Agenda

West Dunbartonshire
Health & Social Care Partnership

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

Date:	Tuesday, 23 September 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 September 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

TUESDAY, 23 SEPTEMBER 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 **5 - 11**

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 25 June 2025.

(b) ROLLING ACTION LIST **13 - 14**

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

6 PROPOSED ANNUAL AUDIT REPORT 2024/25 **15 - 105**

Submit report by Julie Slavin, Chief Financial Officer presenting for review, the formal responses to information requests to those charged with governance and senior management from our external auditor Forvis Mazars.

7/

7 AUDITED ANNUAL ACCOUNTS 2024/25 **107 - 212**

Submit report by Julie Slavin, Chief Financial Officer providing an update on completion of the audit of the Annual Accounts for the year ended 31 March 2025.

8 INDICATIVE INTERNAL AUDIT STRATEGY AND PLAN **213 - 222**

Submit report by Andi Priestman, Chief Internal Auditor, providing the indicative Internal Audit Strategy and Plan for 2025-2026 to the Audit and Performance Committee for approval.

9 CLINICAL AND CARE GOVERNANCE REPORT – QUARTER 1 **223 - 232**

Submit report by Val Tierney, Chief Nurse, providing Committee with regular oversight and assurance about the progress made in strengthening assuring and improving the quality of health and social care.

10 QUARTER 1 PERFORMANCE REPORT **233 - 256**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, providing information to ensure effective monitoring and 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

11 QUARTER 1 REGULATED SERVICES REPORT **257 - 286**

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

12 HEALTH CARE STAFFING ACT ASSURANCE REPORT **287 - 305**

Submit report by Val Tierney, Chief Nurse, reporting on the legal responsibilities conferred on integration authorities and health boards and provides assurance regarding West Dunbartonshire HSCPs level of compliance with the duties and guiding principles within the Act.

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 Wednesday, 25 June 2025 at 2.00 p.m.

Present: Michelle Wailes, Lesley McDonald and Libby Cairns; NHS Greater Glasgow and Clyde; Fiona Hennebry, 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, Fiona Wilson, Clinical Director; David Smith, Unpaid Carers Representative, Fiona Taylor, Head of Health and Community Care; Helen Little, Musculoskeletal Physiotherapy Manager and Val Tierney, Chief Nurse.

Also Attending: Margaret-Jane Cardno, Head of Strategy and Transformation; Sylvia Chatfield, Head of Mental Health, Addictions and Learning Disabilities; Tom Reid, External Auditors – Forvis Mazars, Andi Priestman, Chief Internal Auditor; Anne McDougall, Chair of the Locality Engagement Network – Clydebank; Andrew McCready Staff Representative (NHS Greater Glasgow and Clyde); and Natalie Roger, Committee Officer.

Apologies: Apologies for absence were intimated on behalf of Michelle McGinty, West Dunbartonshire Council; John Kerr, Housing Development and Homeless Manager; Kim McNab, Service Manager - Carers of West Dunbartonshire; Dr Saied Pourghazi, Clinical Director.

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 18 February 2025, 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.

AUDIT PLAN PROGRESS REPORT

A report was submitted 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.

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

GLOBAL INTERNAL AUDIT STANDARDS

A report was submitted 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.

After discussion and having heard the Chief Internal Auditor, in further explanation and in answer to Members' questions, the Committee agreed 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).

ANNUAL REPORT ON THE AUDIT AND PERFORMANCE COMMITTEE FOR THE YEAR ENDED 31 MARCH 2025

A report was submitted 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.

After discussion the Committee agreed:-

(1) that members review and endorse the Chair's Annual Report on the Audit and Performance Committee for 2024/25; and

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

INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2025

A report was submitted by Andi Priestman, Chief 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.

After discussion and having heard the Chief Internal Auditor in further explanation and in answer to Members' questions, the Committee agreed that the West Dunbartonshire Health & Social Care Partnership Board note the contents of this report.

MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE: MEASURING PROGRESS UNDER INTEGRATION

A report was submitted 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"

After discussion and having heard the Head of Strategy and Transformation in further explanation and in answer to Members' questions, the Committee agreed:-

(1) to 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) to agree that given the advanced nature of this work that no further update reports are required.

BEST VALUE STATEMENT

A report was submitted 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.

After discussion and having heard the Chief Officer, the Chief Financial Officer and Head of Strategy and Transformation in further explanation and in answer to Members' questions, the Committee agreed that the HSCP Audit and Performance Committee approve the Best Value Statement, which can be found in Appendix 1 to the report.

EXTERNAL AUDIT PROGRESS REPORT AND INFORMATION REQUEST TO THOSE CHARGED WITH GOVERNANCE

A report was submitted by Tom Reid, External Auditor, Forvis Mazars and Julie Slavin, Chief Financial Officer, presenting a progress update from Forvis Mazars on their responsibilities as external auditors for the HSCP Board.

After discussion and having heard the External Auditor and Chief Financial Officer in further explanation and in answer to Members' questions, the Committee agreed to approve the response to our external auditors on compliance with International Standards for Auditing in relation to fraud, litigation, laws and regulations by the 18 July 2025 deadline.

2024/25 CODE OF GOOD GOVERNANCE AND ANNUAL GOVERNANCE STATEMENT

A report was submitted 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.

After discussion and having heard the Chief Financial Officer and Chief Internal Auditor in further explanation and in answer to Members' questions, the Committee agreed:-

(1) to note the outcome of the annual self-evaluation and the update of the improvement actions; and

(2) to consider the detail of the Annual Governance Statement and approve its inclusion in the 2024/25 Unaudited Annual Accounts.

ANNUAL PERFORMANCE REPORT (SCRUTINY)

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation, providing an overview on HSCP's performance in planning and

carrying out integrated functions. The Annual Performance Report is produced for the benefit of Partnerships and their communities.

After discussion and having heard the Chief Officer, Head of Strategy and Transformation, Head of Children's Health, Care and Criminal Justice, Chief Social Work Officer in further explanation and in answer to Members' questions, the Committee agreed to recommend to the HSCP Board that the West Dunbartonshire HSCP Annual Performance Report 2024/25 (Appendix 1 to the report) be approved.

ADJOURNMENT

The Chair adjourned the meeting for a short recess. The meeting reconvened at 3.35 p.m. with all Members listed in the sederunt present.

DRAFT UNAUDITED ANNUAL ACCOUNTS

A report was submitted 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

After discussion and having heard the Chief Officer and Chief Financial Officer in further explanation and in answer to Members' questions, the Committee agreed:-

(1) to consider the 2024/25 unaudited Annual Report and Accounts;

(2) to approve their submission to the HSCP Board's external auditors for review by 30 June; and

(3) to 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.

ANNUAL CLINICAL AND CARE GOVERNANCE REPORT 2024

A report was submitted 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.

After discussion and having heard the Chief Nurse and Head of Children's Health, Care and Criminal Justice, Chief Social Work Officer in further explanation and in answer to Members' questions, the Committee agreed Members of the IJB 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.

ANNUAL REPORT FOR MUSCULOSKELETAL PHYSIOTHERAPY SERVICE 2024/25

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

After discussion and having heard the Chief Officer and Musculoskeletal Physiotherapy Manager in further explanation and in answer to Members' questions, the Committee agreed:-

(1) to note the content of the report; and

(2) to note the achievements of the MSK service in regard to performance; priority project work; patient feedback and involvement; use of data and work on digital enhancement within the MSK service.

WEST DUNBARTONSHIRE COLLABORATIVE CARE HOME SUPPORT TEAM ANNUAL REPORT 2024

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

After discussion and having heard the Chief Nurse in further explanation and in answer to Members' questions, the Committee agreed to note the content of the report.

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 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.

After discussion and having heard the Head of Strategy and Transformation, Chief Nurse, Head of Health and Community Care and Head of Children's Health, Care and Criminal Justice and Chief Social Work Officer in further explanation and in answer to Members' questions, the Committee agreed:-

(1) to note the content of this report and its appendices.

(2) 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; and

(3) to consider dedicating an informal session with the HSCP regarding Commissioning and the Care Inspectorate to further develop the Committee's knowledge.

STRATEGIC RISK REGISTER SIX MONTH REVIEW

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 Board Audit and Performance Committee.

After discussion and having heard the Chief Officer and Head of Strategy and Transformation in further explanation and in answer to Members' questions, the Committee agreed:-

(1) to comment on the Strategic Risk Register (Appendix 1 to the report), prior to its submission to the HSCP Board for approval on 19 August 2025; and

(2) to 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.

IMPLEMENTATION OF DIRECTIONS POLICY

A report was submitted 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.

After discussion and having heard the Head of Strategy and Transformation in further explanation and in answer to Members' questions, the Committee agreed to note the progress made in respect of the implementation of the Directions Policy.

The meeting closed at 4.45 p.m

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	JS has provided a briefing note to Cllr Rooney.	**Closed**
STRATEGIC RISK REGISTER (SCRUTINY)	Michelle Wailes requested that the description of the risk for MSK Physio be re-looked at within the Register.	Margaret-Jane Cardno	25th June	This has been completed following updates to the Risk Register.	**Closed**

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	This update was provided at the end of the last meeting.	**Closed**

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Julie Slavin, Chief Financial Officer

23 September 2025

Subject: Proposed Annual Audit Report 2024/25 – West Dunbartonshire Integration Joint Board

1. Purpose

1.1 To present to the Audit and Performance Committee for review, the formal responses to information requests to those charged with governance and senior management from our external auditor Forvis Mazars; and

1.2 To present the proposed Annual Audit Report and Auditor's letter, for the audit of the West Dunbartonshire Integration Joint Board (IJB), known locally as the HSCP Board, for the financial year ended 31 March 2025, as prepared by the Board's external auditor, Forvis Mazars.

2. Recommendations

2.1 It is recommended that the HSCP Board's Audit and Performance Committee:

a) Provide assurance to Forvis Mazars that the responses made in the information requests to those charged with governance and senior management remain unchanged since their submissions in June and August respectively;

b) Consider the contents of the proposed Annual Audit Report to the Board and the Controller of Audit for the financial year ended 31 March 2025;

c) Note the expected audit opinion of an unqualified audit, without modification on the financial statements;

d) Consider the key messages, the recommendations and agreed management actions;

e) Provide assurance to the HSCP Board that after consideration of both this proposed annual audit report and management's letter of representation, the 2024/25 accounts can be approved.

3. Background

3.1 As part of the annual approach taken by the HSCP Board's external auditors, Forvis Mazars, they sought responses to a range of enquiries concerning the

HSCP Board's approach and reporting arrangements for a number of key areas, in particular related to themes surrounding fraud, litigation, laws and regulations together with some areas specific to the accounts such as related parties and estimates used in the accounts.

3.2 In addition to the enquiries made to officers, Forvis Mazars also required a response to a number of enquiries relating to the arrangements for identifying, responding to and managing risks around fraud from 'those charged with governance'.

3.3 The responses to these requests were completed by the Audit and Performance Committee and the senior management team, in June and August respectively.

3.4 It is a statutory requirement of the accounts closure process (ISA 260) that those charged with the governance of the HSCP Board's financial affairs receives a report from the appointed external auditors, highlighting the main matters arising in respect of their audit of the financial statements.

3.5 The proposed Annual Audit Report covers the nature and scope of the audit, details any qualifications, any unadjusted misstatements, any material weaknesses in the accounting and internal control systems, gives a view on the qualitative aspects around accounting practices and any other matters specifically required to be communicated to the HSCP Board.

3.6 The draft Management Representation Letter and draft Auditor's Opinion to the HSCP Board are attached at Appendix 3 (sub-appendices B & C). The ISA 580 provides external auditors with assurance around the key accounting requirements and judgements made by the Chief Financial Officer when closing the 2024/25 Accounts.

4. Main Issues

4.1 At the time of writing, the audit of the 2024/25 financial statements is substantially complete and there are no significant matters outstanding. The expected audit opinion as set-out within the Executive Summary section is:

"At the time of issuing this report and subject to the satisfactory conclusion of our remaining audit work, we anticipate issuing an unqualified opinion, without modification."

4.2 As set-out in sections 3.1 to 3.3 above, members of the Audit and Performance Committee approved their response to the information request from our external auditors at the 25 June 2025 meeting. To allow for the completion of the audit process, the committee is asked to review this response, as attached at Appendix 1, and provide assurance of no material change that could impact on the 2024/25 final accounts.

4.3 The senior management team have reviewed their own response, submitted in August, as attached at Appendix 2, and can confirm the response provided remains unchanged.

4.4 As set-out in section 3.5 above, Forvis Mazars 2024/25 Annual Audit Report sets out the findings, main judgements and recommendations arising from the audit. Their proposed annual report is attached at Appendix 3.

4.5 As well as the audit of the financial statements the auditors have wider scope responsibilities as set out in Audit Scotland's Code of Audit Practice 2021 and sits alongside Best Value requirements detailed the Local Government (Scotland) Act 1973. The Code's wider scope framework is categorised into four areas:

- financial management;
- financial sustainability;
- vision, leadership and governance; and
- use of resources to improve outcomes

4.6 There is one recommendation arising from the wider scope audit of Financial Management. The recommendation (set out within Section 8 of Appendix 3) concerns improvement in ***"refresher training for budget holders to ensure procedures are understood and consistently applied"***. This recommendation complements the findings of the recent internal audit report on Budgetary Control Practices.

4.7 Similar to the response to internal audit, this recommendation has been accepted by management and refresher training will be rolled out over the financial year.

4.8 The report also provides members with an update of the recommendation from last year's audit (2023/24) which has been assessed as being complete.

- **Financial Sustainability – Level 2**
  The IJB should refresh its Medium Term Financial Plan (MTFP) to ensure it has a clear plan for how it will use service redesign, transformation and savings to address its financial challenges.
  Implementation timescale: November 2024.
  Update: Complete

4.9 With regards to the internal control environment in which the IJB operates, no significant deficiencies were identified as at the date of this report, however there was one observation made and reported to management. This can be found within Appendix 3 (sub-appendix A: Internal control conclusions) and relates to the timing of the board members' annual declaration of interests, to allow sufficient time to review declarations and any potential impact on related party transactions. This recommendation will be taken forward by the Chief Financial Officer and IJB Standard's Officer for the preparation of the 2025/26 annual accounts.

4.10 As set-out within the Terms of Reference for this committee, it is the responsibility of members to consider both the Annual Audit Report and Management Representation Letter (ISA580). After consideration and agreement on the proposed management actions contained within the annual report, the audited annual accounts will be presented to the HSCP Board for final approval and sign-off.

5. Options Appraisal

5.1 None required

6. People Implications

6.1 None associated with this report.

7. Financial and Procurement Implications

7.1 The Section 95 officer (Chief Financial Officer) has provided written representations on aspects of the annual accounts, including the judgement and estimates made.

8. Risk Analysis

8.1 Detailed within the Annual Audit Report. Other than the observations and recommendations presented, no other significant risks were identified through the audit work undertaken on the 2024/25 financial statements.

9. Equalities Impact Assessment (EIA)

9.1 None required.

10. Environmental Sustainability

10.1 None required.

11. Consultation

11.1 This report has been completed in consultation with the HSCP Board's external auditor's Audit Scotland.

12. Strategic Assessment

12.1 This report is in relation to a statutory function and as such does not directly affect any of the strategic priorities.

13. Directions

13.1 None required.

Julie Slavin – Chief Financial Officer
Date: 16 September 2025

Person to Contact:	Julie Slavin – Chief Financial Officer, Church Street, WDC Offices, Dumbarton G82 1QL Telephone: 07773 934 377 E-mail: julie.slavin@nhs.scot
Appendices:	Appendix 1**:** Response to ISA 240 Letter: Those Charged With Governance Appendix 2: Response to ISA 240 Letter: Senior Management Appendix 3: Draft Annual Audit Report Appendix 3 A: Internal Control Conclusions Appendix 3 B**:** Management Representation Letter Appendix 3 C: Independent Draft Auditor Report
Background Papers:	HSCP Audit and Performance Committee June 2025 – Unaudited Annual Report and Accounts 2024/25
Localities Affected:	All

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.

MAZARS LETTER TO HSCP SENIOR MANAGERS

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

1) ***What are 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);***

  Management Response

  The Annual Governance Statement contains a review of the adequacy and effectiveness of the governance framework including the system of internal control. These systems 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.

  All financial transactions relating to the delivery of HSCP delegated services are hosted within both WDC and NHGGGC ledgers, therefore the HSCP relies on the processes and controls implemented by our partner organisations including approval and authorisation processes, defined limits for all authorised signatories and adherence to WDC Financial Regulations and NHSGGC Standing Financial Instructions. The financial statements reflect the transactions which have been processed by both partners' (WDC and NHSGGC) financial systems.

  The HSCP Board receives a financial performance report at each meeting which is prepared through both individual and collective meetings with managers and Heads of Service on how actual spending plans align to budget plans. Any material deviation is investigated and corrective action taken where appropriate.

  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 IJB's Chief Internal Auditor provides regular reports to the Audit and Performance Committee which include information on control issues identified within the partner organisations and any potential impact on the HSCP.

  The IJB Chief Internal Auditor attends the SMT Finance Core meeting and annually the SMT supported by the CFO identify specific areas that would benefit from an internal audit review to assess controls in place.

- ***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;***

  Management Response

  Risk processes are considered by SMT as part of the annual review of the IJB's own Local Code. The SMT also complete a similar return for WDC's Local Code Review and identify any areas for improvement. For NHSGGC the SMT complete the Internal Control Questionnaire, including confirming the processes for minimising a risk of fraud.

The SMT work with the Chief Internal Auditor each year in the drafting of the annual audit plans for both the HSCP Board and Social Care, using a risk based approach and also considering the risk of fraud. Any control weaknesses identified would be addressed through appropriate management action and reported to respective Audit Committees.

Through support from the HSCP Finance Team and partner's support teams, electronic approvals for raising commitments and paying invoices are linked to organisational structures and authorised signatory levels.

If the SMT became aware of any fraud or suspected fraud then appropriate reporting processes would be followed e.g. the CFO would be notified in conjunction with partner bodies processes including reporting to Internal Audit, Fraud Liaison Officer or Legal teams for cases involving suspected data breaches.

- ***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);***

  Management Response

  Through the Code of Conduct for Staff, all WDC and NHSGGC employed staff are obliged to comply with the partner's Corporate Governance documentation, which includes the responsibilities of managers and other staff arising from the Financial Regulations, SFIs and Fraud Policies – all available on WDC and NHSGGC websites and intranet.

  The daily Core Briefs from NHSGGC and regular Administrator emails from WDC update on core policies and national fraud initiatives where appropriate.

  Training sessions and/or updates at Extended Management Team Forums are also utilised where required.

- ***communicating to those charged with governance the processes for identifying and responding to fraud or error?***

  Management Response

  The HSCP Board's 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. There is ongoing discussions with IJB's CIAs to strengthen the value of updates on internal audit activity received from NHSGGC's auditors.

  Also the Audit and Performance Committee considers the annual review of the Local Code and is provided updates on improvement actions.

2) What is management's processes to identify and respond to the risk of fraud and possible breaches of internal control? Is management aware of any breaches of internal control during 2024/25? Please provide details.

Management 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 and Standing Financial Instructions.

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.

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.

WDC internal audit team completed audits (which straddle financial years) on Supporting Employee Attendance across Council Services. The audit identified some internal control weaknesses however, their opinion was the overall Control Environment Opinion was "Satisfactory.

To provide assurance to the IJB on financial performance reporting, an audit was undertaken on Budgetary Control Arrangements.

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.

Two green issues were identified being:
• 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.

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

Management Response

HSCP staff work with WDC and NHSGGC as required in the National Fraud Initiative. Any issues raised as led by Counter Fraud staff and supported by HSCP as required.

A risk based approach is taken to review of individual packages of care.

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

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

Management Response

The HSCP, WDC and NHSGGC are large complex organisations and 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 NFI, WDC and NHSGGC internal audit work and reported fraud show some low value frauds.

No system of internal control can provide absolute assurance and management are not naïve to the possibility that an individual(s) could be engaged in fraudulent activity. Risk-based audits and identification of weaknesses within the control environment highlight areas for improvement.

Regular review of pathways into the health and care system, robust policies on eligibility, commissioning and procurement support, training, multi-disciplinary team decisions, regular budget monitoring and regular supervision all help mitigate risks of fraud(s).

There have been no reported suspicions of fraud reported in the 2024/25 financial year flagged to senior management.

- ***Has management identified any specific fraud risks within the organisation? Please provide details.***

Management Response

The HSCP commission social care services in excess of £62m and SMT recognise that this presents a fraud risk that can be reduced through robust commissioning support and expanding automated self-billing transactional processes.

Improvements to internal controls and processes are overseen by the CareFirst Programme Board, the Programme Management Office (PMO) and service specific workstreams.

- ***Does management have any concerns that there are areas within the organisation that are at risk of fraud? Please provide details.***

Management Response

Management will discuss with the CIA some potential areas at risk of fraud. Refer to the response above. The HSCP, through both WDC and NHSGGC commission services in excess of £70 million. Robust commissioning and procurement of services should minimise the risk of fraud and this is also supported by a revamped process around reviews and assessment of care.

- ***Are there particular locations within the organisation where fraud is more likely to occur? Please provide details.***

Management Response

Older people or those with a disability with capacity issues maybe unable to provide full financial information for the assessment process and family members may have to provide info. There is potential for capital and non-capital not being fully declared. There are controls in place to minimise risk, including searches on the property register and DWP and re-assessments however the risk of fraud cannot be fully mitigated.

Other significant areas with regards to budget are GP Prescribing and payments to Family Health Services. GPs, Community Pharmacists, Opticians, and Dentists etc. are all independent contractors and elements of their payments are linked to volume/list sizes. The HSCP relies on both NHSGGC and Scottish Government systems of internal control to monitor anomalies in these sectors.

5) Are you 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?***

Management Response

See responses above, in particular Q1 & Q2.
HSCP staff are 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 and NHSGGC Internal Auditors have concluded that reasonable assurance can be provided on the partners' system of internal control for 2024/25.

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

Management 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.

Types of concerns would be around services provided to vulnerable clients and ensuring they and their assets are safeguarded. This was covered at a previous EMT Fraud Prevention and Detection session.

7) From a fraud and corruption perspective, what do you consider to be high risk posts within the organisation? Please provide details.

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

Management Response

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. Also revisions to SOPs as required to recognise the complexities of working across the HSCP. E.g. Care at Home Overtime, Carefirst Self-Billing

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.

Both WDC and NHSGGC have recognised that commissioning and procurement of high value services present a risk of fraud. The HSCP has supported this by adding a Commissioning and Contracts Team to our structure. While internal controls of segregation of duties and authorised signatory levels provide assurance, senior posts within the HSCP and partner organisations could pose a fraud risk. Annual reviews of procurement compliance, including use of framework agreements, up-to-date contracts and regulated tendering processes help mitigate these risks.

8) Are you 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?***

Management Response

Senior management are not aware of any related party relationships or transactions that could give rise to instances of fraud. The Code of Conduct requires all senior

managers and HSCP Board members to complete an annual Register of Interests return. At the start of any Board meeting those attending have an opportunity to declare any interests.

There is also processes in place within both partner bodies to register any gifts or hospitality. This includes employees informing their line manager of any gift offered or received and approval given in line with the respective policies.

9) Are you 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.***

  Management Response

  The financial statements reflect the transactions which have been processed by both partners' (WDC and 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.

- ***Are there any assets, liabilities or transactions that it believes were improperly included or omitted from the accounts of the organisation? Please provide details.***

  Management Response

  No. We are not aware of any assets, liabilities or transactions that have been improperly included or omitted from the HSCP Board's annual accounts.

- ***Could a false accounting entry escape detection? If so, how?***

  Management Response

  Senior management 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.

  Again assurance is provided by electronic approval processes for authorisation of orders, invoices and journal entries that allow secondary review. This is supported by regular and robust budget monitoring processes.

- ***Are there any external fraud risk factors which are high risk of fraud? Please provide details.***

  Management Response

  See responses to Q4 above around external contractors Family Health Services, including pharmacy services, delivered by independent contractors.

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

- ***Are you 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.***

  Management Response

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

  It is the responsibility of every budget holder and employee expending financial resource to ensure they are achieving best value, maximising efficiencies and delivering on approved savings programmes. The HSCP Finance Team support monthly budget monitoring with all levels of budget holder and significant variances are investigated. Senior management receive summary information on financial performance and update regularly on progress on savings targets. There is robust support and challenge by the CO, CFO and HSCP Board members and early identification of risk areas. There is no undue management pressure applied or financial incentives offered.

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

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

- ***What process is in place for identifying and responding to changes in laws and regulations? Please provide details.***

  Management 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.

  This is also supported by senior managers being members of partner's corporate management teams and being members of professional organisations. For example Safer Staffing legislation implementation is being resourced by SG, NHSGGC, WDC and the HSCP and supported by Chief Nurses, CFOs, and CSWO through their respective professional organisations.

- ***What arrangements are in place for the Audit and Performance Committee to oversee this process?***

  Management Response

  The HSCP Board and Audit and Performance Committee 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. The Local Code together with the Annual Governance Statement, annual accounts and quarterly performance reports are all scrutinised by the Audit and Performance Committee. All board and committee reports are subject to legal review and comment to ensure key issues are identified.

- ***What arrangements are 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.***

  Management Response

  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. All HSCP Policies reflect relevant legislation e.g. Charging Policy, Self-Directed Support Policy and are available on the intranet and websites.

- ***Do you 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.***

  Management Response

  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.

  There are exceptions in place for the procurement of some social and health care services where a direct award may be made, however these are documented through "Waiver to Tender" processes and must be approved by the CO, CFO and partner's procurement teams.

  Another area which is at risk of breach of current regulations is the Working Time Directive, i.e. working more than 47 hours per week, mainly in frontline services of Care at Home, Residential homes for both children and adults. All managers should minimise this risk where possible, but if an employee is content to work more than 47 hours, they are required to sign a waiver.

