. Data breach registers for both partner organisations are kept and analysed for trends and where relevant mitigation put in place. 2.Breaches are reported to ICO and data subjects where required. 3.There remains an ongoing risk that despite procedures a breach may occur. 4.Ongoing monitoring and management required including relevant training. 5.Records management plan in place and lodged with National Records of Scotland. 6.Contingency planning underway in respect of planned power outages and black start events. 7.Cyber security recognised as a strategic risk by both parent bodies.	2x2 Medium = 4	1x1 Low = 1	Closed
7	Risk Owner: Margaret-Jane Cardno Failure to review and scrutinise performance management information; creates a risk of the HSCP being unable to manage demand analysis, service planning and budget management across totality of the organisational responsibilities.	1. Inadequate structures or accountability for collecting, validating, and analysing performance data. 2. Absence of clear roles and responsibilities for performance monitoring. 3. Limited staff expertise or resources to interpret complex data. 4. Overreliance on manual processes or outdated systems. The fragility of CareFirst is highlighted as a stand alone strategic risk. 5. Fragmented data systems across health and social care services hinder comprehensive analysis. 6. Lack of interoperability between IT platforms. 7. A culture that does not prioritise data-driven decision-making. 8. Resistance to transparency for fear of scrutiny. 9. Performance data not reviewed regularly or in enough detail. 10. Reports may lack actionable insights or be misaligned with strategic goals.	4x4 High = 16	**Controls In Place** 1. Regular performance reports are presented to the HSCP Chief Officer and Heads of Services. 2. Regular performance reports are presented to the Audit and Performance Committee and HSCP Board. 3. The Senior Management Team reviews performance data at both SMT meetings and via the Programme Management Office. 4. Establishment of CareFirst Governance Board **Controls in Progress** 1. Roll out of data literacy training. 2. Ongoing development work to enhance the quality of management information reporting in relation to statutory functions. 3. Data management project to be established to get the HSCP ready for major systems change, such as the introduction of Sharepoint and potentially a replacement system for CareFirst.	3x4 High = 12	2x4 Medium = 8	Live/Active (Lines 5 and 6 updated to form this risk)
8	Risk Owner: Margaret-Jane Cardno Failure to monitor commissioned and other partnership services which could impact on an individual's safety or risk to themselves or others.	Failure to monitor commissioned and other partnership services which could impact on an individual's safety or risk to themselves or others.	4x4 High = 16	1.Commissioning Work Plan agreed and monitored by Head of Service for Strategy and Transformation. 2.Commissioning Reviews linked to medium term financial plan. 3.Development and monitoring of Contract Risk Register. 4.Contracts Risk Register reported to HSCP Board. 5.Commissioning Team represented at an appropriate level across the HSCP. 6.Establish provider networks/forums across all HSCP areas. 7.Develop and implement IRISS Change Makers Project. 8.Develop a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. 9.Quality Assurance reporting to HSCP Board and relevant sub committees for example Clinical & Care Governance. 10.Trend analysis and reporting by exception programmed into HSCP Board reports.	3x3 Medium = 9	2x1 Low = 2	Closed