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

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

Management Response

No. 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 management assessed and satisfied itself that it is appropriate to adopt the going concern basis in preparing the financial statements?

Management Response

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 Integration Scheme requires the Chief Officer and Chief Financial Officer to engage with partners and present to them an annual budget plan which takes account on changes in service delivery, demographics, activity changes, legislative requirements etc. The partners must accept the risk to delivery of delegated services if not appropriately funded. The scheme also 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 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 SMT had dedicated budget setting sessions and HoS have regular 1:1 meetings with the CO and CFO to consider the financial reports produced by the partner's ledger systems. Budget variances discussed and mitigating actions are agreed which include vacancy management, service reviews and use of reserves as earmarked or approved by the HSCP Board.

This coupled with a regular review of strategic risks at both SMT and board level supports management to conclude there are no issues in relation to going concern basis in the preparation of the 2024/25 financial statements.

14) Has management 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.

Management Response

The HSCP Board agreed a balanced 2025/26 budget on 25 March 2025. The 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 in July 2015 there have been financial challenges that required the approval of savings programmes to reduce expenditure and/or increase income. While there have been some factors impacting on the delivery of programmes, including flat cash budget allocations by WDC and not passing through Scottish Government pay award funding, the HSCP management team have agreed a number of actions to support sustainability.

The Medium Term Financial Outlook 2024/25 – 2027/28 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 the financial sustainability of the HSCP.

The HSCP Board have protected a range of funds through earmarking as reserves as well as holding a prudent level of unearmarked reserves to support the transition and delivery of service change. The Board have approved redesign plans for the future shape of Care at Home Services, Children and Families and Learning Disability Services. Therefore, whilst the HSCP does have future budget gaps, management will continue to provide viable options to close the gap supporting the HSCP's financial sustainability and to continue as a going concern.

Also as stated above in response to Q13, partners WDC and NHSGGC have through the Integration Scheme agreed to support the delivery of delegated services by giving due consideration to activity, demographic, legislative and inflationary pressures when agreeing annual contributions. If overspends occur that cannot be fully mitigated through an agreed recovery plan, then it is for the partner organisations to make additional contributions to cover any overspends.

Annual Audit Report

West Dunbartonshire Integration Joint Board – year ended 31 March 2025

September 2025

forvis mazars

Audit and Performance Committee

West Dunbartonshire Integration Joint Board

16 Church Street

Dumbarton
G82 1QL

15 September 2025

Forvis Mazars

100 Queen Street

Glasgow

G1 3DN

Dear Committee Members and Controller of Audit,

Annual Audit Report – Year ended 31 March 2025

We are pleased to present our Annual Audit Report for West Dunbartonshire Integration Joint Board for the year ended 31 March 2025. The purpose of this report is to summarise our audit findings and conclusions.

This report has been prepared in accordance with the responsibilities set out within the Audit Scotland's Code of Audit Practice ("the Code"). This report is intended solely for Audit and Performance Committee for the purpose of communicating certain matters that, in our professional judgement, are relevant to your oversight of the financial reporting process. Except where required by law or regulation, it should not be used, quoted or made available to any other parties without our prior written consent.

We appreciate the courtesy and co-operation extended to us by West Dunbartonshire Integration Joint Board throughout our audit. We would be happy to discuss the contents of this report, or any other matters regarding our audit, with you in more detail.

Yours faithfully,

Tom Reid (Audit Director)

Forvis Mazars LLP

Contents

01

Executive Summary

Executive summary

Scope

We have been engaged to audit the financial statements of West Dunbartonshire Integration Joint Board (the IJB) for the year ended 31 March 2025 which are prepared in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom 2024-25.

We have conducted our audit in accordance with International Standards on Auditing (UK) ('ISAs'), relevant ethical and professional standards, and the requirements set out in the Audit Scotland's Code of Audit Practice 2021. Our responsibilities and powers are derived from our appointment by the Accounts Commission under the Part VII of the Local Government (Scotland) Act 1973.

Audit status

Our audit procedures are now substantially complete for the year ended 31 March 2025.

At the time of preparing this report, there are no significant matters outstanding.

Areas of focus and audit approach, and significant findings

We have not made any changes to our initial risk assessment and planned audit approach that was communicated to the Audit and Performance Committee in our Annual Audit Plan.

Our significant risks and other areas of focus are set out in the *'Audit approach and risk summary'* section, with a summary of our audit approach over those areas. Significant findings from our audit are set out in the *'Significant findings'* section.

Significant control deficiencies

We did not identify any significant deficiencies in internal control.

Audit misstatements

A summary of the adjusted and unadjusted misstatements above our reporting threshold we have identified to date is set out in the *'Summary of misstatements'* section.

Executive summary (continued)

Audit opinion

At the time of issuing this report and subject to the satisfactory conclusion of our remaining audit work, we anticipate issuing an unqualified opinion, without modification, as set out in Appendix C.

Wider scope

We anticipate having no significant wider scope risks to report in relation to the financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes arrangements that the IJB has in place. Further details have been provided in *section 'Wider scope and Best Value'* of this report.

Best Value

We anticipate having no risks in arrangements to report in relation to the arrangements that the IJB has in place to secure economy, efficiency and effectiveness in its use of resources. Further details have been provided in *section 'Wider scope and Best Value'* of this report.

Management Commentary and Annual Governance Statement opinion

We anticipate that we will have no matters to report in respect of the Management Commentary or the Annual Governance Statement preparation as it is consistent with the financial statements and has been prepared in accordance with statutory guidance issued under the Local Government in Scotland Act 2003 and Delivering Good Governance in Local Government Framework 2016. Our proposed Management Commentary and Annual Governance Statement opinion is included in the draft auditor's report in Appendix C.

Matters on which we report by exception

We are required by the Accounts Commission for Scotland to report to you if, during the course of our audit, we have found that adequate accounting records have not been kept; the financial statements and the audited part of the Remuneration Report are not in agreement with the accounting records; or we have not received all the information and explanations we require for our audit. We have nothing to report in respect of these matters.

Other information

We are required to report on whether the other information comprising of the Management Commentary, Annual Governance Statement, Statement of Responsibilities and the unaudited parts of the Remuneration Report, is materially inconsistent with the financial statements; is materially inconsistent with our knowledge obtained in the course of the audit; or is materially misstated. No inconsistencies have been identified and we have issued an unmodified opinion in this respect.

Wider reporting powers

Section 101 of the Local Government (Scotland) Act 1973 requires us to give any person interested, the opportunity to question us about the accounting records of the IJB and to consider any objection made to the accounts.

We received no objections to the accounts.

Executive summary (continued)

Qualitative aspects of IJB's accounting practices

We have reviewed the IJB's accounting policies and disclosures and conclude that they comply with the Code of Practice on Local Authority Accounting in the United Kingdom 2024-25, appropriately tailored to the IJB's circumstances.

Draft accounts were received from the IJB on 26 June 2025 and were of a good quality.

Significant matters discussed with management

During our audit, we did not communicate any significant matters to management:

Significant difficulties during the audit

We encountered no significant difficulties during our audit and had no significant disagreements with management. There was effective co-operation and communication between Forvis Mazars, management, and the Audit and Performance Committee during our audit. All requested information and explanations were provided to us.

Other matters we are required by ISA (UK) 260 *Communication with Those Charged with Governance* to communicate to you have been set out in Appendix E.

02

Status of our audit

Status of our audit

Our audit work is substantially complete and there are currently no matters of which we are aware that would require modification of our audit opinion, subject to the satisfactory resolution of the outstanding matters set out below.

Audit area	Risk of material adjustment or significant change	Description of the outstanding matters
Audit quality control and completion procedures	Low	Our audit work is undergoing final stages of review by the Engagement Lead and further quality and compliance checks. In addition, there are residual procedures to complete, including updating post balance sheet event considerations to the point of issuing the opinion, obtaining final management representations and agreeing adjustments to the final set of accounts.
Annual Report and Accounts and letter of representation	Low	We will complete our final review of the annual report and accounts upon receipt of the signed version of the accounts and letter of representation.

Status

High - Likely to result in a material adjustment or a significant change to disclosures in the financial statements.

Medium - Potential to result in a material adjustment or a significant change to disclosures in the financial statements.

Low - Not considered likely to result in a material adjustment or a change to disclosures in the financial statements.

N/A - Work on Wider Scope and Best Value arrangements therefore no risk of adjustment to the financial statements.

03

Audit approach and risk summary

Audit approach and risk summary

Changes to our audit approach

There have been no changes to the audit approach we communicated in our Annual Audit Plan, issued on 18 February 2025.

Materiality

Our provisional materiality at the planning stage of our audit was set at £5,447k using a benchmark of 2% of gross revenue expenditure at surplus/deficit level as per the Annual Audit Plan. Our performance materiality was set at £3,813k. In determining the overall and performance materiality levels, we made the following significant judgements;

- that the main users of the financial statements are the Scottish Government, other IJBs, Local Authorities, Regulators, Elected Members, Local Community, and other Stakeholders;
- that the primary aggregate that users tend to focus on is gross revenue expenditure, as it reflects the extent of services commissioned by the IJB;
- that the IJB's objective is not to maximise profits, as it has no shareholders. Instead, its focus is on delivering its key priorities. The services provided to the local community are primarily funded by the Scottish Government through the IJB's partner organisations, West Dunbartonshire Council and NHS Greater Glasgow and Clyde.
- that as part of our audit, we have gained an understanding that the IJB has a well established and experienced finance team capable of applying the relevant Accounting Standards. Additionally, the Audit and Performance Committee members demonstrate good ability to scrutinise financial information at a high level.

Based on the final financial statements figures and other qualitative factors, the final overall materiality we applied was £5,558k (final performance materiality: £3,890k; final clearly trivial threshold: £167k).

We maintained a specific materiality of £1k for senior officer remuneration disclosed in the Remuneration and Staff Report.

Audit approach and risk summary (continued)

Significant risks	Fraud risk	Judgement	Error	Substantive audit procedures	Tests of controls	Misstatement identified	Control recommendations	Conclusion	Page ref to finding
Management override of controls	Yes	No	No	Yes	No	No	No	Risk satisfactorily addressed.	14

04

Significant findings

Significant findings

The significant findings from our audit include our conclusions regarding the significant risks we identified and other key areas of judgement, which are set out in this section.

Significant risks

Management override of controls

Description of the risk

Management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur there is a risk of material misstatement due to fraud on all audits.

How we addressed this risk

We addressed this risk by:

- Reviewing the key areas within the financial statements where management had used judgement and estimation techniques and considered whether there were evidence of unfair bias;
- Testing the appropriateness of adjustments made in preparing the financial statements; and
- Considering and testing any significant transactions outside the normal course of business or otherwise and manual adjustments, if any.

Audit conclusion

Our work has provided the assurance we sought in each of these areas and has not highlighted any material issues to bring to your attention.

Significant findings (continued)

Wider responsibilities – statutory reporting

The 1973 Act allows any persons interested to inspect the accounts to be audited and the underlying accounting records of the IJB. The act also allows any persons interested to object to the accounts. No such objections have been raised.

We are required to notify the Controller of Audit when circumstances indicate that a statutory report may be required.

- Section 102(1) of the 1973 Act allows us to prepare a report to the Accounts Commission about the IJB's accounts; matters that have arisen during the audit that should be brought to the attention of the public; or the performance of the IJB in their duties relating to Best Value and community planning. We confirm that no such reports have been prepared.

05

Internal control deficiencies

Internal control deficiencies

As part of our audit, we obtained an understanding of the IJB's internal control environment and control activities relevant to the preparation of the financial statements, which was sufficient to plan our audit and determine the nature, timing, and extent of our audit procedures. Although our audit was not designed to express an opinion on the effectiveness of the West Dunbartonshire Integration Joint Board's internal controls, we are required to communicate to the Audit and Performance Committee any significant deficiencies in internal controls that we identified in during our audit.

Deficiencies in internal control

A deficiency in internal control exists if:

- A control is designed, implemented, or operated in such a way that it is unable to prevent, detect, and/ or correct potential misstatements in the financial statements; or
- A control that is necessary to prevent, detect, and/ or correct misstatements in the financial statements on a timely basis is missing.

The purpose of our audit was to express an opinion on the financial statements. As part of our audit, we have considered the IJB's internal controls relevant to the preparation of the financial statements to design audit procedures to allow us to express an opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the IJB's internal controls or to identify any significant deficiencies in their design or operation.

The matters reported in this section of our report are limited to those deficiencies and other control recommendations that we have identified during our normal audit procedures and which we consider to be of sufficient importance to merit being reported.

If we had performed more extensive procedures on internal control, we might have identified more deficiencies to report or concluded that some of the reported deficiencies need not in fact have been reported.

Our comments in this section should not be regarded as a comprehensive record of all deficiencies that may exist or improvements that could be made.

Significant deficiencies in internal control

A significant deficiency in internal control is one which, in our professional judgement, has the potential for financial loss, damage to reputation, or a loss of information which may have implications on the achievement of business strategic objectives. Our view is that observations categorised as a significant deficiency is of sufficient importance to merit the attention of the Audit and Performance Committee .

We have not identified any significant deficiencies in the IJB's internal controls as at the date of this report.

Other observations

We also record our observations on the IJB's internal controls where, in our professional judgement, there is a need to strengthen internal control or enhance business efficiency that do not constitute significant deficiencies in internal control but which we view as being important for consideration by management.

The other control deficiencies that we have identified as at the date of this report are set out in '*Appendix A: Internal control conclusions*'.

06

Summary of misstatements

Summary of misstatements

Adjusted misstatements

We report all individual misstatements above our reporting threshold that we identify during our audit and which management had adjusted and any other misstatements we believe the Audit and Performance Committee should be made aware of.

We identified no misstatements above our reporting threshold, or that we deem to be material by nature, as at the date of this report.

Unadjusted misstatements

We identified no misstatements above our reporting threshold, or that we deem to be material by nature, as at the date of this report which were not adjusted.

Summary of misstatements (continued)

Disclosure misstatements

We identified the following disclosure misstatements during our audit that have been corrected by management:

- **Management commentary**
  - Correction to reflect that the IJB does not employ any staff.
  - Update to reflect the publication of the Scottish Government's Medium Term Financial Strategy.
- **Movement in Reserves Statement**
  - Disclosure update to show the distinction between movements to statutory adjustments and movements due to accounting practices
  - Disclosure of the descriptions of the nature and purpose for which individual earmarked reserves are held, in line with requirements of the Code.

There were also adjustments to the annual report and accounts for other minor disclosure, consistency or presentational matters.

We identified the following disclosure misstatement during our audit that has not been corrected by management:

- **Provisions**

The unaudited accounts included a provision of £582k (23/24: £439k) in the balance sheet for unrecovered charges for specific social care delegated services. We recommended in 2023/24 and 2022/23 that officers amend the short-term debtors balance to show it net of the bad debt provision. Officers decided not to make this adjustment on the basis that by presenting the balance as a provision, the IJB is recognising the uncertainty associated with it and improving visibility to readers of the accounts. The IJB's contribution from the Council is net of income received from levying charges and other income. If any debt is written off, the IJB accounts for the impact. However ultimately if the IJB cannot cover its costs then the Council would have to account for any deficit in line with the Integration Scheme.

We have accepted the IJB's accounting treatment because the amount disclosed is not material and an alternative accounting treatment would have no impact on total net assets recorded in the balance sheet.

We will obtain written representations confirming that, after considering the unadjusted disclosure misstatements, both individually and in aggregate, in the context of the annual report and financial statements taken as a whole, no adjustments are required.

07

Fraud considerations

Fraud considerations

We have a responsibility to plan and perform our audit to obtain reasonable assurance that the financial statements are free from material misstatement, whether due to fraud or error.

Your responsibilities

Management has primary responsibility for the prevention and detection of fraud. It is important that management, with your oversight, place a strong emphasis on fraud prevention, which may reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit fraud because of the likelihood of detection and punishment. This involves a commitment to creating a culture of honesty and ethical behaviour which is reinforced by your active oversight.

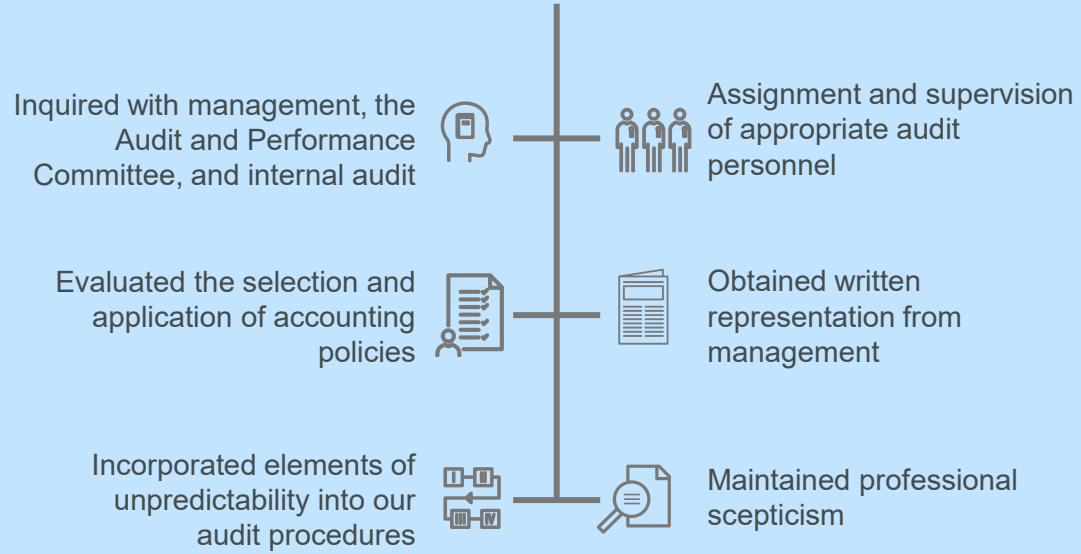
Our responsibilities

We have a responsibility for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether due to fraud or error. The distinguishing factor between fraud and error is whether the underlying action that results in a misstatement is intentional or unintentional. Two types of intentional misstatements are relevant to us – misstatements resulting from fraudulent financial reporting, and misstatements resulting from the misappropriation of assets.

ISA presumed fraud risks

As set out in the *'Audit approach and risk summary'* section, the risks of fraud in management override of controls were identified as significant risks.

Our overall approach to fraud



Our overall conclusion

We did not identify any actual or suspected fraud involving management, employees with significant roles in internal control or others, where the fraud resulted in a material misstatement in the financial statements.

08

Wider Scope

Commentary on Wider Scope

Overall Summary

Commentary on Wider Scope

Wider Scope summary

As auditors appointed by the Accounts Commission, our wider scope responsibilities are set out in the Code of Audit Practice 2021 and sits alongside Best Value requirements detailed in the Local Government (Scotland) Act 1973. The Code requirements broaden the scope of the 2024/25 audit and allow us to use a risk-based approach to report on our consideration of the IJB's performance of best value and community planning duties and make recommendations for improvement and, where appropriate, conclude on the IJB's performance.

The Code's Wider Scope framework is categorised into four areas:

- financial management;
- financial sustainability;
- vision, leadership and governance; and
- use of resources to improve outcomes.

Overall summary by reporting criteria

From the satisfactory conclusion of our audit work, we have the following conclusions:

Reporting criteria	Commentary page reference	Possible significant risks?	Significant risks identified?	Other recommendations made?
Financial management	26	No	No	Yes – see commentary 1 on page 30
Financial sustainability	31	Yes – see risk 1 on page 32	Yes – see recommendation 1 on page 34	No
Vision, leadership and governance	36	No	No	No
Use of resources to improve outcomes	41	No	No	No

Commentary on Wider Scope

Financial management

Financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively.

Financial management

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Financial management culture	The IJB has effective financial management arrangements including: • a Medium-Term Financial Outlook (MTFO) which forecasts income and expenditure and identifies funding gaps for a three-year period from 2024/25 to 2027/28 • regular budget monitoring • budget decisions which can be linked to its strategic priorities • clear delegated authority structures • savings plans which are regularly monitored • an experienced and capable finance team. Internal audit reviewed the IJB's budgetary control arrangements in 2024/25. It found that monthly budget reports are shared with budget holders, variances are investigated, and training materials are available. However, the IJB does not provide regular refresher training to budget holders.	The IJB has effective financial arrangements in place. These could be further strengthened by ensuring budget holders receive regular training.	No significant risks identified. See page 31 for our recommendation.

Financial management (Continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Accountability	Budget holders received monthly financial reports. These include detailed variance analysis which allows timely monitoring and supports informed decision making and accountability. The IJB has developed a Budgetary Control and Monitoring Procedures Manual, demonstrating a structured approach to financial governance. However, it remains in draft form. Its finalisation and formal rollout would ensure budget monitoring is applied consistently across the IJB. Officers present Financial Performance Update Reports to the Board. These reports provide detailed insights into the IJB's budget position and the progress of its savings programme, enabling effective scrutiny by Board members. Savings plans are also closely monitored by the Senior Management Team and the Project Management Office. In 2024/25, the IJB recorded an overall deficit of £0.247 million. After planned transfers to and from reserves, the final position was a net underspend of £0.072 million, which was added to unearmarked reserves. This is a significant improvement from the previous year's £1.731 million deficit (after reserve adjustments), however the IJB's reserves continue to be below its target level of 2% of net expenditure.	The IJB's budget monitoring arrangements support financial accountability. However, it continues to rely on use of reserves to balance budgets, which is not sustainable.	See financial sustainability risk identified on page 33.

Financial management (Continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Arrangements to prevent and detect fraud, error and other irregularities, bribery and corruption	The IJB does not maintain its own fraud and corruption policies but relies on the frameworks of its partner bodies, West Dunbartonshire Council (the Council) and NHS Greater Glasgow and Clyde (NHSGGC). The Council and NHSGGC provide comprehensive anti-fraud measures. These include dedicated fraud teams, whistleblowing channels, and regularly reviewed policies. NHSGGC has a Fraud Response Plan and a staff Code of Conduct covering ethical behaviour, gifts, contracts, and whistleblowing. West Dunbartonshire Council also has a Code of Conduct covering these areas. The IJB has adopted its own Code of Conduct for Board members, covering areas such as declarations of interest and lobbying, and its own Local Code of Good Governance. These documents support ethical standards and transparency at Board level. The IJB's Senior Management Team annually reviews the Local Code and identifies areas for improvement to control risks, including fraud risks. The IJB promotes an anti-fraud culture through the Council and NHSGGC Codes of Conduct and fraud awareness training. Allegations of corruption or irregularity are investigated under formal business irregularity procedures dependent on the employing organisation, which includes the possibility of disciplinary action.	The IJB has appropriate arrangements in place to prevent and detect fraud, error and other irregularities, bribery and corruption. The IJB's use of partner-led fraud teams and whistleblowing channels ensures that staff and stakeholders have access to clear mechanisms for reporting concerns.	No significant risks identified.

Financial management (continued)

Identified risks in financial management arrangements and recommendations for improvement

As a result of our work we have identified risks in the IJB's financial management arrangements. These identified risks have been outlined in the table below. We have assigned priority rankings to each of them to reflect the importance that we consider each poses to your organisation and, hence, our recommendation in terms of the urgency of required action; see Appendix F for further details.

	Financial management significant risks identified	Recommendation for improvement	IJB's response and implementation timescale
1	**Financial Management (Training for budget holders) – Level 3** Training materials are available to support budget holders to scrutinise their budgets. However, the IJB does not provide regular refresher training. There is a risk that budget holders may not consistently apply procedures which could affect the accuracy of budget monitoring and reporting.	The IJB should ensure refresher training is provided to budget holders to ensure procedures are understood and consistently applied.	**Management's response** In parallel with the actions agreed by management in response to Internal Audit's similar recommendation to review the adequacy of refresher training for budget holders, draft training materials will be finalised and rolled out in a phased way throughout the next year. **Responsible officer** HSCP's Chief Financial Officer and Head of Human Resources. **Implementation date** Training materials finalised by November 2025 and phased roll-out, incorporating feedback throughout 2026.

Commentary on Wider Scope

Financial sustainability

Financial sustainability looks forward to the medium and longer term to consider whether the body is planning effectively to continue to deliver its services or the way in which they should be delivered.

Financial sustainability

Significant risks

We have outlined below the significant risks in arrangements that we have identified as part of our continuous planning procedures, and the work undertaken to respond to each of those risks.

	Significant Risk in Arrangements Identified	Work undertaken and the results of our work
1	**Financial sustainability** West Dunbartonshire Integration Joint Board (IJB) is forecasting significant budget gaps in future years. Its financial challenges include rising prescribing and care at home costs and uncertainty over the level of financial support from partner bodies. The IJB used reserves to achieve financial balance in 2023/24. This reduced its unearmarked reserves below the 2% of total budget level set in its reserves policy. Officers expect the IJB to again draw on reserves to fund a projected overspend for 2024/25. The Accounts Commission's Integration Joint Boards' Finance and Performance 2024 report further highlights the unprecedented pressures and financial uncertainties facing community health and social care across Scotland. These challenges put the partnership's financial sustainability at risk.	**Work undertaken** We reviewed the IJB's financial performance and updates to its financial planning throughout the year, including the implications for general reserves balances. In addition, We reviewed the IJB's achievement of planned recurring and non-recurring savings **Results of our work** For the 2024/25 financial year, the IJB delivered Health and Social Care services amounting to £256.27m against funding contributions of £256.02m, resulting in an overall deficit on the provision of services of £0.247m. The deficit was funded by a drawdown of earmarked reserves of £0.319m resulting in a net underspend of £0.072m. Although this resulted in a marginal increase in the unearmarked reserves for 2024/25 to £3.58m, they remain below the target level. Officers presented regular financial performance reports to the Board to update members on the IJB's position against budget and the progress of savings programmes. The IJB continues to face challenges and cost pressures in delivering its services with an initial indicative budget gap of £7.77m for 2025/26 closed through savings options, management adjustments and use of reserves. While these measures result in a balanced budget for 2025/26, the IJB is projecting cumulative budget gaps of £9.00m for 2026/27 and £18.85m for 2026/27 after the application of savings measures. There is a significant risk that the IJB may be unable to identify and achieve the savings required to ensure financial sustainability. See recommendation 1 on page 35

Financial sustainability (continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Financial planning	The Board approved the IJB's Medium Term Financial Outlook (MTFO) in November 2024, which provided a three-year financial forecast and high-level ten-year projection of financial gaps. The IJB identified a budget gap of £7.77m for 2025/26 which it agreed to address through use of earmarked reserves (£3.05m), savings initiatives (£1.99m), and management adjustments (£2.73m). The MTFO projects a cumulative budget gap of £9.00m in 2026/27, rising to £18.85m by 2027/28. The IJB has agreed a financial plan, which includes achieving savings through prescribing efficiencies, improved workforce management and service redesign.	The MTFO is critical in ensuring the IJB has clear sight of the scale of its financial challenges over the medium term and can respond effectively. The IJB should continue to regularly review and update the MTFO and its financial plan. The financial sustainability of the IJB is heavily dependent on the level of financial support provided by partner bodies. Officers should continue to work to ensure stakeholders understand their collective responsibility for the IJB's finances.	**Financial sustainability** There is a risk to the longer-term financial sustainability of the IJB. See page 35 for further information and our recommendation made to the IJB.

Financial sustainability (continued)

Identified risks in financial sustainability arrangements and recommendations for improvement

As a result of our work we have identified risks in the IJB's financial sustainability arrangements. These identified risks have been outlined in the table below. We have assigned priority rankings to each of them to reflect the importance that we consider each poses to your organisation and, hence, our recommendation in terms of the urgency of required action; see Appendix F for further details.

	Financial sustainability significant risks identified	Recommendation for improvement	IJBs response and implementation timescale
1	**Financial sustainability – Level 2** The MTFO projects a cumulative budget gap of £9.00m in 2026/27, rising to £18.85m by 2027/28. The IJB has agreed a financial plan, which includes achieving savings through prescribing efficiencies, improved workforce management and service redesign. The challenges faced by the IJB put its longer-term financial sustainability at risk.	The IJB should continue to regularly review and update the MTFO and its financial plan. As part of this process, the IJB should ensure its partners understand the challenges it faces and their collective responsibility to ensure the IJB's finances are secure.	**Management's response** The MTFO was fully refreshed in November 2024 and covers the period to 2027/28. This Outlook will be refreshed in line with the production of the IJB's next Strategic Plan effective from 1 April 2026. **Responsible officer** Chief Financial Officer **Implementation date** 1 April 2026

Financial sustainability (continued)

Follow up of previously-reported recommendations

In September 2024 we reported one recommendation to the IJB to address risks identified from our Wider Scope audit for financial sustainability. As part of our work in 2024/25, we followed up on the progress made by the IJB against the recommendations made and determined whether the risk remained during the year.

	Financial sustainability finding as previously reported	Management response and implementation timeframe	Work undertaken and judgements made in 2024/25	Conclusions reached
1	**Financial sustainability – Level 2** The IJB's medium to long-term financial plan projects significant budget gaps in future years. The IJB faces significant financial challenges, including demographic pressures, inflation, pay awards, prescribing costs exceeding funding allocations and the extent to which partner organisations choose to pass on funding. It also has the ongoing challenge of identifying and delivering savings which do not adversely impact service delivery. These challenges put the IJB's longer term financial sustainability at risk. The IJB should routinely refresh its Medium Term Financial Plan to reflect the current environment it is operating in and provide a clear plan to its use of savings and other transformational options in addressing its challenges. As part of this process, the IJB should continue working with its partners to agree actions that will help reduce cost pressures and ensure it is delivering its strategic outcomes.	**Management Response:** The IJB and Management acknowledge the benefit of regular updates to the MTFP. It also recognises the challenge of one-year budget settlements that don't reflect significant financial pressures, mainly public sector pay and demographics. Work is ongoing to update the current MTFP for the November IJB, including a range of scenarios via sensitivity analysis. As transformational change programmes gather pace, financial assumptions on savings will be reflected. **Implementation timescale:** November 2024 and annual refresh from March 2026.	**Progress against the recommendation** The IJB approved its refreshed Medium Term Financial Outlook 2024/25 – 2027/28 in November 2024. This included revised funding gap projections and updated sensitivity analysis. This ensured the IJB's financial forecasts better reflected the current fiscal environment.	**Conclusions** Complete

Commentary on Wider Scope

Vision, leadership and governance

Vision, Leadership and Governance is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision making, and transparent reporting of financial and performance information.

Vision, leadership and governance

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Clarity of plans to implement the vision	The IJB has articulated a clear and inclusive vision – “Improving Lives with the People of West Dunbartonshire” – supported by a well-structured Strategic Plan (2023–2026). The plan is built around four strategic outcomes: Caring Communities, Safe and Thriving Communities, Equal Communities, and Healthy Communities. These outcomes are directly aligned with the nine national health and wellbeing outcomes, ensuring consistency with national policy. Oversight is maintained through the Strategic Planning Group and Programme Management Office, which monitor progress against the strategic outcomes. The Strategic Plan and performance reports are publicly available online, complemented by plain language summaries, infographics, and visual dashboards. Community engagement is actively promoted through consultations, social media, and newsletters. The IJB’s Participation and Engagement Strategy was designed to ensures that diverse voices are heard and that information is shared inclusively across all community groups. The IJB’s strategic priorities are regularly monitored based on performance data, inspection findings, and community feedback. Initiatives such as the Learning Disability Review and prescribing efficiency programmes show targeted action.	The Strategic Plan is well-constructed and provides a good foundation for delivering the IJB’s priorities.	No significant risks identified.

Vision, leadership and governance (Continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Strategy and priorities	West Dunbartonshire HSCP Board's Strategic Plan 2023–2026 presents a clear and structured roadmap, built around four strategic outcomes aligned with national health and wellbeing goals. It is supported by a Strategic Needs Assessment, a Strategic Delivery Plan, and the Medium Term Financial Outlook (MTFO), ensuring that priorities are evidence-based and linked to financial decision making. Strategic priorities are shaped by local needs and national policy, with strong alignment to partner organisations including NHS Greater Glasgow and Clyde and West Dunbartonshire Council. The Strategic Plan seeks to address key challenges including poverty, mental health, addiction, and multi-morbidity, with measurable actions and timelines to guide implementation. Community involvement is embedded through a dedicated Participation and Engagement Strategy, Locality Engagement Networks, and consultations with seldom-heard groups. Targeted interventions, including support for carers, mental health outreach, and service redesigns, demonstrate the IJB's commitment to equity and responsiveness.	The IJB has a clear strategy and priorities that reflect both national expectations and local realities.	No significant risks identified.

Vision, leadership and governance (continued)

Our overall assessment (continued)

Area assessed	Our findings	Our judgements	Significant risks identified
Governance arrangements	The IJB has well established governance arrangements that support strategic oversight and operational delivery. These include the Board, Audit and Performance Committee, Strategic Planning Group, Clinical and Care Governance Group, and Programme Management Office. Governance arrangements are inclusive and collaborative, with representation from West Dunbartonshire Council, NHS Greater Glasgow and Clyde, third-sector organisations, carers, and staff. Regular meetings, structured agendas, and published reports ensure transparency. Internal and external audits, along with performance reporting, provide assurance and inform strategic decision making. The Board demonstrates responsiveness to change, with strategic priorities regularly reviewed considering legislation, financial pressures, and service redesigns. Multi-agency collaboration is evident in initiatives including: • the Learning Disability Review • Self-Directed Support Policy updates • Care at Home redesign • Children and Families “What Would It Take”.	The IJB has appropriate, well established governance arrangements which support effective and transparent scrutiny and decision making.	No significant risks identified.

Vision, leadership and governance (continued)

Our overall assessment (continued)

Area assessed	Our findings	Our judgements	Significant risks identified
Financial and performance information	The Board has a well-established performance reporting framework, with quarterly and annual reports aligned to strategic priorities and national health and wellbeing outcomes. These reports track 51 performance indicators, incorporating benchmarking and trend analysis to monitor progress and identify areas for improvement. Financial and workforce data is integrated into performance reports and scrutinised by the Board and Audit and Performance Committee. These reports are supported by Clinical and Care Governance processes, ensuring that quality, safety, and resource use are considered together. Continuous improvement is embedded through the Strategic Plan, Programme Management Office, and follow-up of internal audit recommendations. Improvement actions are tracked using the Pentana system and regularly reviewed by governance groups.	The Board and Audit and Performance Committee receive sufficient information to support effective scrutiny of the IJB's performance.	No significant risks identified.

Commentary on Wider Scope

Use of resources to improve outcomes

Audited bodies need to make best use of their resources to meet stated outcomes and improvement objectives, through effective planning and working with strategic partners and communities. This includes demonstrating economy, efficiency, and effectiveness through the use of financial and other resources and reporting performance against outcomes.

Use of resources to improve outcomes

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Resources deployed to improve strategic outcomes	The IJB has established mechanisms to identify and monitor cost drivers, including detailed financial performance reports, strategic needs assessments, and benchmarking data. These tools help identify high-cost areas and inform service redesign and transformation planning, with oversight provided by the Strategic Planning Group and Audit and Performance Committee. In response to financial pressures and strategic priorities, the Board has implemented alternative service delivery models. These include redesigning MSK physiotherapy referrals, closing the Work Connect service, and introducing the “Call Before You Convey” model in care homes. Efficiency improvements have also been made in prescribing and through digital tools and flexible working. Benchmarking is embedded in performance management, with comparisons made against national health and wellbeing outcomes. The Strategic Planning Group reviews performance trends and uses benchmarking to inform service redesign and assess Best Value. Participation in national frameworks further supports comparative analysis. The Board aligns financial resources with strategic outcomes through its Strategic Plan and Delivery Plan. The Board considers financial performance reports tracking progress and spending trends each time it meets (six times a year). The Annual Performance Report and Best Value Statement demonstrate how resources support service delivery and improvement.	The IJB has developed arrangements to help ensure its resources are aligned with its strategic priorities. Its significant financial challenges mean it will need to continue regularly reviewing the effectiveness of these arrangements.	No significant risks identified.

Use of resources to improve outcomes (Continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Needs of service users being met	The IJB involves users in service evaluation and design. This is evidenced by its Participation and Engagement Strategy, regular engagement sessions with service users and carers, and the use of varied feedback tools such as surveys and consultation forums. Service users are represented on the Board and Strategic Planning Group, ensuring that user perspectives are considered in decision-making. Service user needs are further addressed through transparent performance monitoring. Benchmarking against local and national targets helps identify areas for improvement, while oversight by the Strategic Planning Group ensures that delivery plans remain responsive to user needs. The IJB reports publicly on how it meets user needs through its Annual Performance Report. This includes performance against strategic priorities, integration indicators, and Care Inspectorate gradings. The IJB regularly updates the Performance Framework to ensure alignment with local priorities and national developments.	The IJB has a clear approach to involving service users in shaping services. The IJB's performance monitoring and benchmarking practices are effective in assessing how effectively it is meeting the needs of service users.	No significant risks identified.

Use of resources to improve outcomes (Continued)

Our overall assessment

Area assessed	Our findings	Our judgements	Significant risks identified
Arrangements to deliver continuous improvements in priority services	The IJB supports continuous improvement through clear strategic planning and regular performance reporting. Improvement efforts are supported by service redesigns, risk-based planning, and oversight from the Programme Management Office. Public reporting and benchmarking ensure transparency and help identify areas for further development. Further findings from our review of the IJB's arrangements to deliver continuous improvements in priority services are detailed in Best Value section of this report (Section 9).	The IJB has appropriate arrangements in place to support continuous improvement.	No significant risks identified.

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Best Value

Best Value

Best Value summary

Under the Code of Audit Practice, the audit of Best Value is fully integrated within our annual audit work. We are required to report on how the IJB demonstrates and reports that it has Best Value arrangements in place, to secure continuous improvement. We have used a risk-based approach that is proportionate to the size and type of the body, to assess whether the IJB has made proper arrangements for securing Best Value and is complying with its community planning duties. We have also followed up on previously reported Best Value findings, and have assessed the pace and depth of improvement implemented by the IJB.

Overall summary by reporting criteria

From the satisfactory conclusion of our audit work, we have the following conclusions:

Reporting criteria	Commentary page reference	Possible significant risks?	Significant risks identified?	Other recommendations made?	Overall conclusion
Best Value	47	No	No	No	Satisfactory

Best Value (continued)

Overall commentary on the Best Value reporting criteria

The IJB has a statutory duty to have arrangements to secure Best Value. To achieve this, IJBs are expected to have effective processes for scrutinising performance, monitoring progress towards their strategic objectives and holding partners to account.

The IJB prepares a Best Value Statement which is reviewed and updated on an annual basis. This statement considers the IJB position in relation to ten key Best Value prompts, prepared by Audit Scotland.

The questions cover:

- consideration of the responsible parties for securing Best Value
- how delivery assurances are measured
- whether there is sufficient partner buy-in on the longer-term vision of the IJB
- how value for money is demonstrated in decision making
- whether there is a culture of continuous improvement
- whether identified improvements actions which have been prioritised are those that are likely to have the greatest impact.
- whether improvement actions have been identified and prioritised in terms of those likely to have the greatest impact
- steps are taken to ensure that quality of care and service provided is not compromised due to cost saving measures
- whether performance information reported to the Board is of sufficient detail to enable value for money to be assessed and
- how the IJB ensure that management of resources (finances, workforce etc.) is effective and sustainable.

The last update was reviewed by the Senior Management Team on 3 June 2025 and reported to the Audit and Performance Committee on 25 June 2025. The Best Value statement highlights opportunities for improvement, specifically it was acknowledged that key performance indicators be better linked with budget projections.

The Board of the IJB is the key decision-making body accountable for securing Best Value in the IJB. Its membership includes six voting members from both partner bodies.

The Board is supported by the Audit and Performance Committee, Project Management Office and Senior Management Team to ensure effective reporting in accordance with the law and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

The Board meets six times per year, with regular financial and performance reporting. All agenda, papers and minutes are published on the IJB's website and made available to the public, while complaints received from the public are also regularly reported to the Board and investigated to demonstrate openness and transparency.

The IJB work closely with its partners, West Dunbartonshire Council and NHSGGC to ensure the agreed IJB strategic plan meets its objectives and long-term vision. The partners have made significant input into the IJB strategic plan by providing value added comments, attending strategic needs assessment workshops and completing relevant surveys.

Our wider scope work has not identified any significant weaknesses in the governance and accountability of the IJB or its use of resources. The IJB has assessed its Best Value arrangements and identified areas for improvement which it is working to address.

Appendices

A

A: Internal control conclusions

B: Draft management representation letter

C: Draft audit report

D: Confirmation of our independence

E: Other communications

F: Wider scope ratings

G: Current year updates, forthcoming accounting & other issues

Appendix A: Internal control conclusions

Other deficiencies in internal control

A deficiency in internal control exists if:

- A control is designed, implemented, or operated in such a way that it is unable to prevent, detect, and/ or correct potential misstatements in the financial statements; or
- A control that is necessary to prevent, detect, and/ or correct misstatements in the financial statements on a timely basis is missing.

The purpose of our audit was to express an opinion on the financial statements. As part of our audit, we have considered West Dunbartonshire Integration Joint Board's internal controls relevant to the preparation of the financial statements to design audit procedures to allow us to express an opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of West Dunbartonshire Integration Joint Board's internal controls or to identify any significant deficiencies in their design or operation.

The matters reported in Appendix A are limited to those deficiencies and other control recommendations that we have identified during our normal audit procedures and which we consider to be of sufficient importance to merit being reported. If we had performed more extensive procedures on internal control, we might have identified more deficiencies to report or concluded that some of the reported deficiencies need not in fact have been reported. Our comments in Appendix A should not be regarded as a comprehensive record of all deficiencies that may exist or improvements that could be made.

Appendix A: Internal control conclusions (continued)

Other deficiencies in internal control

This Appendix sets out the internal control observations that we have identified as at the date of this report. These control observations are not, in our view, significant control deficiencies but have been reported to management directly and are included in this report for your information. In our view, there is a need to address the deficiencies in internal control set out in this section to strengthen internal control or enhance business efficiency. Our recommendations should be actioned by management in the near future.

Review of related parties' transactions

Description of deficiency

Board members' annual declarations of interest were submitted after the unaudited annual report and accounts were approved for issue. This meant that officers were unable to review members' declarations and ensure any identified related party transactions were appropriately disclosed in the unaudited accounts.

We subsequently reviewed the declarations of interest against the IJB's transactions listings and did not identify any undisclosed related party transactions.

Potential effects

Officers may not be fully aware of Board member's interests leading to incorrect or incomplete disclosure of related party transactions in the annual accounts.

Recommendation

Officers should ensure annual declarations are received in suitable time for a full review to be carried out prior to issue of the unaudited accounts.

Management's response

The Chief Financial Officer will work with the IJB's Standard's Officer to agree to issue earlier requests for annual declarations of interest and ensure a full review is undertaken to identify or discount any related parties transactions.

Responsible officer

Chief Financial Officer

Implementation date

31 March 2026

Appendix B: Draft management representation letter

Forvis Mazars
100 Queen Street
Glasgow
G1 3DN

XX September 2025

Dear Tom Reid,

West Dunbartonshire Integration Joint Board - Audit for Year Ended 31 March 2024

This representation letter is provided in connection with your audit of the financial statements of West Dunbartonshire Integration Joint Board (the IJB) for the year ended 31 March 2025 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom 2024/25 (the Code), and applicable law.

I confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy myself that I can properly make each of the following representations to you.

My responsibility for the financial statements and accounting information

I believe that I have fulfilled my responsibilities for the true and fair presentation and preparation of the financial statements in accordance with the Code, as amended by applicable law.

My responsibility to provide and disclose relevant information

I have provided you with:

- access to all information of which I am aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the audit; and
- unrestricted access to individuals within the IJB you determined it was necessary to contact in order to obtain audit evidence.

I confirm as Chief Financial Officer that I have taken all the necessary steps to make me aware of any relevant audit information and to establish that you, as auditors, are aware of this information.

As far as I am aware there is no relevant audit information of which you, as auditors, are unaware.

I confirm that there is no information provided to you as part of the audit that I consider legally privileged.

Appendix B: Draft management representation letter (continued)

Accounting records
I confirm that all transactions that have a material effect on the financial statements have been recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all Board and committee meetings, have been made available to you.

Accounting policies
I confirm that I have reviewed the accounting policies applied during the year in accordance with International Accounting Standard 8 and consider these policies to faithfully represent the effects of transactions, other events or conditions on the IJB's financial position, financial performance and cash flows.

Accounting estimates, including those measured at fair value
I confirm that the methods, significant assumptions and the data used by the IJB in making the accounting estimates, including those measured at fair value, are appropriate to achieve recognition, measurement or disclosure that is in accordance with the applicable financial reporting framework.

Contingencies
There are no material contingent losses including pending or potential litigation that should be accrued where:
- information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the IJB have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the Code, as amended by applicable law.

Laws and regulations
I confirm that I have disclosed to you all those events of which I am aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

The IJB has complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Appendix B: Draft management representation letter (continued)

Fraud and error

I acknowledge my responsibility as Chief Financial Officer for the design, implementation and maintenance of internal control to prevent and detect fraud and error and I believe I have appropriately fulfilled those responsibilities.

I have disclosed to you:

- all the results of my assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the IJB involving:
- management and those charged with governance;
- employees who have significant roles in internal control; and
- others where fraud could have a material effect on the financial statements.

I have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the IJB's financial statements communicated by employees, former employees, analysts, regulators or others.

Related party transactions

I confirm that all related party relationships, transactions and balances, have been appropriately accounted for and disclosed in accordance with the requirements of the Code, as amended and applicable law.

I have disclosed to you the identity of the IJB's related parties and all related party relationships and transactions of which I am aware.

Charges on assets

All the IJB's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

The IJB has no plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Subsequent events

I confirm all events subsequent to the date of the financial statements and for which the Code, as amended by the Code Update and applicable law, require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, I will advise you accordingly.

Appendix B: Draft management representation letter (continued)

Impacts of Russian Forces entering Ukraine

I confirm that I have carried out an assessment of the potential impact of Russian Forces entering Ukraine on the IJB, including the impact of mitigation measures and uncertainties, and that the disclosure in the Annual Report and the subsequent events note 5 to the financial statements fairly reflects that assessment.

Tariffs

I confirm that I have carried out an assessment of the potential impact of changes in US trade policy in respect of tariffs, including the impact of reciprocal tariffs by other countries, including the impact of mitigation measures and uncertainties, and that the disclosure in the Annual Report and the subsequent events note 5 to the financial statements fairly reflects that assessment.

Going concern

To the best of my knowledge there is nothing to indicate that the IJB will not continue as a going concern in the foreseeable future. The period to which I have paid particular attention in assessing the appropriateness of the going concern basis is not less than twelve months from the date of approval of the accounts.

Performance related allocations

I confirm that I am not aware of any reason why the IJB's funding allocation limits would be changed.

Annual Governance Statement

I am satisfied that the Annual Governance Statement (AGS) fairly reflects the IJB's risk assurance and governance framework and I confirm that I am not aware of any significant risks that are not disclosed within the AGS.

Annual Report

The disclosures within the Annual Report and the Remuneration Report fairly reflect my understanding of the IJB's financial and operating performance over the period covered by the financial statements.

Unadjusted misstatements

I confirm that there are no unadjusted misstatements.

Appendix B: Draft management representation letter (continued)

Wider scope and best value arrangements

I confirm that I have disclosed to you all findings and correspondence from regulators for previous and ongoing inspections of which I am aware. In addition, I have disclosed to you any other information that would be considered relevant to your work on wider scope and best value arrangements.

Yours faithfully,

Chief Financial Officer

Appendix C: Draft audit report

Independent auditor's report to the members of West Dunbartonshire Integration Joint Board and the Accounts Commission

Report on the audit of the financial statements

Opinion on the financial statements

We certify that we have audited the financial statements in the annual accounts of West Dunbartonshire Integration Joint Board ("the IJB) for the year ended 31 March 2025 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Comprehensive Income and Expenditure Statement, the Movement in Reserves Statement, the Balance Sheet and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2024/25 (the 2024/25 Code).

In our opinion the accompanying financial statements:

- give a true and fair view of the state of affairs of the IJB as at 31 March 2025 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the 2024/25 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Basis for opinion

We conducted our audit in accordance with applicable law and International Standards on Auditing (UK) (ISAs (UK)), as required by the Code of Audit Practice approved by the Accounts Commission for Scotland. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report. We were appointed by the Accounts Commission on 18 May 2022. Our period of appointment is five years, covering 2022/23 to 2026/27. We are independent of the IJB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. Non-audit services prohibited by the Ethical Standard were not provided to the IJB. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern basis of accounting

We have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Appendix C: Draft audit report (Continued)

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the IJB's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

These conclusions are not intended to, nor do they, provide assurance on the IJB's current or future financial sustainability. However, we report on the IJB's arrangements for financial sustainability in a separate Annual Audit Report available from the **Audit Scotland website.**

Risks of material misstatement

We report in our Annual Audit Report the most significant assessed risks of material misstatement that we identified and our judgements thereon.

Responsibilities of the Chief Financial Officer and the Audit and Performance Committee for the financial statements

As explained more fully in the Statement of Responsibilities, the Chief Financial Officer is responsible for the preparation of financial statements, that give a true and fair view in accordance with the financial reporting framework, and for such internal control as the Chief Financial Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Chief Financial Officer is responsible for assessing each year the IJB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless there is an intention to discontinue the IJB operations.

The Audit and Performance Committee is responsible for overseeing the financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities outlined above to detect material misstatements in respect of irregularities, including fraud. Procedures include:

- using our understanding of the local government sector to identify that the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003 are significant in the context of the IJB;
- inquiring of the Chief Financial Officer and Chief Officer as to other laws or regulations that may be expected to have a fundamental effect on the operations of the IJB;

- inquiring of the Chief Financial Officer and Chief Officer concerning the IJB's policies and procedures regarding compliance with the applicable legal and regulatory framework;
- discussions among our audit team on the susceptibility of the financial statements to material misstatement, including how fraud might occur; and
- considering whether the audit team collectively has the appropriate competence and capabilities to identify or recognise non-compliance with laws and regulations.

The extent to which our procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the IJB's controls, and the nature, timing and extent of the audit procedures performed.

Irregularities that result from fraud are inherently more difficult to detect than irregularities that result from error as fraud may involve collusion, intentional omissions, misrepresentations, or the override of internal control. The capability of the audit to detect fraud and other irregularities depends on factors such as the skilfulness of the perpetrator, the frequency and extent of manipulation, the degree of collusion involved, the relative size of individual amounts manipulated, and the seniority of those individuals involved.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website **www.frc.org.uk/auditorsresponsibilities.** This description forms part of our auditor's report.

Reporting on other requirements

Opinion prescribed by the Accounts Commission on the audited parts of the Remuneration Report

We have audited the parts of the Remuneration Report described as audited. In our opinion, the audited parts of the Remuneration Report have been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014.

Other information

The Chief Financial Officer is responsible for the other information in the annual accounts. The other information comprises the Management Commentary, Statement of Responsibilities, Annual Governance Statement and the unaudited part of the Remuneration Report.

Our responsibility is to read all the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon except on the Management Commentary and Annual Governance Statement to the extent explicitly stated in the following opinions prescribed by the Accounts Commission.

Appendix C: Draft audit report (continued)

Opinions prescribed by the Accounts Commission on the Management Commentary and Annual Governance Statement

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with statutory guidance issued under the Local Government in Scotland Act 2003; and
- the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with the Delivering Good Governance in Local Government: Framework (2016).