9	Risk Owner: Julie Slavin West Dunbartonshire HSCP Board (IJB) being unable to achieve and maintain financial sustainability within the approved budget in the short to medium term due to the financial challenge of delivering services with increasing costs and demographic pressures against a backdrop of flat-cash allocations from partners	Risk Owner: Julie Slavin West Dunbartonshire HSCP Board (IJB) being unable to achieve and maintain financial sustainability within the approved budget in the short to medium term due to the financial challenge of delivering services with increasing costs and demographic pressures against a backdrop of flat-cash allocations from partners and depletion of reserves below 2% target as set out within our current Reserves Policy.	5x5 Very High = 25	**Controls In Place** 1. Active engagement with all partner bodies in budget planning process and throughout the year. This includes HSCP senior officers being active members of both council and health board corporate management teams. 2. Working in partnership across the 6 GGC HSCPs. Also working collectively in local and national forums for health and social care e.g. National Chief Officers Group, CIPFA Chief Financial Officers Section, Scottish Government Sustainability and Value Groups. Local and NHSGGC Prescribing Efficiency Programmes. CIPFA CFO Section working with Scottish Government and COSLA officials on the importance of timely notification of funding, the need to have recurring allocations that attract inflationary uplifts to support full delivery and financial sustainability of policies. 3. Regular financial reporting to the HSCP Board. Budget monitoring reports are prepared and informed by the range of actions, controls and mitigations. These reports support the HSCP Board to agree on any corrective actions required to support financial sustainability. All actions are predicated on the adherence to Financial Regulations, Standing Financial Instructions, Procurement Regulations and implementation of Directions issued by the Board. 4. Service Redesign Programmes managed by Project Boards and scrutinised by the Project Management Office (PMO). 5. Regular analysis of performance and financial data with updates to SMT. 6. Regular meetings with operational budget holders to monitor progress of savings as well as overall budgetary performance and corrective action taken as required. 7. Focus on service redesign programmes and regular programme of review that support the outcomes of service users and patients. 8. Weekly Vacancy Management Panel to scrutinise and challenge recruitment requests. Balanced against reduction in use of agency staff. 9. Regular review of the Medium Term Financial Outlook (MTFO). The MTFO, the annual budget setting report and the regular financial performance reports update on key financial risks and any mitigating actions. 10. Robust Reserves Policy and protection of earmarked reserves to support short to medium term financial planning. This includes, the creation, maintenance and application of some key earmarked reserves for GP Prescribing, Redesign and Transformation, Unachievement of Savings and Fair Work Practices. 11. Area Resource Group now well established and a key control in challenging best value aspect of packages. 12. Robust application of Eligibility Criteria in completion of My Life Assessments and regular reviews of current packages of care. Further supported by Supervision Policy. **Controls In Progress** 1. Accelerate and increase level of recurring savings programmes across services to close in-year gaps, future gaps and replenish reserves balances. 2. Continuing to refine commissioning processes linked to strategic priorities and eligibility and self-directed support. Establishment of regular meetings between Commissioning, Finance, Legal and Procurement. 3. Non-residential Social Care Charging Policy was reviewed and updated for 2025/26, after extensive consultation with a range of stakeholders. Plan to revisit this year to compare actual cost of providing a service versus current charge. Outcome will feed into the budget setting process. 4. Approval by HSCP Board in March 2025 to implement an Equivalency Model. Equivalency rates have to be set for 2025/26 to reflect Living Wage uplifts and will be phased in as individual reviews are undertaken.	5x4 Very High = 20	3x3 Medium = 9	Tolerated
10	Risk Owner: Gillian Gall Inability to develop and deliver sufficient workforce capacity to deliver strategic objectives. Insufficient workforce will impact ability to meet service demands, caused by the inability to recruit, retain or deploy the workforce with necessary skills, which could potentially lead to disruption of services.	1. Failure to attract and retain people to work for the organisation and the unavailability of labour market. 2. National workforce challenges in Social Work and other professional groups adding to risk in the current system.	3x4 High = 12	**Controls In Place** 1. Organisational Development plan in place and Workforce Plans are being updated to align to the new strategic plan and reporting cycle. Continued activity to address specific recruitment and retention issues. There continues to be pressures around Social Work vacancies as more requests for assessment are being received, additional FTE have been appointed for a temporary period to progress outstanding reviews. Succession planning processes underway across HSCP in the event that management positions are more adversely affected. NQSW Peer Support Forum and programmes for support and development in place. Workforce planning oversight locally. 2. Local recruitment drives ongoing to support delivery of workforce plans and shortage occupational gaps. 3. Recruitment stats monitored through workforce team and assessed through vacancy control group.	3x3 Medium = 9	3x3 Medium = 9	Tolerated