Matters on which we are required to report by exception

We are required by the Accounts Commission to report to you if, in our opinion:

- adequate accounting records have not been kept; or
- the financial statements and the audited part of the Remuneration Report are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in respect of these matters

Conclusions on wider scope responsibilities

In addition to our responsibilities for the annual accounts, our conclusions on the wider scope responsibilities specified in the Code of Audit Practice, including those in respect of Best Value, are set out in our Annual Audit Report.

Use of our report

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 108 of the Code of Audit Practice, we do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Tom Reid
Director
For and on behalf of Forvis Mazars LLP

Appendix D: Confirmation of our independence

We communicate any matters which we believe may have a bearing on the independence or the objectivity of Forvis Mazars LLP and the audit team. As part of our ongoing risk assessment, we monitor our relationships with you to identify any new actual or perceived threats to our independence within the regulatory or professional requirements governing us as your auditors.

We confirm that no new threats to independence have been identified since issuing our Annual Audit Plan and therefore we remain independent.

Appendix D: Confirmation of our independence (continued)

Fees for work as the IJB's auditor

We reported our proposed fees for the delivery of our work under the Code of Audit Practice in our Annual Audit Plan presented to the Audit and Performance Committee on 18 February 2025. Having completed our work for the 2024/25 financial year, we can confirm that our fees are as follows:

Area of work	2024/25 fees	2023/24 fees
Auditor remuneration	£37,150	£35,650
Pooled costs	£930	£1,300
Contribution to PABV costs	£7,130	£7,610
Sectoral cap adjustment	(£11,200)	(£11,200)
Total fees	**£34,000**	**£33,360**

Fees for other work

We confirm that we have not undertaken any non-audit services for the IJB in the year.

Appendix E: Other communications

Other communication	Response
Compliance with Laws and Regulations	We have not identified any significant matters involving actual or suspected non-compliance with laws and regulations. We will obtain written representations from management that all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements have been disclosed.
External confirmations	We did not experience any issues with respect to obtaining external confirmations.
Related parties	We did not identify any significant matters relating to the audit of related parties. We will obtain written representations from management confirming that: a. they have disclosed to us the identity of related parties and all the related party relationships and transactions of which they are aware; and b. they have appropriately accounted for and disclosed such relationships and transactions in accordance with the requirements of the applicable financial reporting framework.
Going Concern	We have not identified any evidence to cause us to disagree with the Chief Financial Officer that West Dunbartonshire Integration Joint Board will be a going concern, and therefore we have not identified any evidence to cause us to consider that the use of the going concern assumption in preparation of the financial statements is not appropriate. We will obtain written representations from management, confirming that all relevant information covering a period of at least 12 months from the date of approval of the financial statements has been taken into account in assessing the appropriateness of the going concern basis of preparation of the financial statements.

Appendix E: Other communications (continued)

Other communication	Response
Subsequent events	We are required to obtain evidence about whether events occurring between the date of the financial statements and the date of the auditor's report that require adjustment of, or disclosure in, the financial statements are appropriately reflected in those financial statements in accordance with the applicable financial reporting framework. We will obtain written representations from management that all events occurring subsequent to the date of the financial statements and for which the applicable financial reporting framework requires adjustment or disclosure have been adjusted or disclosed.
Matters related to fraud	Our audit was designed to obtain reasonable assurance whether the financial statements as a whole are free from material misstatement due to fraud. Please refer to the section titled '*Fraud considerations*' for our fraud considerations and conclusion. We will obtain written representations from management and, where appropriate, the Audit and Performance Committee, confirming that a. they acknowledge their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud; b. they have disclosed to the auditor the results of management's assessment of the risk that the financial statements may be materially misstated as a result of fraud; c. they have disclosed to the auditor their knowledge of fraud or suspected fraud affecting the entity involving: i. management; ii. employees who have significant roles in internal control; or iii. others where the fraud could have a material effect on the financial statements; and d. they have disclosed to the auditor their knowledge of any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

Appendix E: Other communications (continued)

Other communication	Response
System of Quality Management	To address the requirements of ISQM (UK) 1, our firm's System of Quality Management team completes, as part of an ongoing and iterative process, a number of key steps to assess and conclude on our firm's System of Quality Management, including: • Ensuring there is an appropriate assignment of responsibilities under ISQM (UK) 1 and across Leadership • Establishing and reviewing quality objectives each year, ensuring ISQM (UK) 1 objectives align with our firm's strategies and priorities • Identifying, reviewing, and updating quality risks each quarter, taking into consideration a number of input sources (such as FRC / ICAEW review findings, internal monitoring findings, findings from our firm's root cause analysis and remediation functions, etc.) • Identifying, designing, and implementing responses as part of the process to strengthen our firm's internal control environment and overall quality • Evaluating responses and remediating control gaps or deficiencies We perform an evaluation of our system of quality management on an annual basis. Our latest evaluation was performed as of 31 August 2024. Details of that assessment and our conclusion are set out in our 2023/2024 Transparency Report, which is available on our website here.

Appendix F: Wider scope and Best Value ratings

We need to gather sufficient evidence to support our commentary on the IJB's arrangements and to identify and report on any risks. We will carry out more detailed work where we identify significant risks. Where significant risks are identified we will report these to the IJB and make recommendations for improvement. In addition to local risks, we consider challenges that are impacting the public sector as a whole.

We have assigned priority rankings to each of the risks identified to reflect the importance that we consider each poses to your organisation and, hence, our recommendation in terms of the urgency of required action. The table below describes the meaning behind each rating that we have awarded to each wider scope area based on the work we have performed.

Rating	Description
Level 1	The identified risk and/or significant deficiency is critical to the business processes or the achievement of business strategic objectives. There is potential for financial loss, damage to reputation or loss of information. The recommendation should be taken into consideration by management immediately.
Level 2	The identified risk and/or significant deficiency may impact on individual objectives or business processes. The audited body should implement the recommendation to strengthen internal controls or enhance business efficiency. The recommendations should be actioned in the near future.
Level 3	The identified risk and/or significant deficiency is an area for improvement or less significant. In our view, the audited body should action the recommendation, but management do not need to prioritise.

Appendix G: Current year updates, forthcoming accounting & other issues

Applicable for IFRS Reporters

Current and forthcoming accounting issues

New standards and amendments

Effective for accounting periods beginning on or after 1 January 2023

Amendments to IFRS 17 *Insurance Contracts*: Initial Application of IFRS 17 and IFRS 9 (Issued December 2021)

- The amendments address potential mismatches between the measurement of financial assets and insurance liabilities in the comparative period because of different transitional requirements in IFRS 9 *Financial Instruments* (IFRS 9) and IFRS 17. The amendments introduce a classification overlay under which a financial asset is permitted to be presented in the comparative period as if the classification and measurement requirements of IFRS 9 had been applied to that financial asset in the comparative period. The classification overlay can be applied on an instrument-by-instrument basis. The amendments have been UK-adopted and endorsed by the EU.

Amendments to IAS 1 *Presentation of Financial Statements* and IFRS Practice Statement 2 *Making Materiality Judgements: Disclosure of Accounting Policies* (Issued February 2021)

- The amendments set out notable new requirements for accounting policy disclosures that change the requirements for entities to disclose material accounting policy information, rather than significant accounting policies, and not to disclose immaterial accounting policy information, explaining that accounting policy information taken in isolation is unlikely to be material, but it is when the information is considered together with other information in the financial statements that may make it material. Earlier application is permitted. The amendments have been UK-adopted and endorsed by the EU.

Amendments to IAS 8 *Accounting Policies, Changes in Accounting Estimates and Errors: Definition of Accounting Estimates* (Issued February 2021)

- The amendment introduces a new definition for accounting estimates and clarifies how entities should distinguish changes in accounting policies from changes in accounting estimates. The distinction is important because changes in accounting estimates are applied prospectively only to future transactions and other future events, but changes in accounting policies are generally applied retrospectively to past transactions and other past events. Earlier application is permitted. The amendments have been UK-adopted and endorsed by the EU.

IFRS 18 *Presentation and Disclosure in Financial Statements* (Issued April 2024)

- IFRS 18 Presentation and Disclosure in Financial Statements (IFRS 18) is a new standard that replaces IAS 1 Presentation of Financial Statements. The new standard aims to increase the comparability, transparency and usefulness of information about companies' financial performance. It introduces three key new requirements focusing on the presentation of information in the statement of profit or loss and enhancing certain guidance on disclosures within the financial statements.

Contact

Forvis Mazars

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WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

Report by Julie Slavin, Chief Financial Officer

23 September 2025

Subject: Audited Annual Accounts 2024/25

1. Purpose

1.1 To provide an update to the Audit and Performance Committee on the completion of the audit of the HSCP Board's (IJB) Annual Accounts for the year ended 31 March 2025.

2. Recommendations

2.1 The HSCP Board's Audit and Performance Committee is asked to:

a) Consider the audited Annual Accounts for 2024/25; and

b) Remit the audited Annual Accounts and the associated Annual Audit Report from our external auditor, Forvis Mazars, to the September HSCP Board for approval and signature.

3. Background

3.1 In line with the Local Authority Accounts (Scotland) Regulations 2014, the Audit and Performance Committee considered the unaudited Annual Accounts for 2024/25 at its meeting of 25 June 2025. These accounts were subsequently submitted for audit to the Board's external auditor, Forvis Mazars.

3.2 The Regulations also require that Board or Committee responsible for overseeing and providing independent assurance on the internal control environment and the financial governance arrangements of the Partnership Board must consider the audited annual accounts and approve them for signature to the HSCP Board no later than 30 September and published no later than 31 October immediately following the financial year to which the accounts relate.

3.3 The audit of the 2024/25 Annual Accounts has now been substantially completed by Forvis Mazars and at the time of preparing this report, there are no significant matters outstanding. The final set of accounts is appended to this report at Appendix 1.

4. Main Issues

4.1 The audited Annual Accounts for the year ended 31 March 2025 were prepared in line with the proper accounting practice and statute. The 2014 Regulations specify that the audited accounts should be signed by the statutory deadline of 30 September and published no later than 31 October immediately following the financial year to which the accounts relate.

4.2 During the course of the audit there were some presentational adjustments identified which have been accepted and incorporated into the final, audited version. The overall movement in reserves balances for the HSCP Board are shown in Table 1 below.

Table 1: Movement in Reserves

Movement in Reserves During 2024/25	Un-earmarked Reserves £000	Earmarked Reserves £000	Total General Fund Reserves £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)**

4.3 The Audit and Performance Committee are requested to consider the audited Annual Accounts for 2024/25 and remit them to the 30 September HSCP Board for approval and signature.

5. Options Appraisal

5.1 None required.

6. People Implications

6.1 None associated with this report.

7. Financial and Procurement Implications

7.1 The HSCP Board ended the 2024/25 financial year with an adjusted surplus (after all planned application of earmarked reserves) of £0.072m. This surplus was transferred to un-earmarked reserves. The closing reserves balances are set-out in Table 1 above and will be retained in accordance with the Integration Scheme and Reserves Policy.

7.2 Integrated Joint Boards are specified in legislation as 'section 106' bodies under the terms of the Local Government Scotland Act 1973, and consequently are expected to prepare their financial statements in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom. The audited annual accounts comply with the code.

8. Risk Analysis

8.1 The Annual Accounts identify the usable funds held in reserve to help mitigate the risk of unanticipated pressures from year to year.

9. Equalities Impact Assessment (EIA)

9.1 None required.

10. Environmental Sustainability

10.1 None required.

11. Consultation

11.1 This report has been completed in consultation with the HSCP Board's external auditor's Forvis Mazars.

12. Strategic Assessment

12.1 This report is in relation to a statutory function and as such does not directly affect any of the strategic priorities.

13. Directions

13.1 None required.

Julie Slavin – Chief Financial Officer
Date: 16 September 2025

Person to Contact:	Julie Slavin – Chief Financial Officer E-mail: julie.slavin@ggc.scot.nhs.uk
Appendices:	Appendix 1: HSCP Board's (IJB) Annual Accounts for the year ended 31 March 2025
Background Papers:	HSCP Audit and Performance Committee June 2025 – Unaudited Annual Report and Accounts 2024/25
Localities Affected:	All

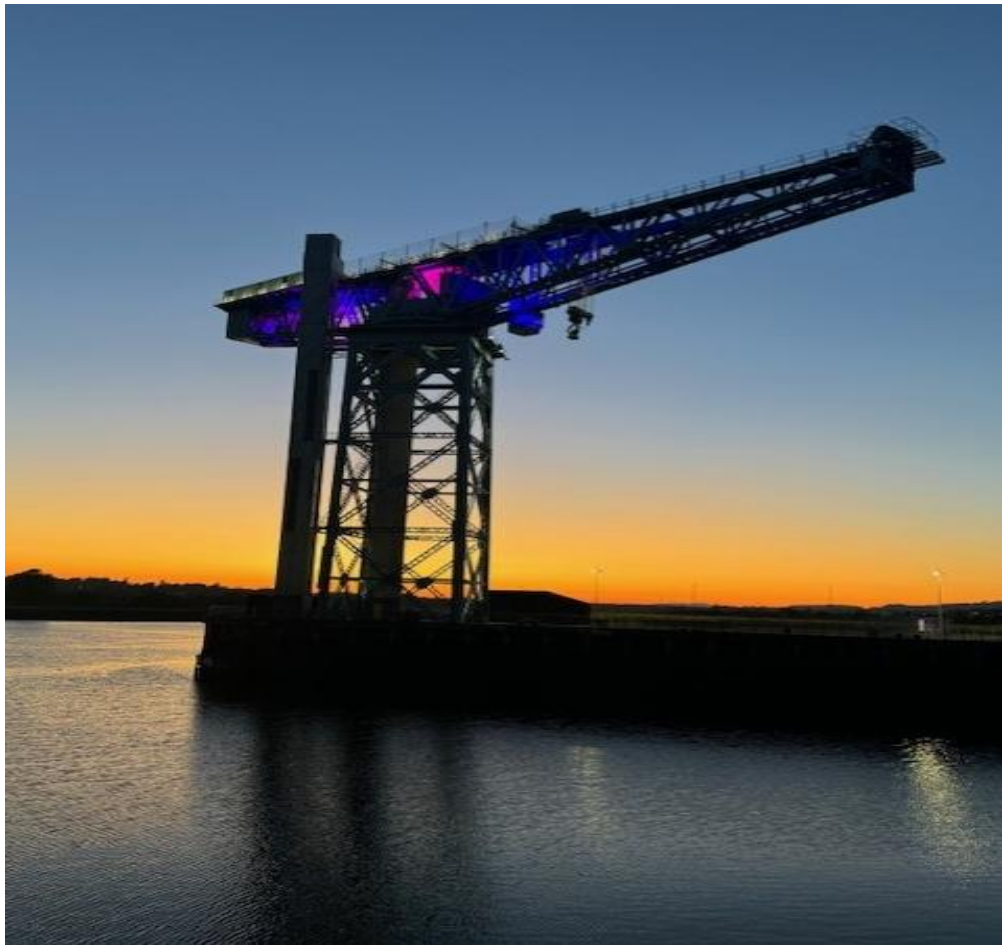
West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Integration Joint Board

Commonly known as
West Dunbartonshire
Health and Social Care Partnership Board

Audited 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)

2,207 health and social care staff are employed by our partners (NHS Greater Glasgow and Clyde and West Dunbartonshire Council) 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.

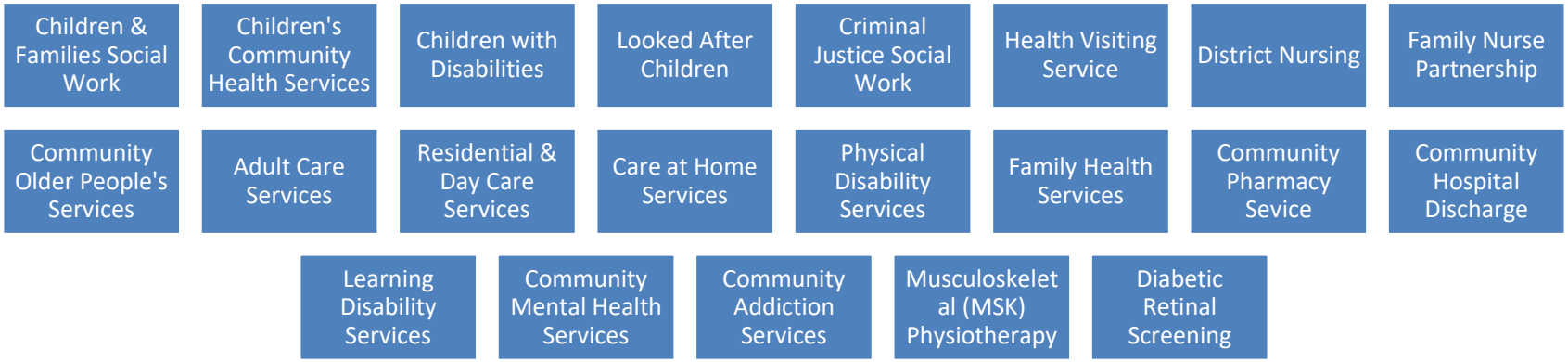
West Dunbartonshire HSCP Board Remit and Vision

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

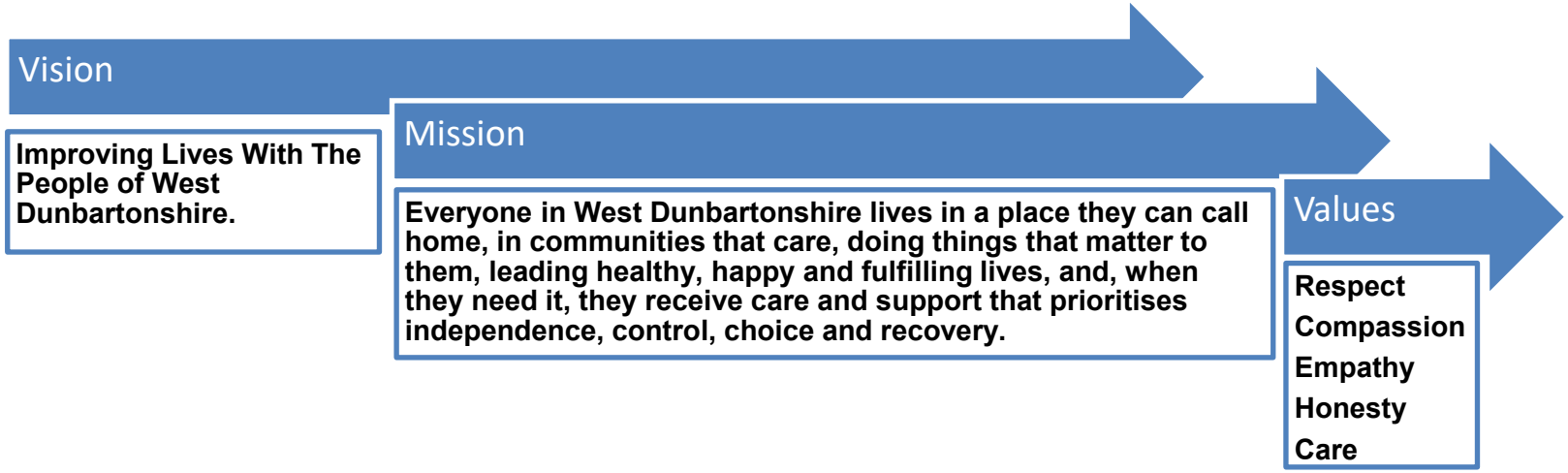


The 2014 Act requires that Integration Schemes undergo review within five years of establishment. A review was undertaken jointly by senior officers from all 6 HSCPs in the Greater Glasgow and Clyde area and partner bodies representatives. The group co-developed updated versions of the Schemes for their 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).

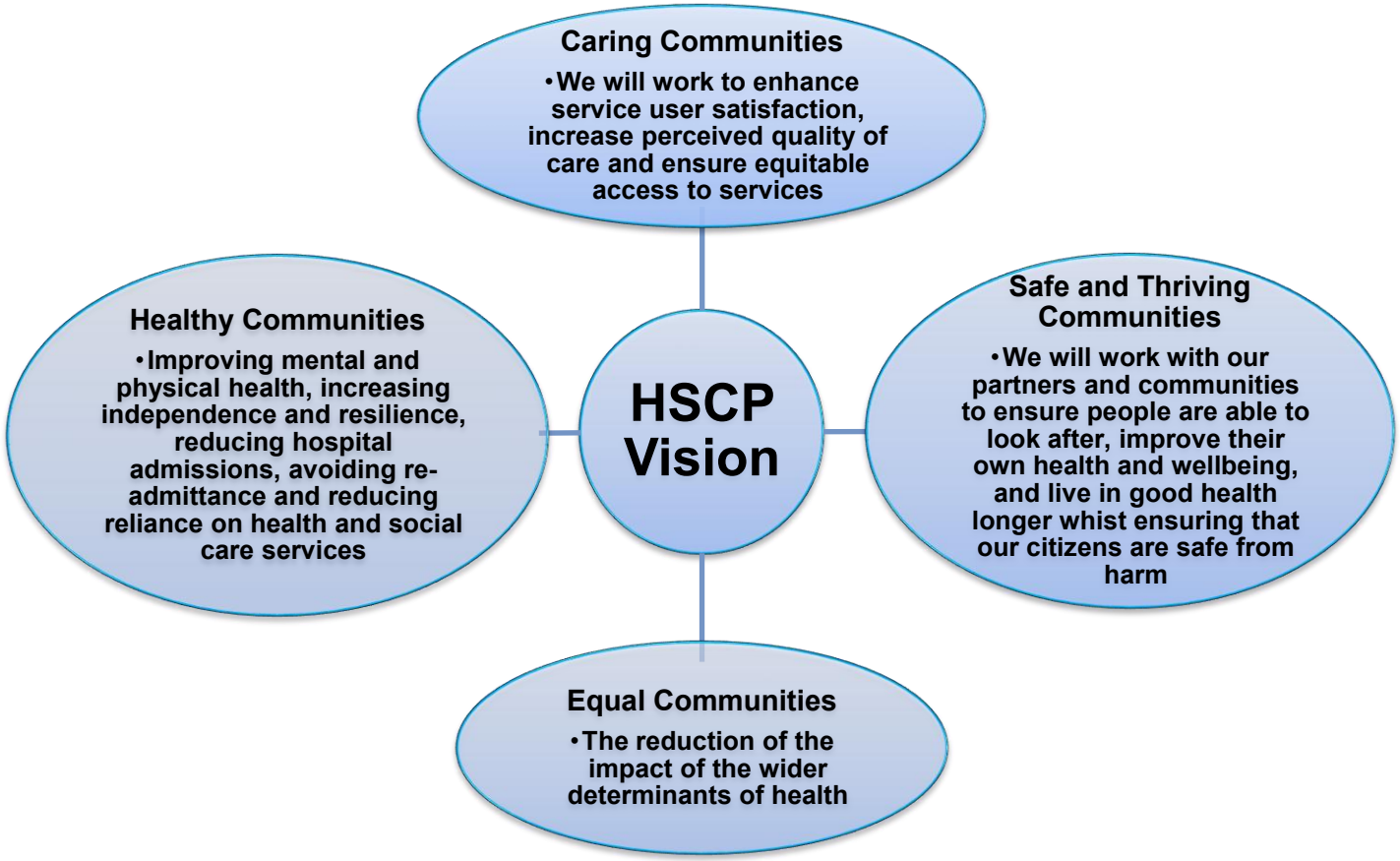
Exhibit 2: HSCP Vision, Mission and Values



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.

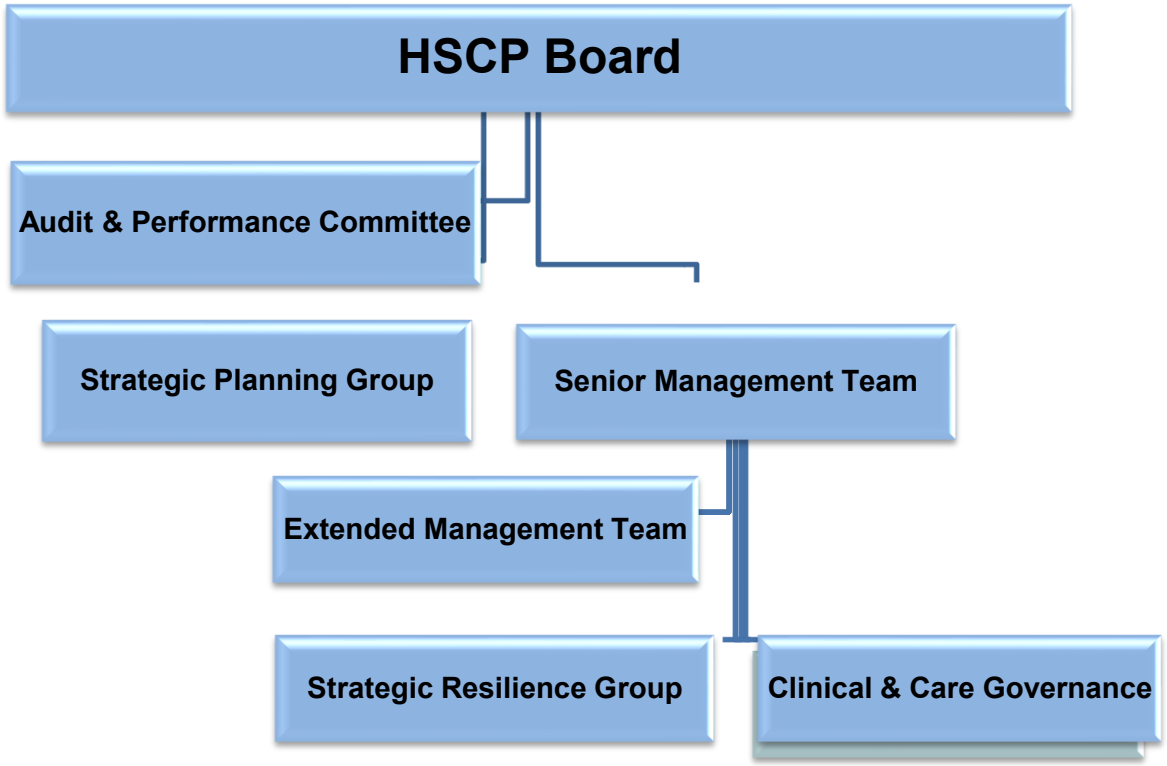
Exhibit 3: Strategic Outcomes



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.

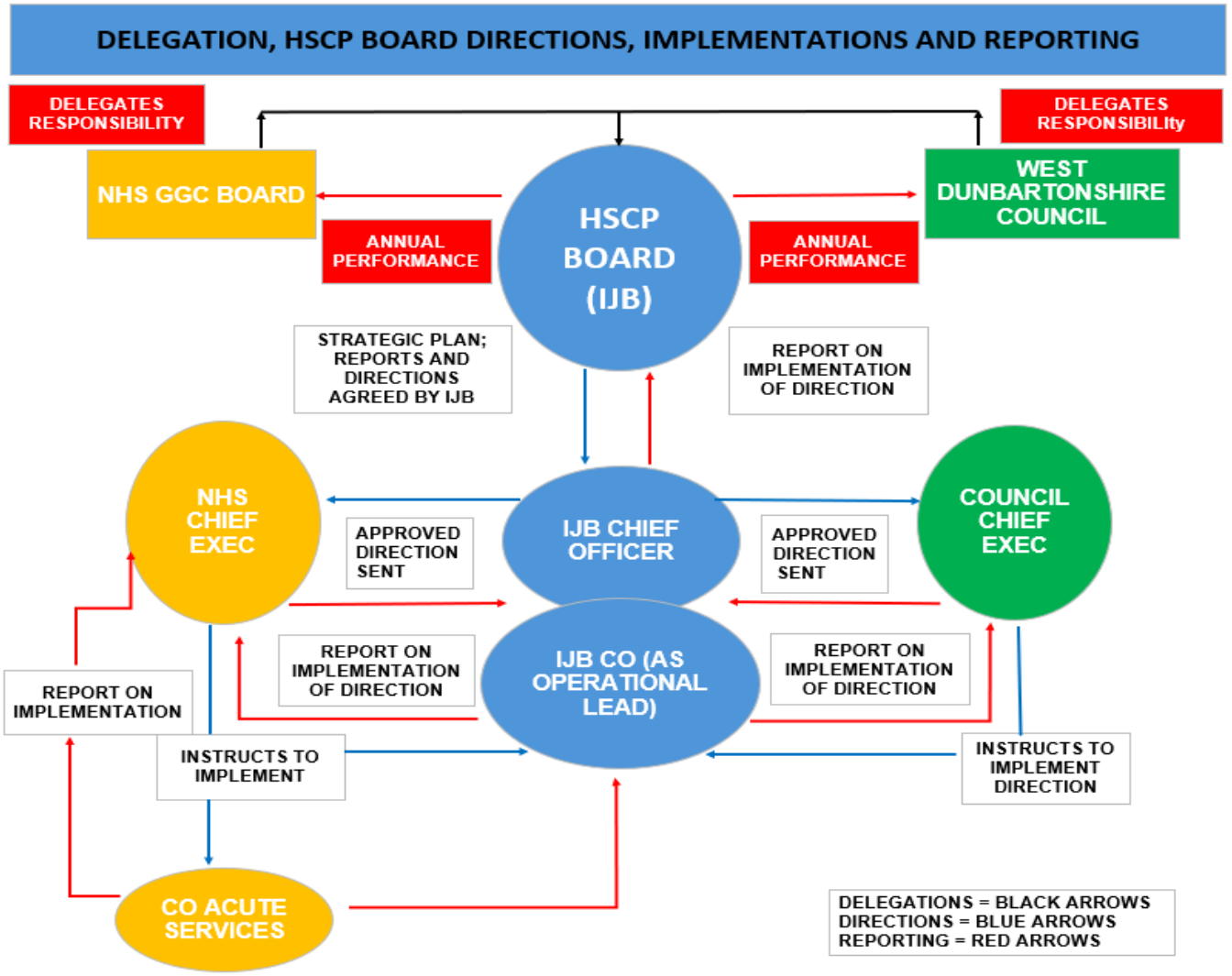
The HSCP Board also includes several non-voting professional and stakeholder members.

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:

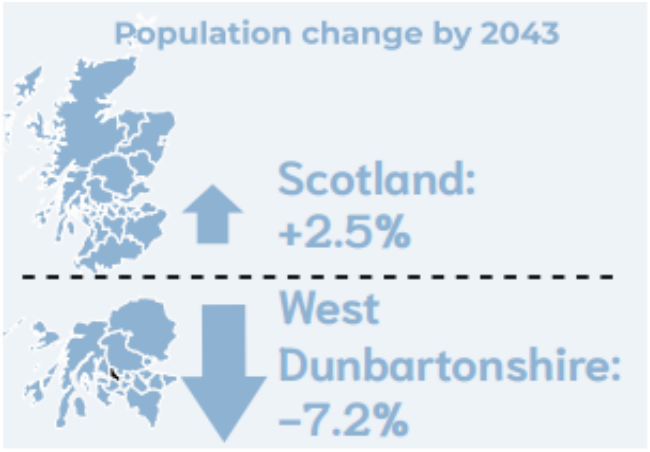
- Health and Social Care provision in the community;
- Why some population groups or individuals are at greater risk of disease e.g., socio-economic factors, health behaviours; and
- Whether the burden of diseases are similar across the population of West Dunbartonshire's localities.

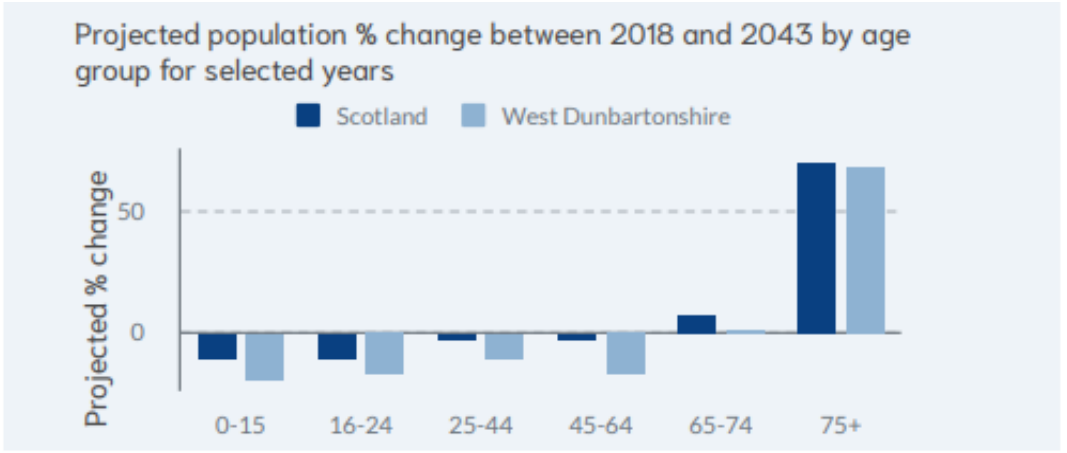
The main sections are structured around:

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





West Dunbartonshire has the lowest net migration level in Scotland

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.

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

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

4x higher

for the **most deprived** than the least deprived areas in Scotland

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.

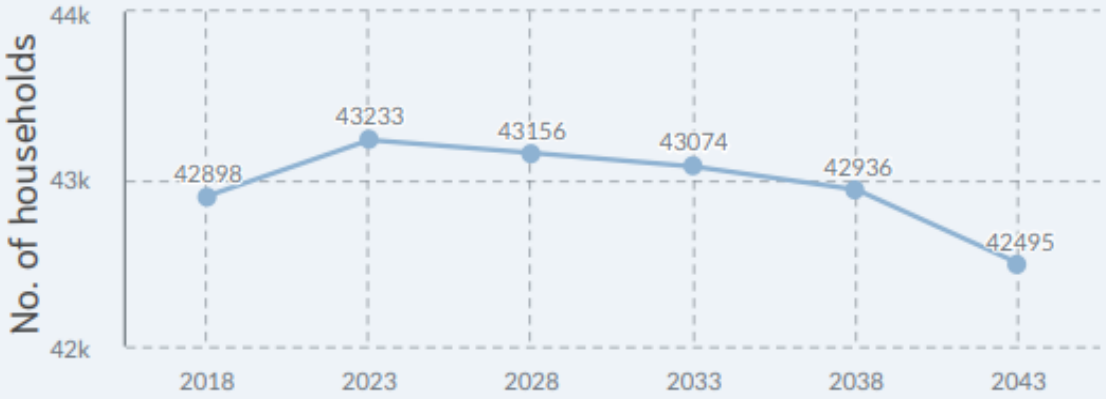
Food Insecurity

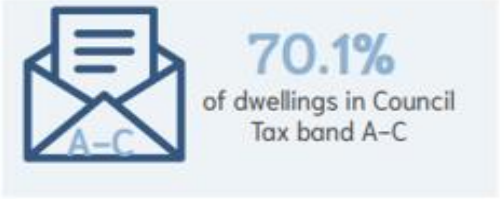
Of people in Scotland live in households with marginal, low or very low food security

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

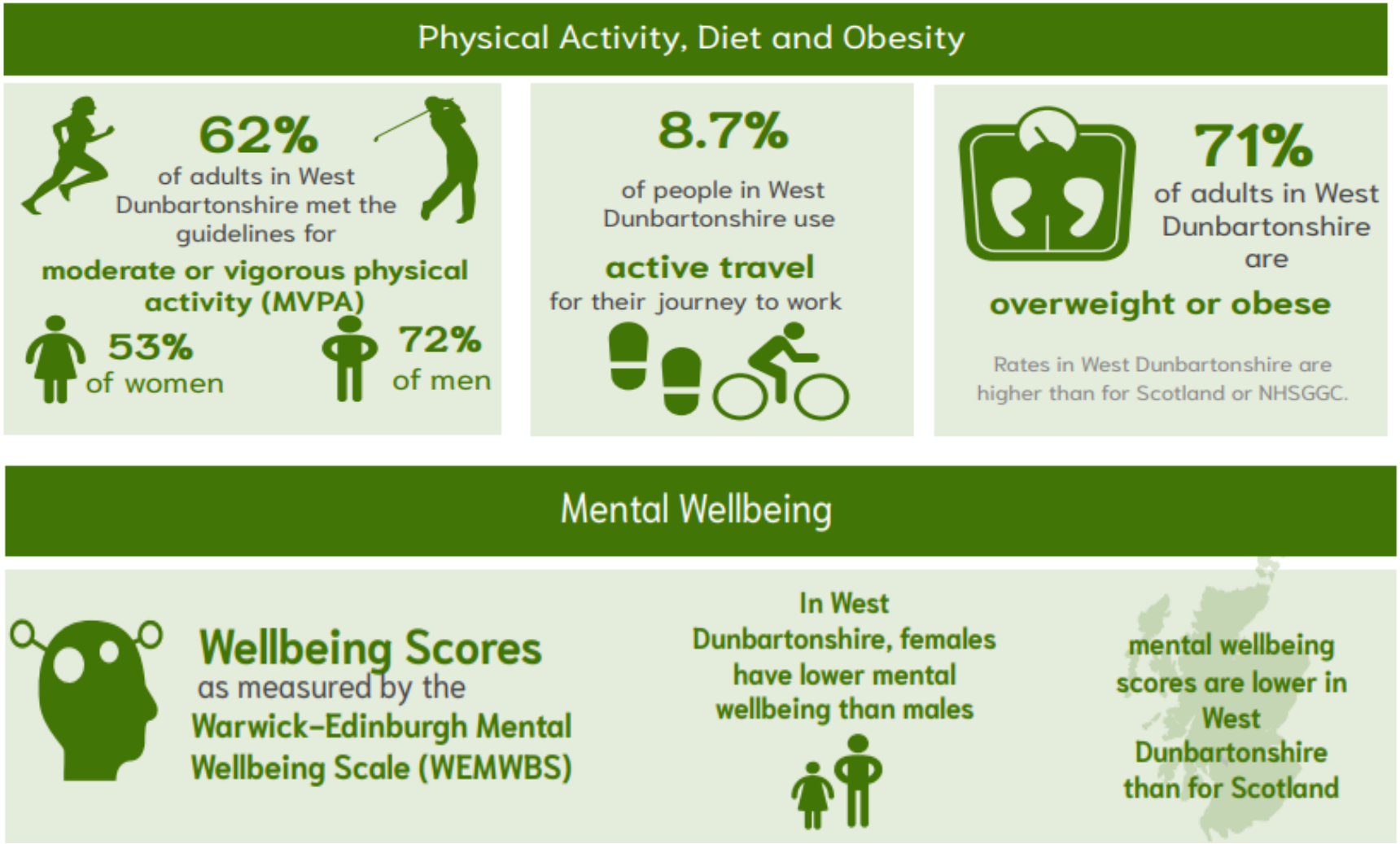
The impact of rising inflation and planned tax increases will affect the living standards of the whole population. People on fixed and low incomes will be disproportionally affected.

West Dunbartonshire Household Projections 2018-2043

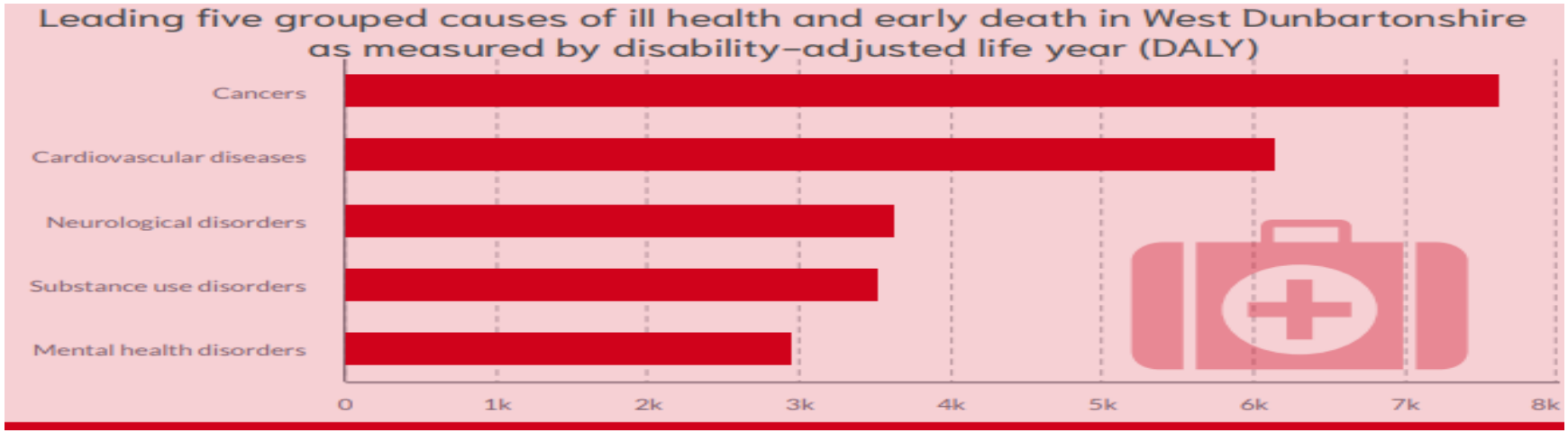




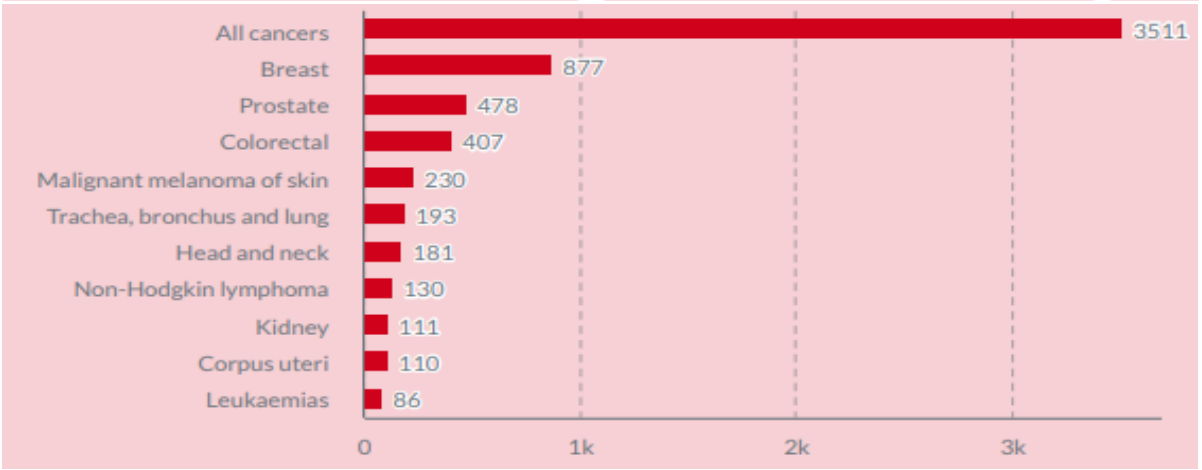
Individual Behaviours

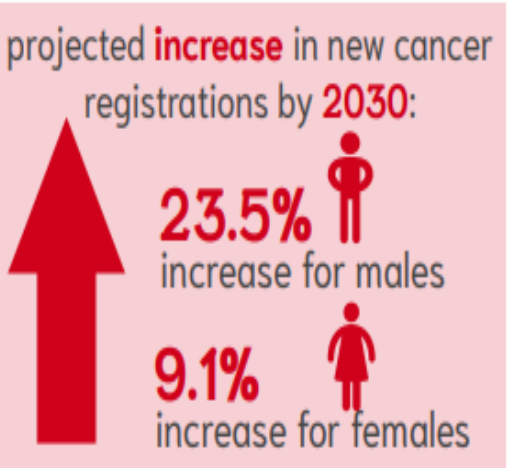


Burden of Disease



Cancer is the top burden of disease.





Cardiovascular Disease is the 2nd highest burden of disease.

In West Dunbartonshire there is a prevalence rate of

Coronary Heart Disease

54.81 per 1,000

14,424

Individuals in West Dunbartonshire were living with

Hypertension

In West Dunbartonshire There is a prevalence rate of

150.05 per 1,000

2,465

individuals in West Dunbartonshire were living with

Stroke

In West Dunbartonshire there is a prevalence rate of

25.64 per 1,000

Health and Care in the Community

Climate Change

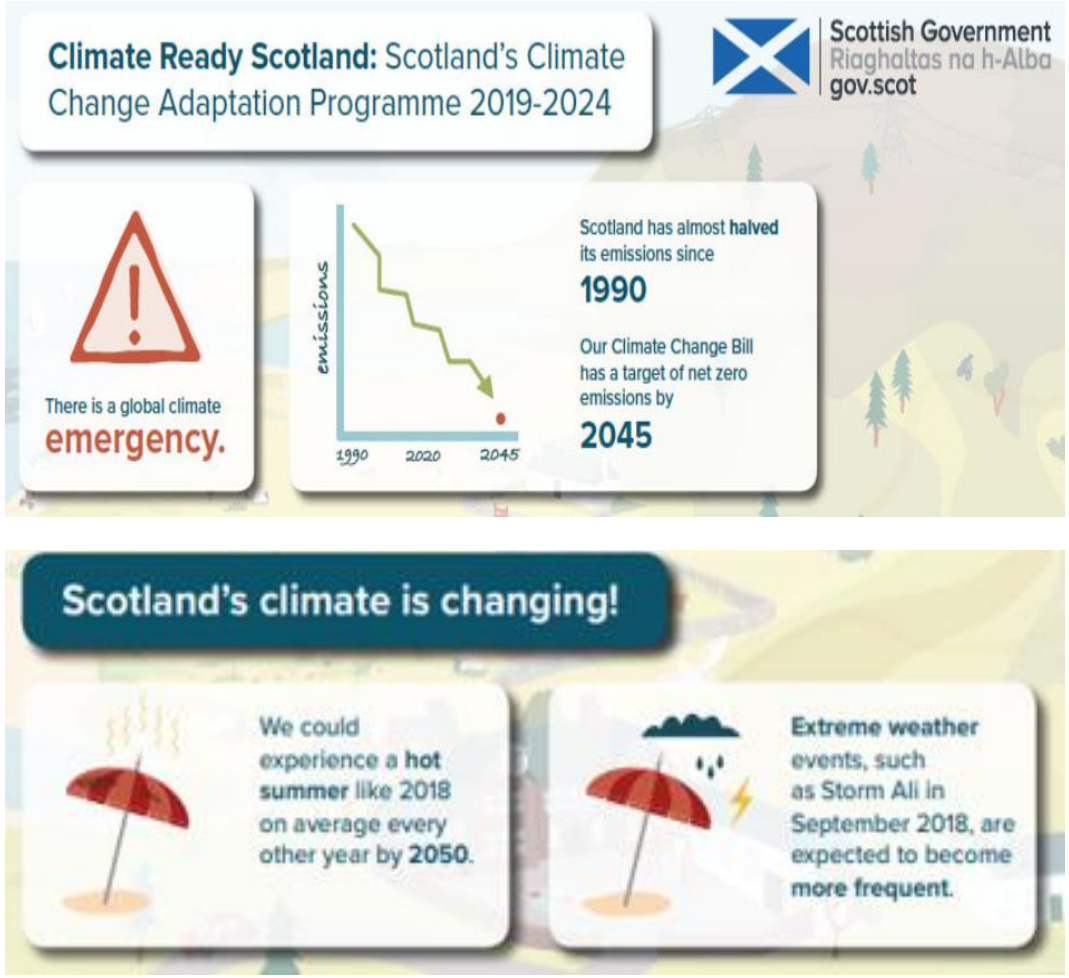
Tackling climate change is one of the Scottish Government's top four priorities as detailed within their 2024/25 Programme for Government. Public bodies have a duty to adapt their operations and demonstrate measurable climate-related improvements. Auditors of public bodies are mandated to report on climate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

Following scrutiny at the Audit and Performance Committee on 25 June 2025 the updated 2024/25 APR was presented to the HSCP Board on 19 August 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 and progress measured against:

- 21 local benchmarks;
- 12 national benchmarks; and
- 18 monitoring indictors shown for data purposes only with no targets set.

These indicators help assess how well the HSCP Board is advancing integration objectives, particularly in supporting people to live independently in their communities and are assessed across the 4 Strategic Plan priorities.

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.

A summary of overall strategic plan performance analysis, covering key performance indicators, action plan progress and strategic enablers, is provided in Exhibit 10 below with the detail contained within the August 2025 APR. Analysis on key performance indicators reported for monitoring purposes only have been excluded due to the subjective interpretation of RAG status.

Exhibit 10: Overall Strategic Plan Performance Analysis

Overall Sratetic Plan Performance Analysis	21 Local Targets R	A	G	12 National Targets R	A	G
Key Performance Indicators						
Caring Communities	0	2	2	1	0	2
Safe and Thriving Communities	1	2	5	2	0	1
Equal Communities	0	1	1	3	0	0
Healthy Communities	7	0	0	1	1	1

Target missed by 15% or more
Target narrowly missed
Target achieved

Overall Sratetic Plan Performance Analysis	60 Actions R	A	G
Strategic Plan Action Plan Progress			
Caring Communities	7	2	16
Safe and Thriving Communities	6	3	8
Equal Communities	3	3	8
Healthy Communities	0	1	3

Overdue
Not yet due
Due date achieved

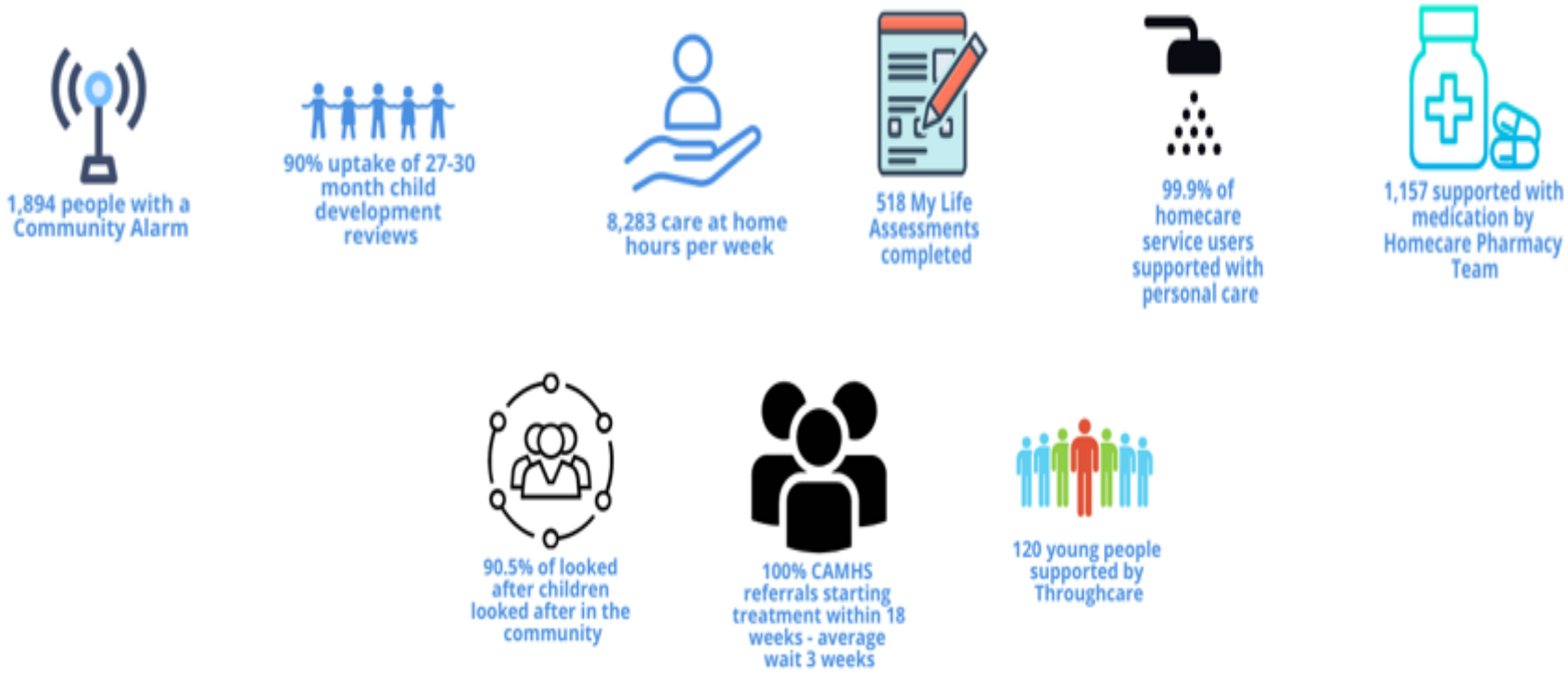
Overall Sratetic Plan Performance Analysis	25 Actions R	A	G
Sratetic Enablers			
Workforce	3	2	2
Finance	0	1	2
Technology	0	5	1
Partnerships	0	2	3
Infrastructure	2	0	2

Overdue
Not yet due
Due date achieved

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.