11	Risk Owner: Gillian Gall New Risk Description: Absence increases resulting in staffing challenges which has arisen as a consequence of sickness absence, difficulties in recruiting and retraining staff, staff wellbeing. There is a risk that the HSCP is unable to cover the duties expected due to inability to cover planned or unlanned absence from existing workforce and wider HSCP services.	1. Risk that perception of staff dissatisfaction due to increased workload pressure increases likliehood of staff absence and turnover, leading to further loss of skills and knowledge. There is a particular issue with long term sickness and other absence in Care at Home and across other management structures which is resulting in reduced support to frontline staff and increasing pressure on remaining management staff. Increased risk of failure to meet legislative duties in relation to the Health and Care (Staffing) (Scotland) Act 2019. That perception of negative culture results in increased difficulties in recruiting and retraining staff, staff wellbeing and wider reputation of the HSCP. 2. Challenging limitations to public funding and recruitment in social care render this a difficult environment for the implementation of the Health and Care (Staffing)(Scotland) Act 2019. There is concern that due to the workloads and challenges over the last year that teams are weary and/or do not have capacity at this moment in time. Managers are working with teams to establish readiness and their capacity and sense of wellbeing and the collated output will inform plans going forward.	1x2 Low = 2	**Controls In Place** 1. Efforts are being made to provide support but the situation remains challenging. Staff Wellbeing is a key focus and there are many initiatives being made available to all staff including training, support, information and access to activities. Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers. Care at Home services have commenced weekly reporting of workforce sit reps for Senior Management Team oversight highlighting sickness absence and opertaional impacts so that issues can be identified and assessed quickly. Council and NHS systems are in operation with reporting being further developed scrutinised relating to vacancies, turnover and staff absences which is integral to this. The HSCP Workforce Planning Group includes Health Care Staffing Oversight and Implementation. The baseline understanding of compliance levels and identification of gaps has informed an action plan for 2025-2026 developed to mitigate associated risks and to embed this work in business as usual processes. Mechanisms for ongoing oversight, assurance and reporting are proposed for consideration. 2. Use of workload tools and common staffing framework fully implemented where mandated. 3. Data reported through performance reporting frameworks provided and improvement measures identified where data is below the required standard. This presents opportunity for any workforce risks to be highlighted or escalated. 4. A robust, proactive approach to analysis and triangulation of this data could support management teams in monitoring the workforce to identify areas where support can be given. **Controls in Progress** 1. The IMatter survey results for 2024 were received by managers for review and action plans. Preparatory work is commencing on the survey which will lead to further action plans for IMatter 2025. 2. Discussions are underway with HR in both Council and NHS to develop access to appropriate HR information at a summarised level to facilitate the necessary workforce planning and subsequent monitoring of plans.	2x2 Medium = 4	1x2 Low = 2	Tolerated
12	Risk Owner: Fiona Taylor Failure to support timely discharge and minimise delayed discharge; creates risk for the HSCP to effectively manage patient, client and carer care	Increasing complexity of people admitted to hospital, resulting in longer stays which in turn decondition an individual, increasing the risk of the need for HSCP care at the point of discharge. Delays are incurred when there is no POA in place and Guardianship applications are required before a discharge can be progressed.	3x3 Medium = 9	Quality improvement activities are ongoing to address a range of issues impacting on the ability to discharge people in a timely manner. Daily HSCP huddles to scrutinise the HSCP daily delays list, Effective dialogue between HSCP and Acute Hospital Discharge team to facilitate speedy resolution to operational issues impacting on bed days lost. Whole System approach across GG&C to implement additional innovations to reduce admissions, bed days and delays.	3x3 Medium = 9	2x3 Medium = 6	Closed
13	Risk Owner: Fiona Taylor Failure to plan and adopt a balanced approach to manage the unscheduled care pressures and related business continuity challenges that are faced in winter; creates risk for the HSCP to effectively manage patient, client and carer care	Risk of long-term impacts of the pandemic with potential for increasing demand for unscheduled care. Despite lower levels of presentations at Emergency Departments and lower numbers of emergency admissions, there is an increased number of Unscheduled Care Bed days that attests to increasing acuity and complexity in our general population post-pandemic. Risk of high levels of absence across the workforce, impacting of the delivery of effective and preventative care in the community to maintain health and social care. This may result in deconditioning, declining health and a negative impact on social care.	3x3 Medium = 9	A range of GG&C and WDHSCP specific unscheduled care activities are in progress and reported via the Unscheduled Care group. A refreshed design and delivery plan will be implemented in early 2025 to further develop HSCP wide activities to reduce the incidence of unscheduled care, both in the community and attendance at Acute sites. Whole System action plan across HSCP's and Acute sites developed Nov 2024 with a range of actions to reduce unscheduled care demand. Adult Vaccination programme Business Continuity Plans in place for all Health and Community care Services, inclusive of adverse weather events. Service users in District Nursing and care at Home are RAG rated to identify those with greatest need. Annual leave monitored to reduce risk of lack of staff availability at key points. Integrated approach across Health and Community Care services to target shared care opportunities if increased demand is experienced.	2x3 Medium = 6	2x3 Medium = 6	Closed
14	Risk Owner: Fiona Taylor Failure to monitor and ensure the wellbeing of adults in independent or WDC residential care facilities. Failure of staff to recognise, report and manage risk.	Lack of managerial scrutiny of a high standard of care in external and internal care homes. Lack of ASP awareness in external and internal care homes.	2x4 Medium = 8	Care Home Collaborative and Clinical and social care Governance process has oversight of quality indicators. 6 monthly quality assurance visits, conducted by District Nursing and Social Work. Care Inspectorate have regulatory responsibility and conduct robust inspections based on a risk matrix. Annual reviews of residents submitted to the HSCP and this is overseen by a Senior Social Worker. At present a proportion of reviews are completed by the HSCP, based on risk. HSCP Contracts and Commissioning team have oversight of all commissioned care homes.	2x3 Medium = 6	2x3 Medium = 6	Closed

15	Risk Owner: Sylvia Chatfield Failure to meet waiting times targets - Psychological Therapies	Increase in referral numbers, staffing absence, or inability to fill vacant posts	4x4 High = 16	**Controls In Place** 1. Full data cleanse has taken place with ongoing admin support around accurate data recording. 2. Continue to maximise staff capacity and use of peripatetic psychology for additional weekly session. 3. Impact has been substantially due to vacancies and absence however staffing position is improving. The data for these services is impacted due the small number of staff and service users. This will continue to be monitored and reporting is boardwide. 4. Senior managers meet with staff fortnightly to ensure that allocation is more streamlined and throughput improves. Procedural issue has been identified with how data is entered which is being resolved. This should show an improvement on the data.	4x3 High = 12	1x2 Low = 2	Live/Active
16	Risk Owner: Sylvia Chatfield Failure to meet waiting times targets - Drug and Alcohol Treatment.	Increase in referral numbers, staffing absence, or inability to fill vacant posts	1x2 Low = 2	Target continues to be reached and maintained. Only impact would be due to substantial absences. Staff team stable with minimum vacancies	1x2 Low = 2	1x1 Low = 1	Closed
17	Risk Owner: CSWO Lesley James There is a statutory requirment to ensure users of adult and children's services recieve an assessment of their needs , individualised care plans are in place and that these are subject to review as defined in relevant statute .Services where this applies will be subject to external regulation and the impact of not meeting these requirements presents a risk to service users , appropraite service access and more broadly reputatational damage to the HSCP	1. Failure to embed in practice Integatred and Initial Assessments across Adult and Children's Services. 2. Failure to ensure each service user receiveing a service has a written and up to date care plan. 3. Failure to ensure every sevice user has a review of their plan in line with stautory regulation.	4x4 High = 16	**Controls In Place** 1. The Adult Area Resource Group standard operational guide defines the roles and responsibilities across services and ensures there is consistence governance across adult services where new service requirments are made. 2. There have been significant imporvemnet in ensuring that care plans and reviews are in place for service useres who recieve a care at home service , and these have been key requirmenets as specificaied by the care inspectoarte . Developement work has taken place to ensure this is now reportable and management oversight has been strengthened with more to do to ensure all statutory reviews and care plans are in place. 3. In 2023 HSCP agreed with the CSWO recommendation to utilise ring fenced CSWO funding from Scottish Government in the devlopment of an Independent review team to support statutory reviews for community packages of support in adult services . The team is now partially in place and a pathway developed. 4. The Childrens Area Resource Group has been reviewed and re- implemented in September 2024 with Education now being a core memebers for all children's care placement considerations. Indpendent Chairof Children s have been funded using reserved and agreed by IJB . 5. A system of regular statutory reviews is in place for all looked after children with theiur care plans being reviewed every 6 months in line with statutory requirmenst 6. Self- evaluation reagrding the quliaty of the assessment require to be progressed in order activity is required to determine quality beyond implementation and this has been taken forward by Team Leader and parctitioner agreed by the Stratgey Board for What Would It Take ? 7. There is a concern that the duty to assess for report requests form the reporter is not being fully met due to staffing shortages and the required assessment provision not being able to be undertaken. Ongoing liaison with SCRA and Panel Chairs is in place to implement range of shared solutions to initial enquiry requests. 8. Close working with Children's reporter in relation to the duty to carry out enquires is in place with agreed processes and solution being developed to ensure information is shared appropriately with the reporter. **Controls in Progress** 1. The implementation of My Assessment and Plan conlcuded in July 2023. An evaluation on the implementation and quality of assessment was concluded early in 2024. 2. A number of improvements and actions are identified from the independent evaluation being progressed lead by Head of Service in Adults. 3. An action plan is in development and review of the assessment documentation with consultataion with practitioners is planned. 4. Evaluation reagrding the quliaty of the assessment was part of the external review of implemetation and further self- evlautaion is required to understand the quality of revised assessment tools. 5. Work is taking place with the care first team to ensure all children looked after reviews as detailed can be reported form care fisrt as this obversight is currently capatured on spreadsheet. 6.Further developement of carefirst reporting on adult statutory reviews is required.	4x4 High = 16	2x4 Medium = 8	Live/Active

18	Risk Owner: Lesley James Failure to ensure that staff are appropriately trained and adhere to standards for risk assessment and risk management across child, adult and public protection work.	1. Resources to support Learning and development opportunities for staff have not been recruited to (temporary resource funding). 2. Skills passports for council staff are in place and self serve arrangemnst to managers are availble to ensure complinace on mandatory training	4x4 High = 16	**Controls In Place** 1. Reporting mechanisms are at early stages to ensure both Training needs analysis of staff and training delivered and attended is both captured and able to be reported within social work and social care. 2. The appointment of two learning and developments officers will ensure this can be effectively progressed. The learning and development officers have been approved with 2 year reserve funding and advertised. A further advert is planned for June 2025 . **Controls in Progress** 1. On an interim basis training and development opportunities are being promoted through a range of commissioned training and through ilearn modules and scheduled management training. 2. Signifcant improvements have been made in devloping reporting for care at home in order to evidence the requirments in relation to staff learning and training with an agency memeber of staff dedicated to delivering this for the service . This is to support organisors to ensure care plans and review are in place for those recieving care at home services.	4x4 High = 16	4x2 Medium = 8	Live/Active
19	Risk Owner: Lesley James Failure to meet legislative duties in relation to child and adult protection.	1. Capacity workforce risk due to vacancies and absence. Gaps in data oversight 2. Training and development in National child Protection Guidance required	4x4 High = 16	**Controls In Place** 1. The learning and dvelopements of staff is identified in a number of learning reviews across adult and children services and training is being commissioned , however there remains some gaps .	3x4 High = 12	2x4 Medium = 8	Live/Active (line 20 is incorporated in this updated risk)
20	Risk Owner: Lesley James Failure to meet legislative duties in relation to adult support & protection.	Learning and development aligned to capacity and data oversight	4x4 High = 16	1. A national data set is being implemented by April 2023 and routine reporting to the Adult Protection Committee is in place with an independent chair to ensure objective scrutiny. 2. Performance and conversion rates in relation to case conferencing is regularly reported and identified improvement in timescales is progressing. 3. Further development is required to report on staff core and mandated training to ensure training compliance in ASP is in place for Social Work and Social Care.	4x4 High = 12	4x2 Medium = 8	Closed
21	Risk Owner: Lesley James Failure to meet legislative duties in relation to multi-agency public protection arrangements (MAPPA).	1. Rising demand of Multi Agency Public Protection Arrangemnets (MAPPA) 2. Pay awards for staff have not been passed on to the HSCP in this ringfenced budgeted area causing use of reserves to support operational delivery . 3. Staffing recruitemnet has been unable to be progressed at times where budget is projected as insufficient and use of reserves required	4x3 High = 12	**Controls In Place** 1. West Dunbartonshire is part of the North Strathclyde Partnership and oversight reporting structures namely the SOG and MOG meet regularly in relation to all MAPPA activity where reporting of MAPPA activity and the associated risk register is in place. MAPPA activity forms part of reporting to PPCOG to ensure effective oversight and scrutiny. 2. Meeting with SG Justice Team and communication drafted in repscet of Justice Pay award which has not been passed over by local authority in 22/23 and 23/24 which has a commuilative impact on the available budget . Recent confirmation of Caledonian Funding to support delivery of prgarmmed interventions will ease pressure on budget	4x4 High = 16	4x2 Medium = 8	Live/Active