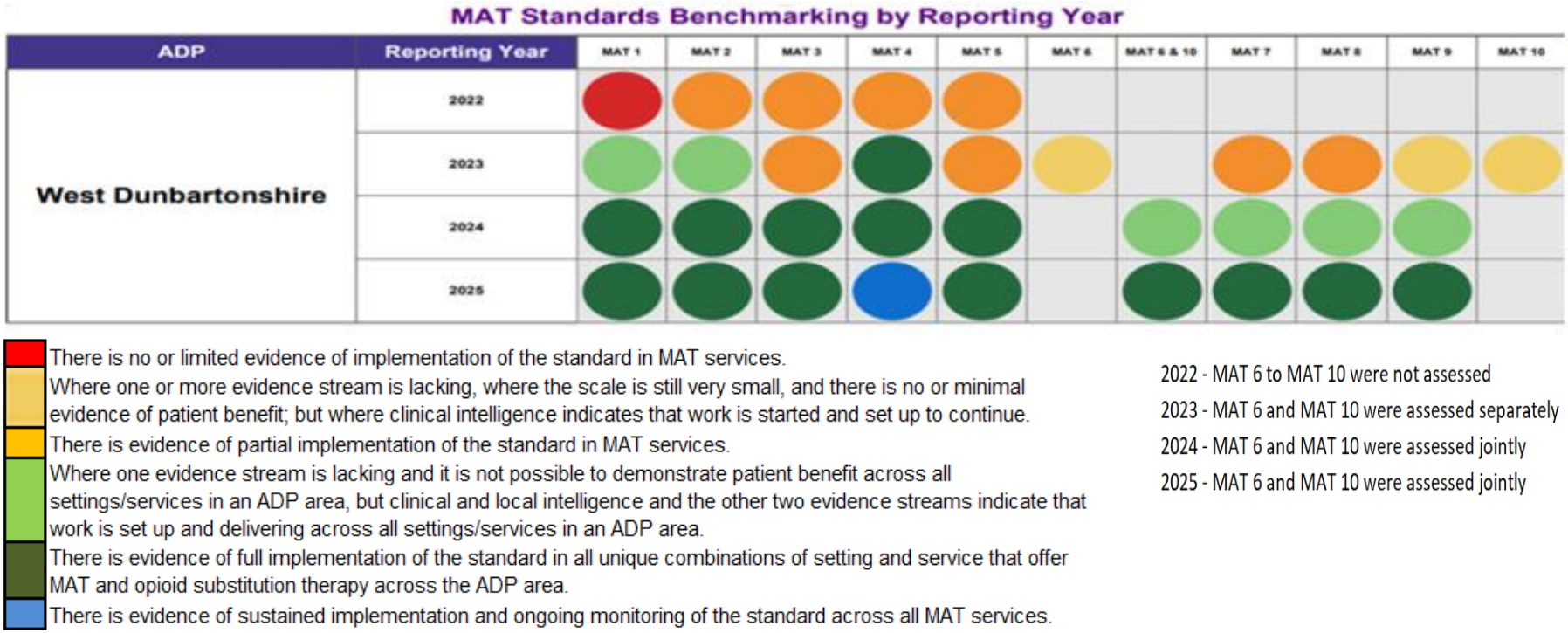
- **In relation to Social Circumstances Reports (SCRs), the Mental Health Team has made notable improvements.** SCRs required within 21 days of a Short-Term Detention Certificate are essential for reflecting individuals' circumstances and views under the Mental Health (Care and Treatment) (Scotland) 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

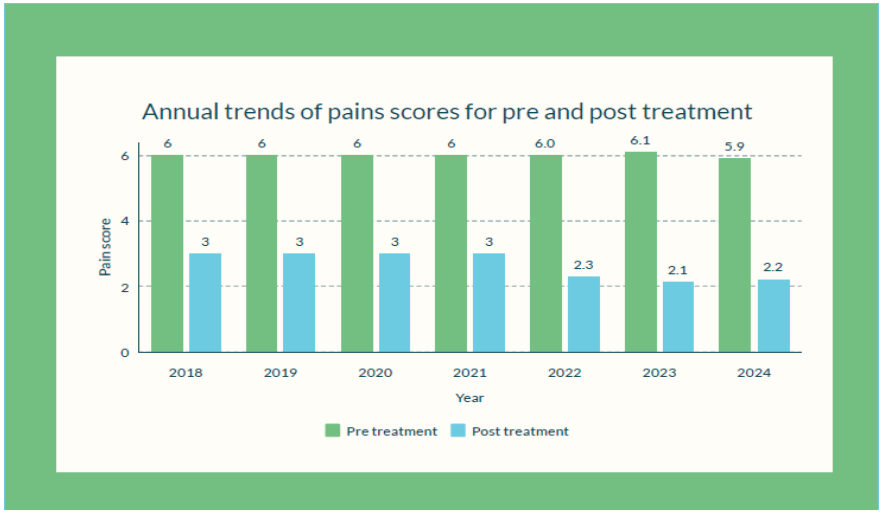
Musculoskeletal (MSK) conditions are a leading cause of disability and work absence, significantly impacting quality of life. The MSK Physiotherapy Service delivers a person-centred approach, offering tailored assessments and care plans focused on symptom relief, movement, exercise, and supported self-management.

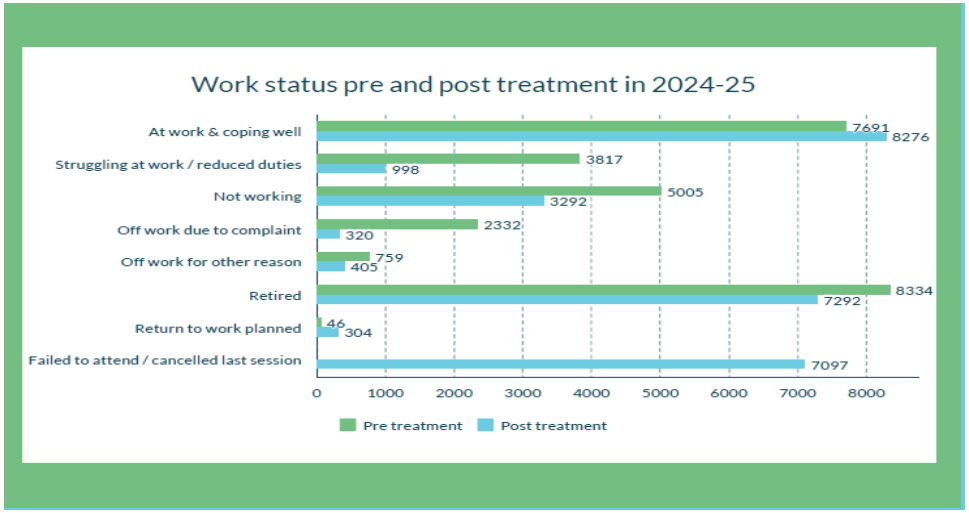
Demand for the MSK Physiotherapy Service continued to rise in 2024/25, with referrals increasing by 6.8% on top of a 13.3% rise the previous year. The service received a total of 78,746 referrals, averaging between 6,000 and 7,000 per month, highlighting sustained and growing need for MSK support.

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 76 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 86). 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” pages 92 to 94.

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 76 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 pages 92 to 94 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 the update, if required, will be reported to a future meeting of the HSCP Board. 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

Risks are assessed using a matrix as detailed in Exhibit 14.

The risk matrix assesses each risk based on the cause of the risk and the controls currently in place and in progress to reduce the likelihood and impact of the risk.

and there are twenty-one key strategic risks as summarised in Table 6 below.

Exhibit 14 – Risk Matrix

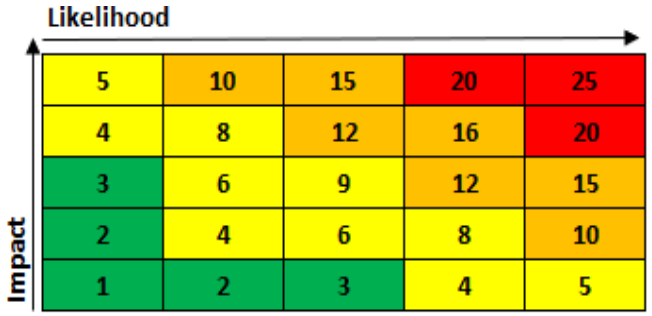


Table 6: Key Strategic Risks

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

Financial sustainability has been assessed as high arising from the risk of the West Dunbartonshire HSCP Board (IJB) being unable to achieve and maintain financial sustainability within the approved budget in the short to medium term due, however there are a number of controls already in place with further controls progressing to mitigate the risks identified and reduce the risk level from red to yellow.

A full review of the Strategic Risk Register is undertaken every six months with the latest review being presented to the 19 August 2025 HSCP Board for their approval and can be viewed here (see Appendix 1, 12).

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;

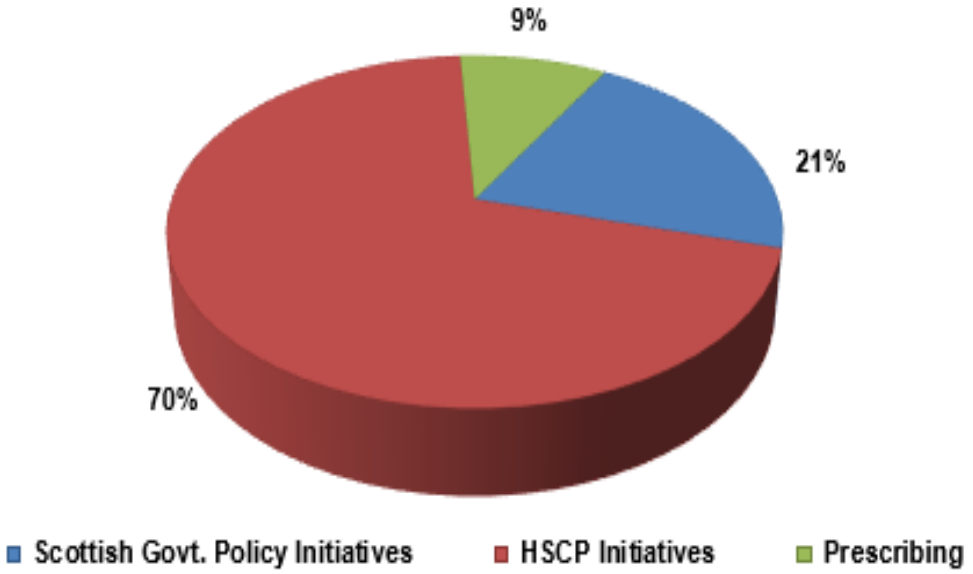
- £2.057m was drawn down to cover planned expenditure for addictions, learning disabilities, mental health, children and family priorities, participatory budgeting, digital developments, hosted services, and the cost of complex care packages; and

- £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:

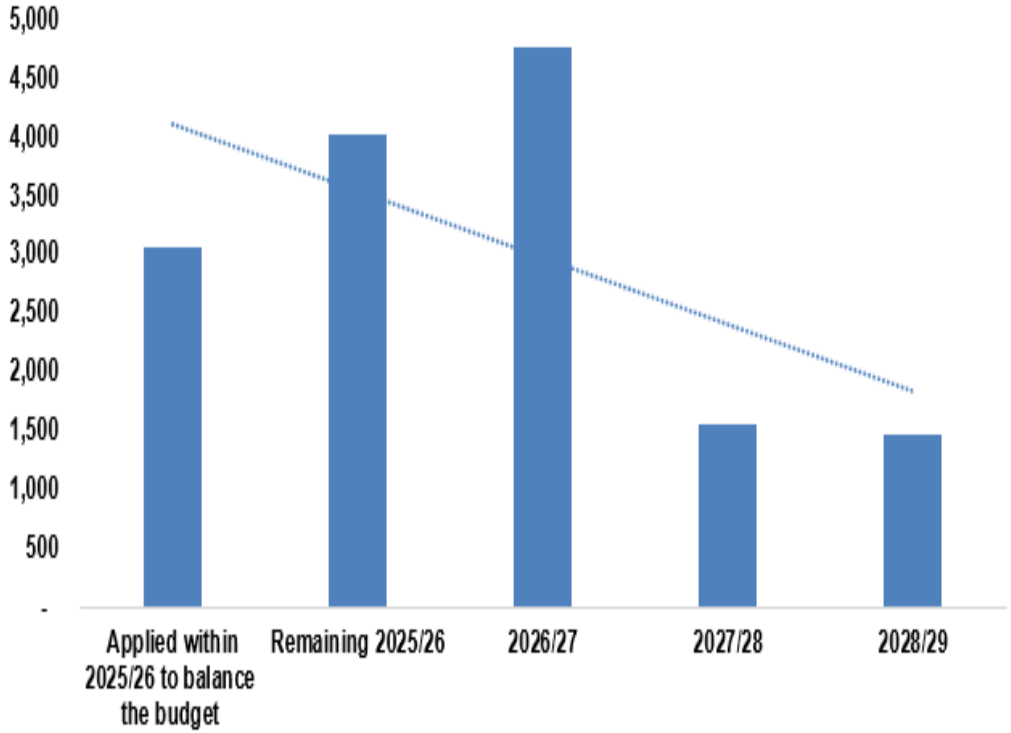
- 21% of reserves support Scottish Government policy commitments such as Unpaid Carers, Mental Health, Alcohol and Drugs Partnership, and Winter Pressures. Some funding flows depend on regular reporting of activity and costs;

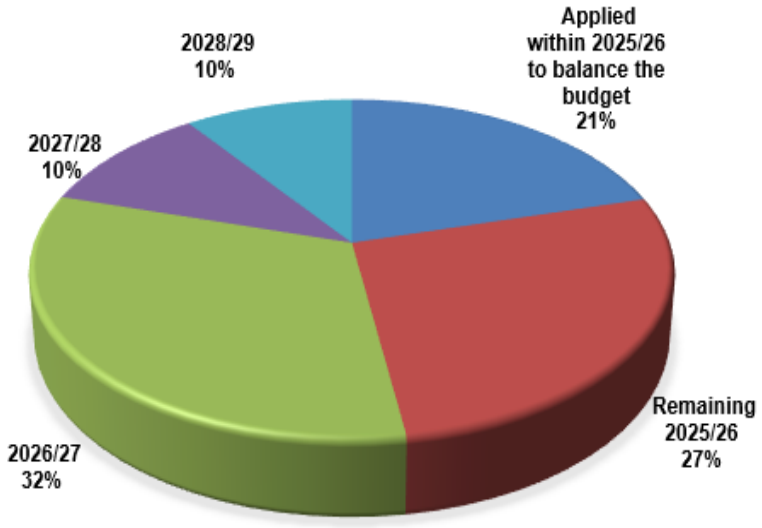
- 70% relate to HSCP initiatives to support service redesign and transformation, community engagement and recovery and renewal in services; and

- 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:

- 8.16% cumulative 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 was for:

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

Union colleagues balloted Council staff regarding the new two year pay offer with the offer being accepted in July 2025.

The recent NHS pay agreement, and SJC pay offer, effectively overrides the existing Public Sector Pay Policy detailed within the Scottish Government's Medium Term Financial Strategy (MTFS) published on 30 September 2025. While the NHS pay agreement is formally referenced under Inflation protection clauses there is no mention of the SJC pay offer as it remained unaccepted at the publication of the MTFS.

The Scottish Government's Medium-Term Financial Strategy (MTFS) 2025 commits to multi-year funding settlements, particularly through the introduction of a multi-year Scottish Spending Review due to be published alongside the Budget in December 2025.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 7 below:

Table 7: 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 7 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.

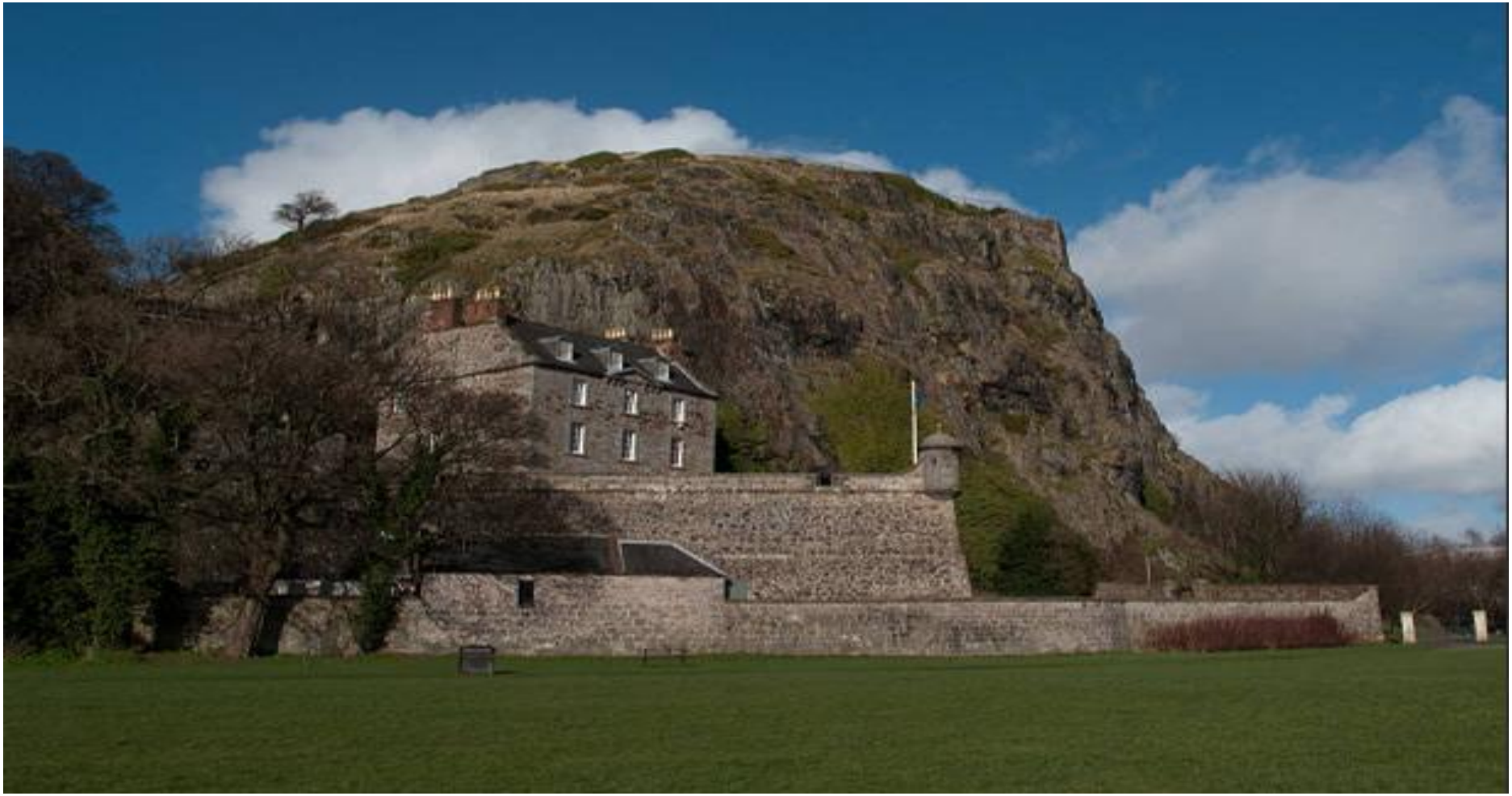
Looking ahead to 2025/26, we will build on our strong foundations—strengthening governance, deepening stakeholder engagement, managing risk proactively, and investing in our workforce and communities to ensure sustainable, high-quality services.

Michelle Wailes
HSCP Board Chair **Date: 30 September 2025**

Beth Culshaw **Date: 30 September 2025**
Chief Officer

Julie Slavin **Date: 30 September 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 Audited Annual Accounts were approved at a meeting of the Audit and Performance Meeting on 30 September 2025.

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

Michelle Wailes **Date: 30 September 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: 30 September 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 8: 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
Michelle McGinty	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
Fiona Hennebry	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
Michelle Wailes	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
Michelle Wailes	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 9 below.

Table 9: 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 10: Pension Benefits

Senior Officers	Position at 31/03/25	In Year Pension Contributions		Accrued Pension Benefits	
		For Year to 31/03/2024	For Year to 31/03/2025	For Year to 31/03/2025	Difference from 31/03/2024
		£	£	£000	£000
B Culshaw	Chief Officer	25,419	8,823	22	3
J Slavin	Chief Financial Officer	20,562	23,354	18	2

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 11: 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: 30 September 2025**
HSCP Board Chair

Beth Culshaw **Date: 30 September 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 12 below:

Table 12: 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. Business Continuity Planning across all HSCP services focuses on resilience, ensuring that critical services can continue or recover rapidly in the face of disruption. Services identify key operational risks, assess their potential impact and outline mitigation strategies. Services engage in training and scenario planning events and these inform continuous improvement.	Reviews business continuity and pandemic plans. Work is ongoing to present Board Members with an annual business continuity assurance statement.
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.

Feature	Description	Summary
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.
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.

Feature	Description	Summary
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 30 September

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 13 below. The HSCP Board approved the update from officers that seven of the eight previously agreed actions could be closed off as complete. The one remaining action classed as ongoing is detailed in Table 14 below. The priority for 2025/26 will be to advance the remaining ongoing action to further strengthen the governance framework.

Table 13: 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 14: Previously Agreed Action Ongoing

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.

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
HSCP Board Chair

Date: 30 September 2025

Beth Culshaw
Chief Officer

Date: 30 September 2025

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 15 below. Table 16 provides information for 2023/24 for comparison purposes. Any movement which may arise due to statutory adjustments which affect general fund balances are reflected by the partner bodies, West Dunbartonshire Council and/or NHS Greater Glasgow and Clyde Health Board within their own annual accounts. They are excluded from the HSCP Board's annual accounts as they do not form part of the delegated budget for which these financial statements relate to.

Table 15: 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
(Increase)/Decrease in 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 16: 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
(Increase)/Decrease in 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 17 below:

Table 17: HSCP Board Balance Sheet

2023/24 £000	BALANCE SHEET	Notes	2024/25 £000
19,093	Short Term Debtors	9	18,894
19,093	**Current Assets**		**18,894**
0	Short Term Creditors		0
(439)	Provisions	10	(487)
(439)	**Current Liabilities**		**(487)**
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 audited accounts were issued on 30 September 2025.

Julie Slavin CPFA **Date: 30 September 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 audited accounts were authorised for issue by the Chief Financial Officer on 30 September 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 Analysed by Nature

The movement in the General Fund balance is therefore solely due to the transactions shown in the Comprehensive Income and Expenditure Statement.

Table 18 provides a summary of Expenditure and Income Analysed by Nature.

Table 18: Expenditure and Income Analysed by Nature

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 19 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 19: 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 20 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 20: 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 21 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 21: 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 22: Debtors

2023/24 £000	Short Term Debtors	2024/25 £000
0	NHS Greater Glasgow and Clyde Health Board	0
19,093	West Dunbartonshire Council	18,894
19,093	**Total**	**18,894**

Note: Totals may not add due to rounding

10. Table 23: Provisions

Bad Debt Provision	£000
Opening Provision as at 1 April 2024	439
Contributions in year	121
Amounts utilised in year	(73)
Unutilised amounts reversed in year	0
Closing Provision as at 31 March 2025	**487**

Note: Totals may not add due to rounding

Bad Debt Provision - This provision is for the potential write off for sundry debt more than 6 months old and relates to the risk of potential non-payment of invoices raised for specific social care delegated services.

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 partners exert significant influence through legislation and the IJB funding mechanism on the HSCP Board which in turn may also exert influence on each partner.

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 24: 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 25: 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 26: Summary of Reserves Movements

Table 26 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

The nature and purpose of each reserve is defined below:

- Scottish Government Policy Initiatives – These are reserves held due to the timing of funds being released by the Scottish Government and the expenditure being incurred by the HSCP. The main initiatives that reserves are held for include mental health recovery and renewal, alcohol and drugs addictions and additional social work capacity funding.

- HSCP Initiatives – These are reserves that have been created from prior and in year HSCP underspends to support a number of service redesign and transformational strategic programmes and to underwrite ongoing work in relation to recovery and renewal of services across several HSCP services.

- Prescribing – This reserve is held to underwrite the prescribing pressure arising from volatility in demand and price.