22	Risk Owner: CSWO Lesley James Failure to ensure effective reporting and provide the necessry oversight of statutory functions to the CSWO though Clinilcal Care Governance sub group. This applies to both in- house and commisioned service	1. Gaps in data oversight of statutory functions. 2. Statutory reviews are not always taking place within required timeframes. Self evaluation and quliaty assurance within operational team delivering social work and regulated services requires to be strengthened	4x4 High = 16	**Controls In Place** 1. Clinical and Care Governance oversight is being strengthened in this area with Guardianship oversight data to be reported form CareFirst with performance being reported quarterly. 2. Data has been collated and reported to the Mental Welfare Commission who have an external scrutiny role. 3. A report from CareFirst is now being run to ensure performance in statutory areas such as guardianship area being regularly reported and monitored however there are still reporting gaps form care first. 4. Data form children services in repact of new referrals of concern and referral source is now available with tghe implamentaion of the Access help and Support Team . 5. The Care first broard is established to strengthen improvemnets and reporting from care first and support care first governance 6. External scrutiny by the care inspectorate was recntly published In May 2025 and West Dunbartonshire analysis of staff questionaire is now available. 7. Bench marking againt the local and national findings of the staff questionaire is taking place to support improvemnet work in relation to social work governance identified as a priority by the SMT .	4x4 High = 16	4x2 Medium = 8	Live/Active
23	Risk Owner: Helen Little Failure to meet waiting times - MSK Physiotherapy.Failure to meet Scot Gov MSK waiting times target of 90% patients seen within 4 weeks. Longer waits for a routine appointment leads to increased chronicity of the MSK condition and therefore increased risk of absence from the workplace leading to increased economic burden. Risk to partner organisations as longer MSK waits result in increased patient numbers at ED; increased impact on GP practice (evidence shows patients are more likely to return to their GP as they wait); increased prescribing costs (pain medication) and increased inappropriate referral to orthopaedics (all of which can be evidenced)	1. Demand continues to be greater than service capacity due to ongoing year on year increase in referral numbers. Demand has risen by 7% in 2024/25 on top of a 13.3% increase in 2023/24. 2. Capacity impacted by staffing absence, and length of recruitment process to fill vacant posts. 3.Continuation to breach on the AHP MSK Scottish Government waiting times target of 90% patients seen within 4 weeks. Over 18k patients currently waiting on a routine appointment.	5x3 High = 15	**Controls In Place** 1. Clinical vetting to ensure all patients are clinically vetted and those identified as having urgent clinical need are seen within 4 week target. 2. Service continues to have a QI approach to address waiting times as a priority project. 3. Scrutiny monthly by Health Board and monthly reporting. 4. Ongoing filling of vacancies as they arise (although end to end recruitment process still lengthy and impacts on capacity). 5. Operational SOPs in place to ensure maximum efficiency. **Controls In Progress** 1. Ongoing priority project work using QI methodology. 2. Several ongoing tests of change/QI work initially supported by Health Improvement Scotland. 3. Ongoing work on capacity/efficiency.	4x3 High = 12	2x1 Low = 2	Live/Active
24	Risk Owner : Fiona Taylor Care at home service delivery	Requirement to deliver the service in budget whilst negotiating concurrent priority improvement workstreams (redesign, Inspection and business as usual)	5 x 4 Very High = 20	**Controls In Place** 1.Weekly reporting to CO/ Head of Service inclusive of agency and overtime spend. Implementation of new rosters (for 70% workforce) to improve staffing weekends/ evenings. 2.Gap analysis of areas to ensure equity of FTW allocation based on demand. 6 weekly workload tool analysis per organiser to identify areas of high spend and mitigate appropriately. **Controls In Progress** 1. Controls are being embedded however 30% of workforce will not move until March 2026 therefore some rosters remain incomplete until this time. 2. Workforce post redesign = reduction in workforce availability 4-10pm therefore further analysis is in progress to mitigate	4x4 High = 16	3x3 Medium = 9	New
25	Risk Owner : Fiona Taylor Speech & Language Therapy Resource	1. The HSCP historically holds responsibility for Speech and Language Therapy (SLT) for in patient adult wards at the Vale of Leven, community referals Dumbarton and Alexandria, and a service level agreement for Helensburgh and Lochside. 2. The WTE for qualified SLT is 1.8, which is insufficient for the volumne of demand. 3. Long term absence means there is no SLT resource currently available. 1WTE due to resume, however workload exceeds capacity for the level of resource. This results in no resource to manage high / medium risk care.	4x4 High = 16	**Controls In Place** 1. Risk raised with SLT leads across GG&C, professional SLT Lead and AHP Director. Leads report no ability to reallocate their resources to support the HSCP during this period of absence. 2. Additional SLT hours offered across SLT workforce, with minimal uptake Resource being targeted to high risk community referrals. Acute swallowing assessments (Vale Of Leven) being provided in an interm basis from HSCP Learning Disability SLT to reduce risk of pateints requiring transferred to RAH for medical treatment pending assessment. 3. No Staff bank SLT resource. Agency being considered but requires a range of assurances from a governance perspective and financial authorisation from CO / CFO **Controls In Progress** 1. AHP Director reviewing SLT across GG&C. 2. Workload analysis to quantify appropriate WTE required for the HSCP service	3x3 Medium = 9	1x2 Low = 2	New