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 27 below:

Table 27: External Audit Fees

2023/24 £000		2024/25 £000
33	Fees Payable	34

Independent Auditor's Report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Independent auditor's report to the members of West Dunbartonshire Integration Joint Board and the Accounts Commission

Report on the audit of the financial statements

Opinion on the financial statements

We certify that we have audited the financial statements in the annual accounts of West Dunbartonshire Integration Joint Board ("the IJB) for the year ended 31 March 2025 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Comprehensive Income and Expenditure Statement, the Movement in Reserves Statement, the Balance Sheet and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards, as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2024/25 (the 2024/25 Code).

In our opinion the accompanying financial statements:

- give a true and fair view of the state of affairs of the IJB as at 31 March 2025 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the 2024/25 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Basis for opinion

We conducted our audit in accordance with applicable law and International Standards on Auditing (UK) (ISAs (UK)), as required by the Code of Audit Practice approved by the Accounts Commission for Scotland. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report. We were appointed by the Accounts Commission on 18 May 2022. Our period of appointment is five years, covering 2022/23 to 2026/27. We are independent of the IJB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. Non-audit services prohibited by the Ethical Standard were not provided to the IJB. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern basis of accounting

We have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the IJB's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

These conclusions are not intended to, nor do they, provide assurance on the IJB's current or future financial sustainability. However, we report on the IJB's arrangements for financial sustainability in a separate Annual Audit Report available from the Audit Scotland Website.

Risks of material misstatement

We report in our Annual Audit Report the most significant assessed risks of material misstatement that we identified and our judgements thereon.

Responsibilities of the Chief Financial Officer and the Audit and Performance Committee for the financial statements

As explained more fully in the Statement of Responsibilities, the Chief Financial Officer is responsible for the preparation of financial statements, that give a true and fair view in accordance with the financial reporting framework, and for such internal control as the Chief Financial Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Chief Financial Officer is responsible for assessing each year the IJB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless there is an intention to discontinue the IJB operations.

The Audit and Performance Committee is responsible for overseeing the financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities outlined above to detect material misstatements in respect of irregularities, including fraud. Procedures include:

- using our understanding of the local government sector to identify that the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003 are significant in the context of the IJB;
- inquiring of the Chief Financial Officer and Chief Officer as to other laws or regulations that may be expected to have a fundamental effect on the operations of the IJB;
- inquiring of the Chief Financial Officer and Chief Officer concerning the IJB's policies and procedures regarding compliance with the applicable legal and regulatory framework;
- discussions among our audit team on the susceptibility of the financial statements to material misstatement, including how fraud might occur; and
- considering whether the audit team collectively has the appropriate competence and capabilities to identify or recognise non-compliance with laws and regulations.

The extent to which our procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the IJB's controls, and the nature, timing and extent of the audit procedures performed.

Irregularities that result from fraud are inherently more difficult to detect than irregularities that result from error as fraud may involve collusion, intentional omissions, misrepresentations, or the override of internal control. The capability of the audit to detect fraud and other irregularities depends on factors such as the skilfulness of the perpetrator, the frequency and extent of manipulation, the degree of collusion involved, the relative size of individual amounts manipulated, and the seniority of those individuals involved.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Reporting on other requirements

Opinion prescribed by the Accounts Commission on the audited parts of the Remuneration Report

We have audited the parts of the Remuneration Report described as audited. In our opinion, the audited parts of the Remuneration Report have been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014.

Other information

The Chief Financial Officer is responsible for the other information in the annual accounts. The other information comprises the Management Commentary, Statement of Responsibilities, Annual Governance Statement and the unaudited part of the Remuneration Report.

Our responsibility is to read all the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon except on the Management Commentary and Annual Governance Statement to the extent explicitly stated in the following opinions prescribed by the Accounts Commission.

Opinions prescribed by the Accounts Commission on the Management Commentary and Annual Governance Statement

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with statutory guidance issued under the Local Government in Scotland Act 2003; and
- the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with the Delivering Good Governance in Local Government: Framework (2016).

Matters on which we are required to report by exception

We are required by the Accounts Commission to report to you if, in our opinion:

- adequate accounting records have not been kept; or
- the financial statements and the audited part of the Remuneration Report are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in respect of these matters.

Conclusions on wider scope responsibilities

In addition to our responsibilities for the annual accounts, our conclusions on the wider scope responsibilities specified in the Code of Audit Practice, including those in respect of Best Value, are set out in our Annual Audit Report.

Use of our report

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 108 of the Code of Audit Practice, we do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

[*Signature*]

Tom Reid
Audit Director
For and on behalf of Forvis Mazars LLP
30 September 2025

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. Performance - West Dunbartonshire HSCP
6. WD_HSCP_August_2025_Performance_Report
7. WD_HSCP_June_2025_Best_Value
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. WD_HSCP_August_2025_Updated_Risk_Register
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 & SOCIAL CARE PARTNERSHIP BOARD

Report by: Chief Internal Auditor

Audit and Performance Committee: 23 September 2025

Subject: Internal Audit Annual Strategy and Plan 2025-2026

1. Purpose

1.1 The purpose of this report is to provide the indicative Internal Audit Strategy and Plan for 2025-2026 to the Audit and Performance Committee for approval.

2. Recommendations

2.1 It is recommended that the Audit and Performance Committee approve the indicative Internal Audit Plan for 2025-2026.

3. Background

3.1 Internal Audit is an assurance function that primarily provides an independent and objective opinion to the organisation on the control environment comprising governance, risk management and control by evaluating its effectiveness in achieving the organisation's objectives.

3.2 As stated in the IRAG (Integrated Resources Advisory Group) Guidance, it is the responsibility of the West Dunbartonshire Integration Joint Board (HSCP Board) to establish adequate and proportionate internal audit arrangements for review of the adequacy of arrangements for risk management, governance and control of the delegated resources.

3.3 The Global Internal Audit Standards UK Public Sector include the requirement for the Chief Internal Auditor to prepare a risk-based plan to determine the priorities of the internal audit activity, consistent with the organisation's goals.

3.4 The Chief Internal Auditor will prepare an annual internal audit plan which will be subject to consideration and approval by the West Dunbartonshire HSCP Board Audit and Performance Committee.

3.5 The provision of Internal Audit services for the IJB is delivered by West Dunbartonshire Council through a directly employed in-house team.

4 Main issues

4.1 Internal Audit follows a risk-based approach and it is intended that audit work will be focused on areas of greater risk taking into account management's own view of risk, previous audit findings and any other internal or external factors affecting the West Dunbartonshire HSCP Board.

4.2 The indicative Internal Audit Strategy and Plan for 2025-2026 is set out at Appendix 1.

4.3 The total budget for the Internal Audit Annual Audit Plan for 2025-2026 has been provisionally set at 20 days. The plan does not contain any contingency provision. Where there are any unforeseen work demands that arise eg special investigations or provision of ad hoc advice, this will require to be commissioned as an additional piece of work which will be subject to a separate agreement.

4.4 The Global Internal Audit Standards UK Public Sector require that the annual audit plan should be kept under review to reflect any changing priorities and emerging risks. Any material changes to the audit plan will be presented to the West Dunbartonshire HSCP Board Audit and Performance Committee for approval.

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 The Plan has been constructed taking cognisance of risks which have implications for the West Dunbartonshire HSCP Board through discussions with management and review of the West Dunbartonshire HSCP Board risk register.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 The HSCP Board's Chief Financial Officer has been consulted on the proposed annual audit plan coverage for 2025-2026.

11.2 There will be regular ongoing discussion with External Audit to ensure respective audit plans area reviewed as circumstances change in order to minimise duplication of effort and maximise coverage for the West Dunbartonshire HSCP Board.

12. Strategic Assessment

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

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

Date: **28 August 2025**

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West Dunbartonshire Council
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Appendices: Appendix 1 – Internal Audit Annual Strategy and Plan 2025-2026

Background Papers: None

INTERNAL AUDIT ANNUAL STRATEGY AND PLAN 2025-2026

1. Introduction

1.1 The Global Internal Audit Standards UK Public Sector set out the requirement for the Chief Internal Auditor to prepare a risk-based audit plan to determine the priorities of the internal audit activity, consistent with the organisation's goals.

1.2 The Chief Internal Auditor must review and adjust the plan as necessary in response to changes in the organisation's business, risks, operations and priorities.

1.3 The audit plan must incorporate or be linked to a strategic or high-level statement of how the Internal Audit Service will be delivered and developed in accordance with the Internal Audit Charter and how it links to the organisational objectives and priorities.

1.4 The strategy shall be reviewed on an annual basis as part of the audit planning process.

2. Internal Audit Objectives

2.1 The purpose of Internal Audit, as defined within Global Internal Audit Standards UK Public Sector is to 'strengthen the organisation's ability to create, protect, and sustain value by providing the board and management with independent, risk-based and objective assurance, advice, insight and foresight'.

2.2 The primary aim of the internal audit service is to provide assurance services which requires the Chief Internal Auditor to provide an annual internal audit opinion based on an objective assessment of the framework of governance, risk management and control.

2.3 The internal audit service also provides advisory services, generally at the request of the organisation, with the aim of improving governance, risk management and control and contributing to the overall opinion.

2.4 The internal audit service supports the West Dunbartonshire HSCP Board's Chief Financial Officer in her role as Section 95 Officer.

3. Risk Assessment and Audit Planning

3.1 The internal audit approach to annual audit planning is risk-based and aligns to the IJB's strategic planning processes and management's own assessment of risk.

3.2 There will be regular ongoing discussion with External Audit to ensure respective audit plans are reviewed as circumstances change in order to minimise duplication of effort and maximise audit coverage for the West Dunbartonshire HSCP Board.

4 Service Delivery

4.1 The provision of the internal audit service is through a directly employed in-house team from West Dunbartonshire Council.

4.2 In relation to the total staff days allocated to the 2025-2026 plan, each member of staff completes a resource allocation spreadsheet for the year which is split between annual leave, public holidays, training days, general administration and operational plan days. This spreadsheet is reviewed and updated each period by each member of staff against time charged to timesheets.

The operational plan is 20 days which will be resourced as follows:

Team Member

Internal Auditor – 15 days
Chief Internal Auditor – 5 days

The Chief Internal Auditor does not directly carry out the assignments included in the annual audit plan but provides the quality review and delivery oversight of the overall plan. Time is also set aside for overall audit planning, reporting on Internal Audit performance and attending the Audit and Performance Committee. Where there are any resource issues which may impact on delivery of the plan, this will be reported to Audit and Performance Committee at the earliest opportunity.

4.3 Given the range and complexity of areas to be reviewed it is important that suitable, qualified, experienced and trained individuals are appointed to internal audit positions. The Global Internal Audit Standards UK Public Sector requires that the Chief Internal Auditor must hold a professional qualification such as CMIIA (Chartered Internal Auditor), CCAB or equivalent and be suitably experienced.

4.4 Internal audit staff members identify training needs as part of an appraisal process and are encouraged to undertake appropriate training, including in-house courses and external seminars as relevant to support their development. All training undertaken is recorded in personal training records for CPD purposes.

4.5 Internal audit staff members require to conform to the Code of Ethics of the professional body of which they are members and to the Code of Ethics included within the Global Internal Audit Standards UK Public Sector. An annual declaration is undertaken by staff in relation to specific aspects of the Code.

4.6 Following each review, audit reports are issued in draft format to agree the accuracy of findings and agree risk mitigations. Copies of final audit reports are issued to the West Dunbartonshire HSCP Board Chief Officer, HSCP Head of Service and HSCP Service Manager responsible for implementing the agreed action plan. A copy of each final audit report is also provided to External Audit.

4.7 The overall opinion of each audit report feeds into the Internal Audit Annual Report and Assurance Statement which is presented to the Audit and Performance Committee and is used by the Chief Financial Officer in the preparation of the Annual Governance Statement.

5 Proposed Audit Coverage 2025-2026

5.1 The proposed audit coverage is set out in the table below. The West Dunbartonshire HSCP Board risk register June 2025 was reviewed for ongoing risks scoring 10 or above or new risks identified scoring 9 or above.

Risk Area/Theme	Previous Assurance Work	Planned Assurance Work 2025-26	Other Assurance Work 2025/26
Financial Sustainability	West Dunbartonshire HSCP Board Audit Plan: 24/25 – Budgetary Control External Audit Annual Audit Plans 22/23, 23/24 and 24/25 West Dunbartonshire HSCP Board Audit Plan: 23/24 – Best Value Arrangements	None	External Audit Annual Audit Plan 24/25.
Procurement and Commissioning	West Dunbartonshire Council Internal Audit Plan: 22/23 – Procurement – Supplier Management 23/24 – Procurement under £10k 24/25 – Procurement compliance review	None	Will be considered as part of the planning process for West Dunbartonshire Council Internal Audit Plan 2025/26.
Performance Management Information	West Dunbartonshire HSCP Board Audit Plan: 21/22 - Performance Management Arrangements	Strategic Planning and Performance Management Arrangements	External Audit Annual Audit Plan 24/25.
Delayed discharge and unscheduled care	NHSGGC Internal Audit Plan: 24/25 – Discharge Planning – hospital discharges NHSGGC Internal Audit Plan – follow up exercises	None	Will be considered as part of the planning process for West Dunbartonshire Council Internal Audit Plan 25/26.
Workforce	West Dunbartonshire HSCP Board Audit Plan: 22/23 – Workforce Planning Arrangements West Dunbartonshire Council Internal Audit Plan: 23/24 – Supporting Employee Attendance NHSGGC Internal Audit Plan: 23/24 – Managing Staff Attendance 23/24 = Staff Training and Development 24/25 - NHSGGC Internal Audit Plan: Follow up exercises	West Dunbartonshire HSCP Board Internal Audit Plan – follow up process	External Audit Annual Audit Plan 24/25.

Appendix 1

INTERNAL AUDIT ANNUAL STRATEGY AND PLAN 2025-2026

Risk Area/Theme	Previous Assurance Work	Planned Assurance Work 2025-26	Other Assurance Work 2025-26
Waiting Times	NHSGGC Internal Audit Plan: 22/23 – Waiting List Management 23/24 – Waiting List Management – Mental Health West Dunbartonshire Council Internal Audit Plan: 22/23 – Occupational Therapy Waiting Times	None	NHSGGC Internal Audit Plan – follow up exercises.
Risk Assessment and Public Protection Arrangements	NHSGGC Internal Audit Plan: 22/23 – Public Protection Arrangements 23/25 – Public Protection Arrangements	None	NHSGGC Internal Audit Plan – follow up exercises. Will be considered as part of the planning process for West Dunbartonshire Council Internal Audit Plan 2025/26.
Major Incident Response Arrangements	New risk identified June 2025 West Dunbartonshire Partnership Board Internal Audit Plan: 22/23 – IJB Pandemic Response and recover Arrangements	None	A range of mitigations have been identified and are being progressed by officers. Improvement action has been included on Annual Governance Statement 2024/25.
Care at Home Service Delivery	New risk identified June 2025	None	A range of mitigations have been identified and are being progressed by officers. Will be considered as part of the planning process for West Dunbartonshire Council Internal Audit Plan 25/26.

Other Work		**Days**
Strategic Planning and Performance Management Arrangements	We will undertake a review of West Dunbartonshire Partnership Board's Strategic Planning and Performance Management arrangements and highlight any areas of improvement to management.	14
Action Plan Follow Up	To monitor the progress of implementation of agreed internal audit action plans by management.	2
Audit Planning and Management	Review and update of the audit universe and attendance at HSCP Board Audit and Performance Committee.	2
Internal Audit Annual Report 2024-2025	Annual report on 2024-2025 audit activity will be provided to CFO to inform the Annual Governance Statement for the IJB.	2
Total Staff Days		**20**

6 Quality and Performance

6.1 The Global Internal Audit Standards UK Public Sector require each internal audit service to maintain an ongoing quality assurance and improvement programme based on an annual self-assessment against the Standards, supplemented at least every five years by a full independent external assessment.

6.2 In addition, the performance of Internal Audit continues to be measured against key service targets focussing on quality, efficiency and effectiveness. For 2025-2026 targets have been set as follows:

Measure	Description	Target
1. Final Report	Percentage of final reports issued within 2 weeks of draft report.	100%
2. Draft Report	Percentage of draft reports issued within 3 weeks of completion of fieldwork.	100%
3. Audit Plan Delivery	Percentage of audits completed v planned.	100%
4. Audit Budget	Percentage of audits completed within budgeted days.	100%
5. Audit Recommendations	Percentage of audit recommendations agreed.	90%
6. Action Plan Follow Up	Percentage of action plans followed up – Internal and External Audit.	100%
7. Customer Feedback	Percentage of respondents who rated the overall quality of internal audit as satisfactory or above.	100%
8. Staff compliance with CPD	Number of training hours undertaken to support CPD	20
9. Management engagement	Number of meetings with Chief Officer and Chief Financial Officer as appropriate	2 per year

6.3 Actual performance against targets will be included in the Internal Audit Annual Assurance Report for 2025-2026.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

AUDIT AND PERFORMANCE COMMITTEE

Report by: Val Tierney, Chief Nurse

23 September 2025

Subject: HSCP Quarter 1 Clinical & Care Governance Committee Report

1. Purpose

The Quarterly Clinical and Care Governance Report (Appendix 1) supplements annual reporting, offering the committee regular updates on progress in oversight, assurance, and improvements regarding the quality of health and social care. It covers services hosted, jointly provided, or commissioned externally, and highlights key achievements, risks, and challenges affecting care quality.

2. Recommendations

2.1 Provide comment on content of the report and the extent to which it provides assurance to board members on care quality.

2.2 Note the activities related to oversight, assurance of care quality, and related improvement efforts.

2.3 Note the risks escalated to the NHSGGC Primary Care Clinical Governance Forum for their information and assessment of potential additional risk mitigation strategies.

3. Background

3.1 The Chief Officer is responsible for ensuring clinical and care governance requirements in the approved integration schemes are met within the Health and Social Care Partnership. Clinical and care governance monitors accountability for care quality, supports staff improvement, and ensures performance issues are 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.

4. Main Issues

4.1 Two risks were escalated to the NHS Greater Glasgow and Clyde Primary Care Clinical and Care Governance Committee for further board-level mitigation: Staffing levels in Speech and Language Therapy Services and lack of resp onsiveness from the NHSGGC Interpreting Service - please see Appendix 1 for more details.

4.2 Staffing levels within Mental Health and Learning Disability teams may influence care quality. As a result, three Community Mental Health Teams, the Psychology team, and the Older People Mental Health Team are undergoing risk stratification, with measures implemented to address identified risks. Inpatient mental health services currently have full staffing.

4.2 Progress is being made in strengthening oversight and reporting on social care and social work governance and care quality.

4.3 Emphasis is placed on improving the management of significant adverse event reviews to support timely completion and ensure alignment with NHSGGC key performance indicators.

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 is responsible for care quality in all services related to illness prevention, diagnosis, and treatment, including those delivered with partners. The National Health Service (Scotland) Act 1978 makes this duty as important as other statutory obligations. Failure to meet these standards may breach legal requirements and harm the organisation's reputation.

8.2 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.

8.3 Staff absence, recruitment, retention, and financial challenges all pose a credible risk to care quality making it critically important that we continue to strengthen our assurance and oversight arrangements and mitigate emerging threats.

8.4 This report updates on NHSGGC key performance indicators for significant adverse event reviews and progress in mitigating outstanding risks. Delays in improvement will postpone learning, sharing insights, and action implementation.

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 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 03.09.2025.

Person to Contact: Val.Tierney@ggc.scot.nhs.uk

Appendices: Appendix 1 - Governance Lead Update for Primary Care and Community Clinical Governance Forum

GOVERNANCE LEAD UPDATE FOR
Primary Care and Community Clinical Governance Forum

NHS Greater Glasgow and Clyde

Report To:	1. West Dunbartonshire SMT (Core 27.05.2024) 2. Primary Care and Community Clinical Governance Forum Meeting 29.05.2025 3. West Dunbartonshire Audit and Performance Committee 23.09.2025
Report Author:	Val Tierney Chief Nurse
Date:	Exception report from WDHSCP Clinical and Care Governance Meeting 21.05.2025
Sector/ Directorate	East Dunbartonshire ☐ East Renfrewshire ☐ Glasgow City ☐ Inverclyde ☐ Renfrewshire ☐ West Dunbartonshire x ☐ Public Protection ☐ Medicines / Pharmacy ☐ GP Out of Hours ☐ Oral Health ☐

Areas of interest:
Clinical incidents, significant clinical incidents, ombudsman, progress with Scottish Patient Safety Programme, national standards and guidance, clinical guidelines, quality improvement, complaints, Person Centred Health and Care Programme, Patient, Public and Carer Involvement and Feedback

SECTION 1: CROSS SYSTEM LEARNING

Please outline any key areas you would like to highlight

1.1Social Work and Social Care

West Dunbartonshire continue to strengthen their oversight and assurance of care quality within social work and social care, this includes strengthening our initial and integrated assessments, care planning and monitoring of data regarding statutory reviews to provide assurance these are being undertaken in line with statutory requirements.

1.2Updated policy and guidance on eligibility criteria and equivalency supports greater transparency and equitable access to adult social care service.

1.3 Shadowing of contract monitoring across services is starting to take place, and the monitoring template for service is being tabled for discussed at the next Social Work oversight group.

1.4 Learning reviews and associated actions continue to be reported through adult and child protection structures and Public Protection Chief Officers Group [PPCOG], supported by the Learning review Committee Subgroup to oversee reporting and progression of improvement planning.

1.5 Development of key social work data is key and a clear understanding for services of fields used for reporting purposes to ensure our care first reporting accurately reports and measures the service activity across key statutory functions. Children services have developed a six weekly data group, and it is proposed a similar group for adults' services is developed and was a key action from the last subgroup.

SECTION 2: KEY SUCCESSES

Please outline any key areas you would like to highlight

2.1 District Nursing – key quality metrics are all positive with work on frailty scoring, future care planning and recording and achieving preferred place of death all exceeding NHSGGC targets and showing positive trends.

2.2 Health Visiting delivery of the universal pathway is also satisfactory.

2.3 Older Peoples Care Homes – The HSCP Collaborative Care Home Support Group first annual report revealed the breadth of positive assurance improvement work underway in collaboration with local care homes and the impact this work is having supporting improvement in care quality across care homes and the encouraging potential for enhanced impact in reducing unnecessary conveyancing to hospital emergency departments and unscheduled care use. This includes the Care Home Liaison Nurse virtual ward round in all care homes, enhanced District Nurse prescribing over weekends and future care planning (FCP) activity to ensure Care Home resident FCP re uploaded to clinical portal meaning they are accessible to all staff who may require access.

The Care Inspectorate visited Queens Quay Nursing Home in December – the requirement around agency staff access to care and support plans has now been met.

2.4 The Access Help and Support Team established by Children and Families Social Work services is fully operational following the launch. Information has updated and is available on HSCP website. This contains key information on children's services. To date early feedback from service users and partners indicates a positive experience of this point of contact. Notifications of concerns being received via SCI gateway.

2.5 Care Opinion 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. This will strengthen options for our service users and their families to provide real-time feedback and for us to respond timeously.

2.6 Adverse Event Oversight We have established a Local Adverse Event Oversight Group [AEOG] with first meeting scheduled for June 4th. The TOR and guidance were discussed for comment at CCG. This will help ensure we meet KPI around NHSGGC Datix and Significant Adverse Event Reviews [SAER] making us more effective with our processes across Health and Community Care and Children and Families in this respect. It also strengthens governance transparency and decision making and recording of the same. We aim to test the guidance and paperwork provided by NHSGGC CGSU and will be happy to feedback lessons learned. To note Mental Health, Addictions and Learning Disability will continue to utilise NHSGGC clinical and care governance routes to review a monitor progress of Datix and saers – but local oversight of progress will also be maintained.

2.7 Mental Health - In mental health there has been concerted effort to support improvement in CCG KPI. Locally this has involved training more staff to undertake Significant Adverse Event Reviews (SAER), streamlining processes and paperwork. In response to learning from the last two saers where completion of the Craft risk assessment and documentation was found to require strengthening training has been delivered which will be followed up in due course by further local audit to provide assurance re impact. Work has also been progressed in response to complaints re staff manner on phone and focussed quality improvement work has been undertaken.

2.8 ADRS - It was reported that the Medicine Assisted treatment Standards for alcohol and drug recovery service are all rag rated green. Standard 5 is blue recognising it is now fully embedded in practice .This means individuals receive support to remain in treatment for as long as they request and are not prematurely discharged particularly during challenging times or key transitions to ensure they can stay in treatment if they choose to do so.

2.9 Health Care Staffing Act
In the first assurance report to NHSGGC West Dunbartonshire HSCP were able to provide reasonable assurance with respect to all requirements and duties within the act with the exception of the duty relating to implementation of the Common Staffing Method where we were able to provide substantial assurance. Place for our Quarter 1 assurance report to NHSGGC. An action plan is in place to move all areas towards substantial assurance.

The group noted the first report re registered care services provided and commissioned by the HSCP is due to be submitted to the Care Inspectorate by the end of June 2025. This work is being progressed by the HSCP Workforce and Health Care Staffing Act Group.

SECTION 3: KEY RISKS

Please outline any key areas you would like to highlight

3.1. An enduring limitation to effective functioning of both the HSCP CCG and the Social Care /Social Work Subgroup is the lack of consistent administrative support to support our ambitions re governance around regulated services and social work and social care services. This will be addressed via the ongoing admin review.

3. 2. Home Care – The most recent care inspectorate report has been published – discussions noted the work to date and the grades - adequate 2, there are clear signs that suggest an improving picture, however there is significant work required to continue the improvement journey. The Head of Service [HOS] provided assurance of the ongoing improvement efforts noting the impact of staffing constraints in the service.