26	Risk Owner : Fiona Taylor Residential and Nursing Care Home Bed challenges	**External factors**: 1. Challenges in terms of availability residential and nursing care home beds within the HSCP. This causes increased delays in discharging people from hospital and also increases risk for thise assessed as requiring long term care in the community if no beds are available. 2. In addition, bed availability is also at risk when Homes have moratoriums placed on them if standards of care fall below contractual agreements. **Internal factors:** 3. bed budget reduced for 25/26 which may impact on available fudning if demand increases.	3x3 Medium = 9	**Controls In Place** **External:** 1. daily monitoring of bed availability and interim beds provided pending moves to place of choice to reduce risk of delays. 2. HSCP Care Home Oversight Group and also Care Inspectorate reports to monitor standards of care across all care homes. 3. Contracts Monitoring Officer works in collaboration with Care Home managers to provide support and early identiofication of emerging issues. 4. 6 monthlyHSCP quality assurance visits. **Internal:** 5. ARG process ensures all placements meet criteria, and that long term care is indicated due to high level of risk of living at home. Approval and authorisation up to £50,000 by an IOM. Over £50K required Head of Service authorisation. 56. Monitoring process in progress for oversight of budget with escalation process if financial regulations will be breached if an emergency placement is indiacted but no budget available. **Controls In Progress** 1. Completion of escalation process.	3x3 Medium = 9	2x2 Medium = 4	New (line 14 forms this updated risk)
27	Risk Owner : Fiona Taylor Risk of pressures on Acute sites due to failure to reduce admissions to hospital and, once admistted, failure to discharge timeously leading to increased number of people delayed in being discharged.	1. Demand on acute beds, previously defined as 'winter pressures', is now continous and unscheduled care data demonstrates high number of admissions from WDHSCP. 2. Workforce capacity to deliver earlier interventions: Eligibility criteria (critical and substantial) neccessitates a targeted approach to thise already at a higher level of need. This creates risk as earlier interventions could prevent / slow functional and / or social care needs decline. 3. Delayed discharge data, despite improvement activity, remains high, inclusive of people being delayed due to AWI legislation, requiring Guardianship applications before discharges can be implemented. Interdependant with care home bed availability risk.	4x3 High = 12	**Controls In Place** 1. GG&C and HSCP specific workstreams to collate and analyse data to identify priority areas. Partnership working with Care Homes, the HSCP and Scottish Ambulance Service to reduce admissions from Care Homes. Completion of Future Care Plans. Focussed Intervention Team to prevent admisissions. Frailty Practitioner. Non Medical Prescribing to allow early treatment e.g. antibiotics for cellulitis / UTI's. 2. Waiting lists for Occupational Therapy and Physiotherapy have been reviewed to reduce waiting times.3. POA initiatve with Citizens Advice in Dumbarton and Alexandria. Improved processes within the discharge team to ensure fast assessments through to discharge. **Controls In Progress** 1. Transforming Together agenda will drive new workstreams to prevent admisions to hospital and support earlier interventions for conditions with high risk of admission. 2. Review of wider OT and physio resources across adult intergtaed services to ensure timeous interventions by the most appropriate professional/ paraprofessional, reducing transfers of care and improving outcomes.	4x3 High = 12	2x3 Medium = 6	New (line 12 and 13 form this updated risk)
28	Risk Owner: Margaret-Jane Cardno. Failure to effectively commission, procure and monitor the quality of externally commissioned services in line with the governance frameworks (eg Financial Regulations) set out by West Dunbartonshire Council and NHS Greater Glasgow and Clyde.	1. Insufficient Needs Assessment: Inadequate understanding of the health and care needs of the population, leading to an inability to effectively commission services to adequately meet population outcomes. 2. Lack of Strategic Planning: Commissioning without a clear long-term vision or strategic direction. 3. Inadequate Stakeholder Engagement: Failing to involve key stakeholders (such as legal, procurement, finance, patients, carers, and community representatives) in decision-making. 4. Financial Constraints: Budget limitations and financial pressures. 5. Fragmented Systems and Silos: Lack of coordination between health and social care providers, including inadequate record management and technological challenges/gaps. 6. Inadequate Contract Monitoring: Insufficient monitoring of service quality and outcomes. 7. Short-Term Focus: Prioritising immediate needs over long-term sustainability. 8. Skill Development: Insufficient knowledge or expertise in commissioning, procuring and monitoring the quality of externally commissioned services, including a lack of understanding of legislative requirements. 9. No agreed quality framework leading to an inability to identify and address potential risks. 10. Failure to adhere to the governance frameworks set out by West Dunbartonshire Council and NHS Greater Glasgow and Clyde.	4x4 High = 16	**Controls In Place** 1. Commissioning Team represented at an appropriate level across the HSCP, this included regular one to one meeting between the Contracts, Commissioning and Quality Manager and HSCP Heads of Service. 2. Established provider networks/forums across all HSCP areas which has led to the development of several frameworks and contracts. 3. Development and implement of IRISS Change Makers Project, embedding ethical and collaborative commissioning principles. 4. Strategic Plan "Improving Lives Together" approved by IJB. The development of this robust strategic plan ensures alignment with local and national priorities. 5. Quarterly report to the HSCP Board Audit and Performance Committee on externally commissioned regulated services. **Controls In Progress** 1. CarePay and CareFinance roll out. Although adult services are now complete, we continue to experience challenges in relation to implementation within children and family's services. 2. Implementation of a Charging and Payments Team. Work is advanced and should be concluded by August 2025. 3. Development of a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. Work is advanced and is under consideration by the Senior Management Team. 4. Procurement of Commissioned Services Report presented annually to the HSCP Board. The first report will be presented in May 2025. 5. Review of Scheme of Delegation. Currently an outstanding audit action which requires the support of parent bodies to action and complete. 6. Development and monitoring of Contract Register. Register is in place and is being monitored at an operational level to ensure compliance with legislative frameworks. This will be presented to the HSCP Board Audit and Performance Committee as part of an exception report.	3x4 High = 12	2x4 Medium = 8	New (lines 1,2, 3,4 and 8 form this updated risk)
29	Risk Owner: Margaret-Jane Cardno Risk of provider failure across all sectors.	1. Increase in employers' national insurance contributions. Recruitment and retention challenges. 2. Unfunded cost of living/cost of delivery increases eg utilities. 3. Limits on public sector contributions towards the Scottish Living Wage. 4. Requirement to contribute to overall HSCP budget savings. 5. Challenges relating to provider fees within national contracts and frameworks, eg the National Care Home Contract.	3x5 High = 15	**Controls In Place** 1. Established provider networks/forums across all HSCP areas presents an opportunity for providers to raise concerns and any emerging issues re sustainability. 2. Early engagement with providers in relation to identifying future budget savings whist also seeking to provide longer term funding packages. 3. Commissioning HSCP services in a different way which addresses budget pressures, whilst linking to strategic priorities (this avoids asking service providers to deliver the same or more services for less funding). This helps to set expectations and supports good HSCP/provider relationships. 4. Notify providers at the earliest opportunity of their annual uplift (for in scope services). 5. Using the Chief Finance Officer Network and SOLACE (Society of Local Authority Chief Executives and Senior Managers) to raise sustainability issues in a joint way to both Scottish Government and COSLA (Convention of Scottish Local Authorities). **Controls In Progress** 1. Contract monitoring will support the identification of any emerging issues in relation to sustainability.	3x5 High = 15	3x5 High = 15	New

30	Risk Owner: Margaret-Jane Cardno Failure to secure an alternative system to CareFirst for Social Work case management and provider financial payments.	1. CareFirst although currently still supported by OLM Systems is reaching the end of its natural life. 2. The HSCP relies on West Dunbartonshire Council to prioritise the replacement of the system within its capital planning framework. Capital funding was removed by the local authority in 2023 and it has been made clear that alternative capital funding sources for ICT modernisation cannot be used for this purpose. 3. Local authority prioritisation is within a context of competing priorities across other Council service, a lack of resources across both the Council and the HSCP and the reliance on Council support functions to progress implementation.	3x5 High = 15	**Controls In Place** 1. A project manager has been appointed on a fixed term basis to progress the work on a business case for system replacement. **Controls In Progress** 1. A business case is under development for consideration within the Councils capital planning framework.	3x5 High = 15	1x1 Low = 1	New
31	Risk Owner: Margaret-Jane Cardno Inability to secure effective and sufficient support services from within the HSCP and across NHS Greater Glasgow and Clyde and West Dunbartonshire Council to plan, monitor, commission, oversee and review services as required including functions delivered by business support services.	1. There are limited resources within the HSCP and across NHS Greater Glasgow and Clyde and West Dunbartonshire Council to manage increasing demands and competing priorities. The HSCP relies on the NHS and the local authority for amongst other things, ICT infrastructure and systems, communication support, legal advice, procurement support, organisational development and HR. 2. Budgetary reductions have, in places, focused on efficiencies within support functions, further reducing already pressurised teams. The frequency of change and the need for major transformational change projects to be implemented places increased pressure on support services as they play a vital role in ensuring that projects are executed efficiently, effectively, and with minimal disruption.	4x4 High = 16	**Controls In Place** 1. The Chief Officer attends constituent body Corporate Management Team and Performance Monitoring Review Group meetings to represent HSCP requirements for support. 2. Collaborative discussions within the HSCP Senior Management Team in respect of budget management and how the use of support services will be allocated/prioritised. 3. Work is underway with the local authority to look at projects which may benefit from robotic process automation (RPA) freeing up capacity within the overall system.	4x2 Medium = 8	4x2 Medium = 8	New
32	Risk Owner: Margaret-Jane Cardno Ability to effectively respond to a major emergency incident, for example a Black Start event or a major cyber security failure.	Major response failures in health and social care during incidents like a Black Start or cyber security attack can be caused by several factors: for example, a lack of training; poor planning; ineffective communication channels; insufficient resources; staff fatigue; decision making failures; system failures and cybersecurity vulnerabilities.	3x4 High = 12	**Controls In Place** 1. HSCP essential services list developed and agreed. 2. Support provided by the relevant civil contingencies services within both NHS and local authority. 3. Participation in desk top training exercises. 4. Cyber security and data protection training embedded across all teams. 5. System back ups in place. 6. Cyber Incident Response Plans in place with our partner bodies. **Controls In Progress** 1. Business continuity plans under development or review in all service areas.	3x4 High = 12	3x4 High = 12	New
33	Risk Owner: Lesley James (Chief Social Work Officer) Failure to respond appropriately within required timeline to the National Historic Abuse Inquiry .	1. The HSCP is required to co-ordinate all responses to the inquiry which are often extensive and resource intensive. There is limited resources to support extensive records searches required through archives and service records 2. The HSCP on Children services routinely identifies one of two managers to co-ordinate each response. The councils legal service is requested to review each submission before it is returned to the inquiry . Often inquiries date back from a period of years and are relevant for multiple services areas across the local authority. A reduction in the available resource in the council who has taken some role in co-ordinating due to retiral and non replacement. There are single points of failure in the requests being effectively service and submitted to the inquiry . There is significant risk of reputational damage should this not be able to be effectively supported.	4x3 High = 12	**Controls In Place** 1. Senior Management Team Admin Support 2. Support from Information Team. 3. Identified Officer from Children's Services.	4x3 High = 12	3x3 Medium = 9	New

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

25 June 2025

Subject: Implementation of Directions Policy

1. Purpose

1.1 The purpose of this report is to provide the HSCP Board with an update on the implementation of the Directions Policy, which was approved by the HSCP Board on the 23 September 2020 and implemented on the 30 September 2020.

2. Recommendations

2.1 It is recommended that the HSCP Board Audit and Performance Committee note the progress made in respect of the implementation of the Directions Policy.

3. Background

3.1 On the 23 September 2020 the HSCP Board approved a new Directions Policy to ensure compliance with the practice set out in statutory guidance, strengthening performance monitoring, accountability, quality and sustainability of services. This Policy was implemented on the 30 September 2020.

3.2 This report is intended to provide an annual update in compliance with the agreed reporting framework.

4. Main Issues

4.1 Directions are the legal basis on which the Local Authority and Health Board deliver services that are under the control of the HSCP Board. As a legal requirement, the use of Directions is not optional for IJBs, Health Boards or Local Authorities, it is obligatory.

4.2 The HSCP Board makes decisions about service change, service redesign, and investment and disinvestment at many of their meetings. Such decisions necessitate Directions to the Health Board or Local Authority, or both, and may indeed require the delivery partners to carry out a function jointly.

4.3 The Scottish Government noted that many IJBs had a minimalist approach to Directions and had an insufficiently robust audit trail. Furthermore, significant variation had developed over how Directions were being used across

Scotland. As such, the Scottish Government issued statutory guidance on the matter, to clarify its expectations and to aid the development of local policy.

4.4 The revised statutory guidance on Directions underpins the Direction Policy. The Policy complies with the guidance by setting out a clear framework for the issuing and review of Directions and confirming governance arrangements.

4.5 During the period 1 April 2024 to 31 March 2025 thirteen directions were issued. Of these thirteen, eight have been superseded by subsequent directions and the remaining five are progressing well against delivery. These five directions relate to the following:

West Dunbartonshire HSCP Participation and Engagement Strategy	Margaret-Jane Cardno
Medium Term Financial Outlook 2024/25 to 2027/28	Julie Slavin
Fair Access To Community Care (Adult Services)	Margaret-Jane Cardno
A Comprehensive Review of Learning Disability Services	Sylvia Chatfield
2025/26 Annual Budget Setting Report	Julie Slavin

5. Options Appraisal

5.1 The recommendation within this report does not require an options appraisal to be undertaken.

6. People Implications

6.1 There are no direct people implications arising from the recommendation within this report.

7. Financial and Procurement Implications

7.1 There are no direct financial and procurement implications arising from the recommendation within this report.

8. Risk Analysis

8.1 There are no risks arising from the recommendation within this report.

9. Equalities Impact Assessment (EIA)

9.1 An EIA is not required as the recommendation within this report does not impact on those with protected characteristics.

10. Environmental Sustainability

10.1 The recommendation within this report does not require the completion of a Strategic Environmental Assessment (SEA).

11. Consultation

11.1 The Chief Officer, Chief Finance Officer, Monitoring Solicitor and the HSCP Senior Management Team have been consulted in the preparation of this report.

12. Strategic Assessment

12.1 On the 15 March 2023 the HSCP Board approved its Strategic Plan 2023 – 2026 "Improving Lives Together". The Plan outlines sustained challenge and change within health and social care, these changes bring with them a host of governance implications: cultural, operational, structural, ethical and clinical.

12.2 Good governance in respect of the development, implementation and monitoring of Directions is essential to ensure the actions agreed by the Board are implemented by the delivery partners who will be required to carry out a function either separately or jointly. This provides further assurance to the Board that the Strategic Plan is being delivered in line with their agreed decisions.

13. Directions

13.1 The recommendation within this report does not require a direction to be issued.

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Date: 9 June 2025

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Background Papers: Board Approval of Directions Policy Item 11 23 September 2020