3.3 Speech and Language therapy. This had been added to the HSCP strategic risk register and is for escalation to NHSGGC board Primary Care Clinical Governance Committee (CPCCCGF). West Dunbartonshire have a 1.8 w.t.e Speech and Language Therapy resource for the HSCP covering some inpatient work as well as community. Staffing challenges compromised resource available and have impacted on and community medium term support. In mitigation the SLT Professional lead has provided considerable support however to date to we have relied on good will. We are requesting consideration of risk sharing across the system in these circumstances and greater collaboration across HSCPs and Inpatient SLT Teams to manage risk more systematically particularly in areas with small teams who are less resilient and can quickly be significantly affected by staff absence. We have an agreed plan to offer additional hours across GGC and have received some support from learning disability SLT HSCP colleagues but will require use of agency staff as no there is no NHSGGC bank resource for SLT (For escalation to NHSGGC CCF)

3.4. There are staffing pressures within Mental Health and Learning disability teams with the potential to impact on care quality within these teams. Three Community Mental Health Teams, Psychology and Older People Mental Health Team are in risk stratification with measures are in place to mitigate risks.
Inpatient mental health services are fully staffed.

3.5. Primary Care
All General Practices at level one which is positive, one practice is in level two escalation due to staffing issues.
The impact of reduction in CLW from 9-5 is being monitored in an effort to minimise the impact.

GPs complaints reports including themes helpful – a number relate to access to available services and clinical care and treatment – 5 were upheld 12 not upheld and 4 partially.

3.6. Large Scale Investigation – One Large Scale investigation – ongoing – Learning Disability Service Provider

SECTION 4: HOSTED SERVICES

Please provide information to date and highlight key areas.

HSCP	Hosted Service	Comments

West Dunbartonshire HSCP	**MSK Physiotherapy**	Main issue is that staff are still released to support orthopaedic colleagues meaning sickness coupled with increase in demand (of 7%) makes managing demand efficiently incredibly challenging. Lack of financial cavalry to bridge demand issues this year challenge particularly challenging. VOL –premises issues – persists additional resource has been identified to address issues. Datix – theme identified regarding incorrect appointment letter resulting in data breech – issue is communal printer, and process has been reviewed to prevent further issues. **Issue with the interpreting service leading to** wasted appointments is getting worse. These are datixed – but no feedback is ever received by the MSK service as to actions being taken to address this. **[Request escalation to NHSGGC PCCGF]** The MSK CCG Annual report was discussed and noted proms and prems good –The annual report shows service is highly effective in securing good outcomes for service users. New spinal pathway –Passed by LMC subcommittee – MSK happy to present to GPs if requested. Anticipate independent auditors' inspection commissioned via NHSGGC to review specialisms. This will be a process audit, month long FP&P origin. Participated in HIS 7-week sprint – Test of Change produced significant.
	Retinal Screening	Level 3 grading seeing improvement in timescales. No risks identified
	Optometry	Behind in development of glaucoma service .

SECTION 5: RELEVENT PROGRESS UPDATE ON ANY KEY ITEMS RAISED AT PRIOR MEETINGS

Please outline any key areas you would like to highlight

Note efforts across HSCP to address CCG KPI and particularly those within mental health services.

SECTION 6: PCCCGF WORKPLAN

Please outline any progress /ideas for shared learning across NHSGGC

Discussion took place on updating 2025 work plan to reflect achievements to date and agree priorities for 2025. Action is required to secure more systematic feedback from service users and families and to better evidence on how we are using this to drive improvement.

SECTION 7: ADULT SUPPORT PROTECTION

Please provide update as discussed at Local HSCP Governance Groups
Nil of note to report

SECTION 8: COMPLIMENTS, COMPLAINTS AND FEEDBACK

Outline any relevant compliments, complaints or feedback as discussed at Local HSCP Governance Groups re HSCP complaints	Outline any relevant compliments, complaints or feedback as discussed at Local HSCP Governance Groups re GP complaints
No complaints report available for CCG Group – this will be reviewed next meeting. Discussion did take place bout strengthening our ability to evidence action taken and learning following complaints and that – we will aim to strengthen this in relation to upheld complaints in the first instance as a pragmatic way to progress this within current capacity.	

9. Significant Adverse Events (SAERS)

9.1 SAERS Closed Q4 2024-5 – await outcome of investigation update from Mental Health regards learning

ID	Directorate admitted	Specialty	Incident date	Risk QA Date Submitted for QA	Risk SAE - Closed	Outcome of investigation
837081	Health and Community Care	District Nursing	28/07/2024	06/01/2025	12/03/2025	4. Issues identified that related to the cause of the event
822334	Mental Health Services	Community Mental Health Team	07/03/2024	28/01/2025	26/02/2025	
830831	Mental Health Services	Crisis Team	08/07/2024	07/01/2025	31/01/2025	
766550	Mental Health Services	Community Mental Health Team	25/05/2023	09/01/2025	12/02/2025	

9.2 SAERS Commissioned Q4 2024- 25

ID	Directorate admitted	Specialty	Incident date	Risk Commissioned Date (if not incident date)	Risk SAE Status
866346	Mental Health Services	Community Mental Health Team	08/02/2025	07/03/2025	Under Review

9.3 Open SAERs

ID	Directorate admitted	Specialty	Incident date	Risk Commissioned Date (if not incident date)	Risk SAE Status
787635	Mental Health Services	Addiction Services	09/10/2023	08/11/2023	Under Review
827146	Children and Family Services	Young Families Support	17/04/2024	20/06/2024	Under Review
809622	Mental Health Services	Older Peoples Mental Health	04/03/2024	03/05/2024	Under Review
776650	Mental Health Services	Crisis Team	06/08/2023	14/09/2023	Under Review
866346	Mental Health Services	Community Mental Health Team	08/02/2025	07/03/2025	Under Review

9.4 Of the open SAERS all are currently overdue with focussed work ongoing to bring them to a conclusion.

9.5 There are19 incident with incomplete or no briefing note list sent to Heads of Service for prompt action. Scheduled for discussion at HSCP Adverse Event Oversight Group 04.06.2025.

9.6 NHSGGC KPI

Key Performance Indicators Datix / SAER

1. Datix Incident Recorded – 24 hours
2. Datix Incident Initial Review – 7 days
3. Datix Incident Finally Approved – 28 days
4. Briefing Note Category 4/5 incidents decision on level of review – 10 days
5. Local Adverse Event Review (LAER) – Completed within 70 days
6. Significant Adverse event Review (SAER) - Completed within 140

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

AUDIT AND PERFORMANCE COMMITTEE

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

23 September 2025

Subject: West Dunbartonshire Health and Social Care Partnership (HSCP) Quarterly Performance Report 2025/26 Quarter One

1. Purpose

1.1 The purpose of this report is to support the West Dunbartonshire HSCP Audit and Performance Committee to fulfil its ongoing responsibility to ensure effective monitoring and 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.

1.2 This report presents the HSCP performance information reported against the strategic priorities for the period April to June 2025 (Appendix I) for the Committees consideration.

1.3 It includes an Exception Report highlighting those indicators which are currently at red status (not meeting local targets and out with tolerances).

1.4 The performance information is presented in order to allow the Committee to fulfil its scrutiny function.

2. Recommendations

It is recommended that the Audit and Performance Committee:

2.1 Comment on the content of the HSCP Quarterly Performance Report 2025/26 Quarter One and performance against the Strategic Plan 2023 - 2026 by exception.

2.2 Note that due to timing issues this report presents partial Quarter One data.

3. Background

3.1 The Performance Framework monitors the HSCP's progress against a suite of performance measures, as outlined in the West Dunbartonshire HSCP's Strategic Plan.

3.2 Development work continues to refine the performance information reported and ensure alignment with local and national developments.

3.3 Performance targets are currently being reviewed for 2025/2026 therefore we continue to report performance against 2024/2025 targets in the interim. The report includes narrative showing key highlights and challenges within the services.

4. Main Issues

4.1 The West Dunbartonshire HSCP performance indicators include a suite of challenging targets. Following the publication of the Strategic Plan 2023 – 2026: Improving Lives Together, informal sessions were held with the HSCP Senior Management Team and HSCP Board members to develop a new framework and agree targets for each of the measures which will be refined moving forward.

4.2 Public Health Scotland provide validated hospital activity data on a quarterly basis with a significant time lag. The latest data which meets completeness requirements of at least 97% is only available up to December 2024. Similarly, validated Drug and Alcohol Waiting Times are published 3 months after the end of the quarter. The Quarter 1 publication is due at the end of September.

4.4 The HSCP have 52 performance indicators. Of the 43 reported on in Quarter one, 11 indicators are in Red Status which is out with target tolerances. These exceptions are detailed in Appendix 1 together with information about improvement actions currently being taken to address these performance issues.

4.5 Ongoing measurement against this suite of indicators provides an indication of how the HSCP is making progress towards the key objectives of integration, in particular how health and social care services support people to live well and independently in their communities for as long as possible.

4.6 Importantly they help to demonstrate how the HSCP is securing best value in respect of ensuring good governance and effective management of resources, with a focus on improvement, to deliver the best possible outcomes for the public.

4.7 It is recognised that the factors influencing changes in performance can be various and complex. Performance monitoring arrangements continue to be refined and developed to ensure appropriate scrutiny and ownership of the factors and issues affecting performance.

5. Options Appraisal

5.1 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 and procurement implications arising from the recommendations within this report.

8. Risk Analysis

8.1 There are no risks identified as a result 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:

- 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.

8.2 The performance information is considered by relevant Managers in line with operational risk registers. No risks have been identified which would be proposed for escalation to 'strategic risk' status for the HSCP Board.

9. Equalities Impact Assessment (EIA)

9.1 An equality impact assessment is not required as the HSCP Audit and Performance Committee 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 Not required for this report.

11. Consultation

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

12. Strategic Assessment

12.1 Not required for this report.

13 Directions

Not required for this report.

Name: Margaret-Jane Cardno
Designation: Head of Strategy and Transformation

Date: 23 September 2025

Person to Contact: Margaret-Jane Cardno
Head of Strategy and Transformation
West Dunbartonshire Health and Social Care Partnership
16 Church Street
Dumbarton
G82 1QL
(Working From Home)

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Appendices: WDHSCP Quarter 1 Performance Report 2025-26

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership Performance Report 2025/26: Quarter 1 April to June 2025

This report will outline the Health and Social Care Partnership's performance against the priorities set out in our Strategic Plan 2023-2026: Improving Lives Together.

Local targets for 2025/26 have not yet been reviewed and 2025/25 targets have been retained in the interim.

Key Highlights/Challenges

A projected overspend of £2.312m (1.07%) after net application of earmarked reserves of £1.325m are accounted for.

Continued financial pressures in relation to care at home services and ongoing demand for supporting children and young people in both community and residential placements.

A slight increase in the proportion of carers who felt able and willing to continue with their caring role when asked as part of their Adult Carer Support Plan.

All children and young people continue receiving Child and Adolescent Mental Health Services treatment within 18 weeks of referral and an average wait of 4 weeks.

A significant decrease in the number of children referred to the Scottish Children's Reporter Administration on non-offence (care and welfare) grounds from 237 during January to March 2025 to 145 during April to June 2025: this is still higher than the Quarter 1 2024/25 figure of 71.

Less than half of people waited less than the target time of 18 weeks for Psychological Therapies treatment.

While higher than in the previous quarter, January to March 2025, we have sustained improvement in the number of bed days lost to delayed discharges for complex cases for adults aged 18 and over.

Continued challenges in reaching targets within Criminal Justice Social Work.

WDC HSCP staff absence has fallen in April to June 2025 after peaking at 7.02 in January to March but is slightly higher than the 6.11 in April to June 2024.

Strategic Plan Performance Indicators

Due to timing issues some data is not yet available and it should also be noted that Unscheduled Care data, i.e. hospital data, is subject to change historically.

PI Status	
	Alert
	Warning
	OK
	Unknown
	Data Only

Target Type	
N	National Target
L	Local Target
M	Monitoring only – no target set

Short Term Trends	
	Improving*
	No Change
	Getting Worse*

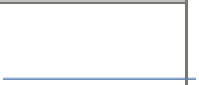
*Where an indicator is Data Only with no target set, the up and down arrows denote whether the number or percentage is increasing (up) or decreasing (down).

Caring Communities

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
1	Percentage of carers who feel able to continue in their caring role when asked through their Adult Carer Support Plan	97.4%	95%	L			96.6%	91.7%	
2	Percentage of carers who feel willing to continue in their caring role when asked through their Adult Carer Support Plan	98.7%	95%	L			96.6%	91.7%	
3	Number of Adult Carer Support Plans completed	77	N/A	M			58	48	
4	Balance of Care for looked after children: % of children being looked after in the Community	89.3%	90%	N			90.5%	89.5%	
5	Number of Looked After Children	484	N/A	M			483	504	
6	Number of Looked After children looked after in a residential setting	52	N/A	M			46	53	
7	Number of Looked After children looked after at home with parents	86	N/A	M			82	68	
8	Number of Looked After children looked after by foster carers	120	N/A	M			122	127	
9	Number of Looked After children looked after in other community settings	226	N/A	M			233	256	
10	Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	100%	90%	N			100%	100%	

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
11	Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	4	18	L			4	3	
12	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	48.5%	90%	N			57.4%	75%	
13	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	Published late Sept	90%	N	Not yet available	Not yet available	97.4%	96.8%	

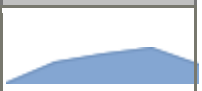
Safe and Thriving Communities

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
14	Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	N			100%	100%	
15	Percentage of child protection investigations to case conference within 28 days	New recording processes in relation to Child Protection have resulted in an issue with dates meaning we are unable to accurately capture timescales for contact to case conference. We have therefore temporarily paused reporting of this performance indicator. Implementation of our new Duty system should address this issue.							
16	Number of Child Protection investigations	86	N/A	M			85	108	
17	Number of children on the Child Protection Register at end of reporting period (Excluding temporary and transfers in)	69	N/A	M			75	58	
18	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on non-offence (care and protection) ground	145	N/A	M			237	71	
19	Number of children referred to the Scottish Children's Reporter Administration (SCRA) on offence grounds	31	N/A	M			30	42	
20	Percentage of Adult Support and Protection clients who have current risk assessments and care plan/protection plan	64.3%	100%	N			67%	63%	
21	Number of delayed discharges over 3 days (72 hours) non-complex cases	22	0	N			22	17	
22	Number of bed days lost to delayed discharge 18+ All reasons	3,512	2,850	L			3,064	3,953	
23	Number of bed days lost to delayed discharge 18+ Complex Codes	1,303	1,440	L			1,197	1,416	

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
24	Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over	2,927	2,335	L			2,577	3,097	
25	Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	929	982	L			981	1,020	
26	Number of clients receiving Home Care Pharmacy Team support	256	312	L			280	288	
27	Number of people receiving Telecare/Community Alarm service - All ages	1,818	1,894	L			1,894	1,844	
28	Number of people receiving homecare - All ages	1,116	N/A	M			1,145	1,241	
29	Number of weekly hours of homecare - All ages	7,242	N/A	M			8,283	9,214	
30	Percentage of people who receive 20 or more interventions per week	44.4%	40%	L			46.8%	46.6%	
31	Percentage of homecare clients receiving personal care	99.6%	99%	L			99.9%	99.8%	
32	Number of people receiving reablement homecare	113	N/A	M			91	25	
33	Number of hours of reablement homecare	153	N/A	M			188	180	

Equal Communities

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
34	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	69.6%	98%	N			71.7%	72.8%	
35	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	67.7%	80%	N			65.3%	54%	
36	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	32.9%	80%	N			31.3%	28.4%	
37	Percentage of children from BME communities who are looked after that are being looked after in the community	81.3%	90%	L			85.7%	92.3%	
38	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	50%	80%	L			100%	67%	

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
39	Percentage of people under 65 consenting to a referral for benefits maximisation at point of assessment/review	25.8%	N/A	L			32.3%	20%	
40	Percentage of people aged 65 and over consenting to a referral for benefits maximisation at point of assessment/review	9.1%	N/A	L			17.2%	10%	
41	Percentage of females consenting to a referral for benefits maximisation at point of assessment/review	8.5%	N/A	L			19.7%	17%	
42	Percentage of males consenting to a referral for benefits maximisation at point of assessment/review	17.1%	N/A	L			22.8%	10%	

Healthy Communities

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
43	Number of emergency admissions 18+	Not yet available	1,989	L	Not yet available	Not yet available	Not yet available	2,367	
44	Number of emergency admissions aged 65+	Not yet available	1,066	L	Not yet available	Not yet available	Not yet available	1,268	
45	Emergency admissions aged 65+ as a rate per 1,000 population	Not yet available	60	L	Not yet available	Not yet available	Not yet available	69.8	
46	Number of unscheduled bed days 18+	Not yet available	20,094	L	Not yet available	Not yet available	Not yet available	24,156	
47	Unscheduled acute bed days (aged 65+)	Not yet available	14,565	L	Not yet available	Not yet available	Not yet available	17,569	
48	Unscheduled acute bed days (aged 65+) as a rate per 1,000 population	Not yet available	817	L	Not yet available	Not yet available	Not yet available	967.1	
49	Number of Attendances at Accident and Emergency 18+	Not yet available	5,005	L	Not yet available	Not yet available	5,789	6,446	
50	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	31%	90%	N			41%	40%	
51	Prescribing cost per weighted patient (Annualised)	£179.35	£187.73	L			£188.77	£193.15	
52	Compliance with Formulary Preferred List	74.28%	78%	N			74.36%	74.51%	

Financial Update

The HSCP Board meeting on 19th August 2025 considered the following financial papers:

- 2024/25 Financial Performance Report as at Period 3 (30th June 2025)

The financial performance report provided an update on the position to 30th June 2025 and a projection to 31st March 2026 based on Quarter 1 activity and performance.

The financial projection based on Quarter 1 data reported an overspend of £2.312m (1.07%) after net application of earmarked reserves of £1.325m are accounted for. There continues to be financial pressures in relation to care at home services and ongoing demand for supporting children and young people (in both community placements and other residential accommodation).

The report highlighted the impact of the current overspend projection and an update to pay and non-pay inflationary assumptions on the previously reported budget gaps for 2026/27 and 2027/28 with gaps of circa £13m and £23m now anticipated as reported below.

Consolidated Budget Gap Analysis	**2025/26**	**2026/27**	**2027/28**
	£000's	**£000's**	**£000's**
Budget Gap Reported March 2025	-	9,003	18,850
Forecast Deficit @ June 2025	2,312		
Reduction in £12 p/hr funding for C&F		148	222
SRA Funding		(38)	(38)
Pay Inflation Funding for Health Care (Assume full funding)	(463)	(1,917)	(1,917)
Budget Adjustments / Pressures not Reported			
Social Care Pay Inflation increased on average 1%	523	810	876
Health Care Pay Inflation increased on average 1.34%	463	1,917	1,917
Increase in NCHC Assumptions		592	632
Increase in Residential Schools Rate Uplift Assumptions		268	285
NHS employees pay award for recharged salaries		5	5
Pressures within Community Placements and Childrens Residential Care		2,000	2,084
Pressures within Older People Services		1,276	1,314
Other		(1,046)	(1,015)
Revised Budget Gap @ June 2025	**2,835**	**13,017**	**23,216**
Health Care	(182)	4,438	7,359
Social Care	3,017	8,579	15,857
Revised Budget Gap @ June 2025	**2,835**	**13,017**	**23,216**

The 2026/27 budget setting process is underway and the Senior Management Team have each been allocated a savings target across the range of services they are responsible for, along with the issue of savings and equality impact assessment templates for completion and return by mid-September. A range of savings options for 2026/27 and options to close the gap will be presented to the HSCP Board at a future meeting.

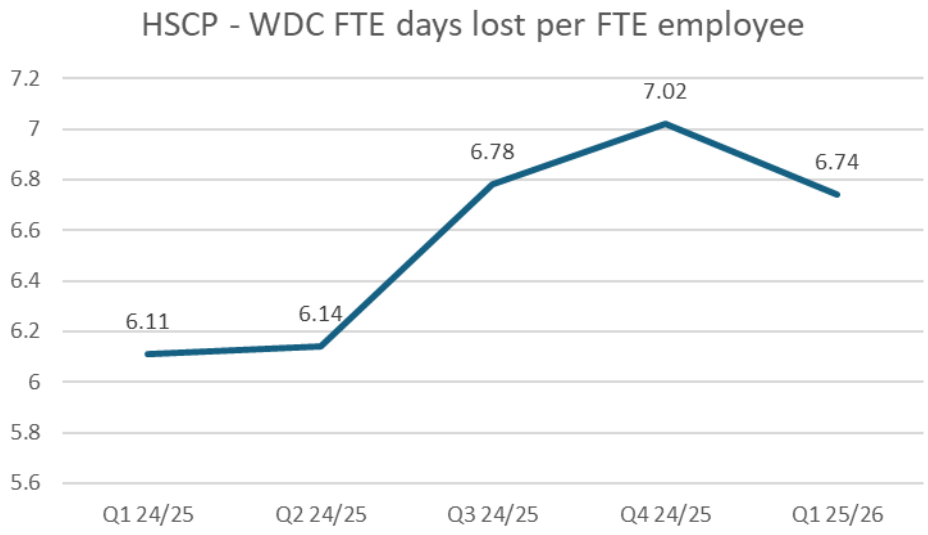
Minimising the projected overspend will be an ongoing priority and is likely to take the form of early adoption of proposed management adjustments and savings options (where possible) along with a range of actions including review of individual care packages across a range of services, ongoing vacancy management and no discretionary spend unless authorised by the Chief Officer.

The HSCP's Chief Officer and Chief Financial Officer continue to meet with both NHS Greater Glasgow and Clyde and West Dunbartonshire Council Chief Executives to consider the reported financial position of the Health and Social Care Partnership.

Absence

West Dunbartonshire Council and NHS Greater Glasgow and Clyde report staff absence for West Dunbartonshire HSCP staff in different ways: WDC by Full Time Equivalent (FTE) lost per FTE employee each quarter and NHS by the percentage of rostered hours lost to staff absence.

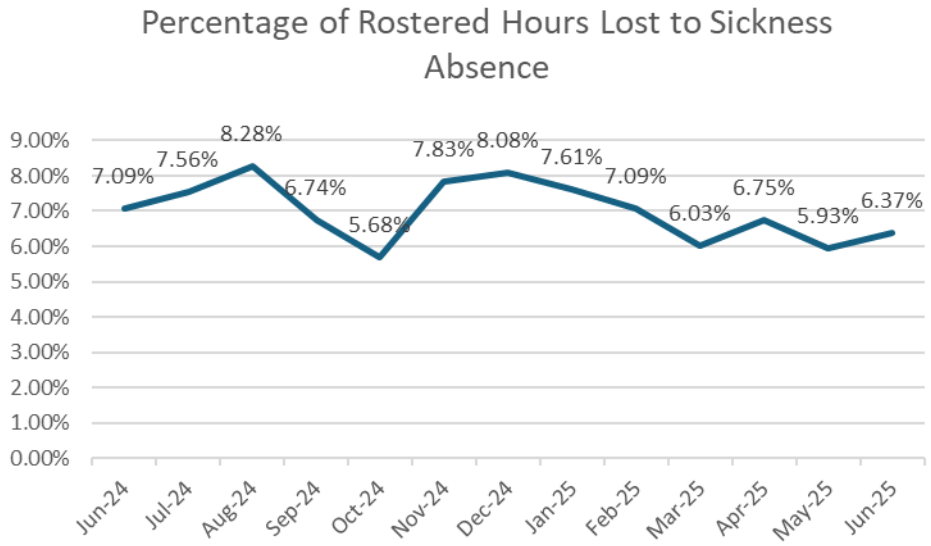
WDC HSCP staff absence has fallen in April to June 2025 after peaking at 7.02 in January to March but is slightly higher than the 6.11 in April to June 2024.



Nationally, West Dunbartonshire Council (all non-teaching staff) absence is published by the Improvement Service through the Local Government Benchmarking Framework. Latest figures are for 2023/24 where WDC had a higher number of Full Time Equivalent (FTE) days lost per employee at 15.06 than the Scotland figure of 13.89 but had improved slightly on the previous year's figure of 15.32 and had moved from 27th lowest (or 6th highest) in Scotland to 24th lowest (9th highest).

	WDC	Scotland	Ranking 1 - lowest to 32 - highest FTE days lost per employee
2020/21	8.38	9.58	8
2021/22	13.28	12.17	23
2022/23	15.32	13.21	27
2023/24	15.06	13.89	24

NHS HSCP staff absence is reported monthly. Absence rates saw a decreasing trend during April to June 2025 with the 2nd lowest rate in the last year in May 2025 at 5.93%. June 2025 was also 0.72% lower than in the same month in 2024.

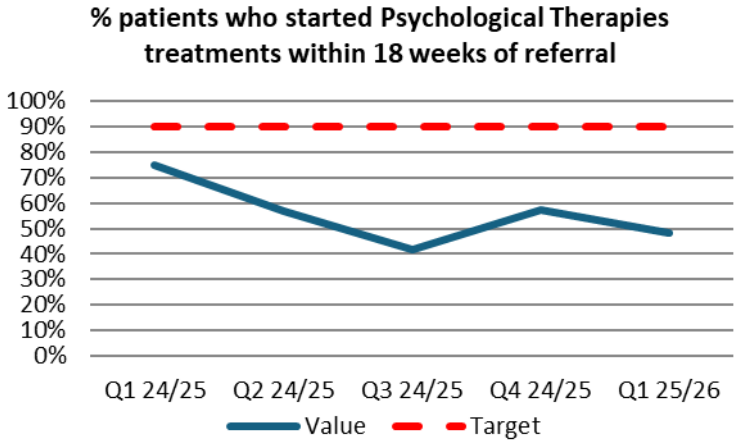


West Dunbartonshire Health and Social Care Partnership
Exceptions Reporting: Quarter 1 April to June 2025

Performance Area: Psychological Therapies

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
12	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	48.5%	90%	N			57.4%	75%	

Quarter	Value	Target
Q1 24/25	75.0%	90%
Q2 24/25	57.0%	90%
Q3 24/25	41.6%	90%
Q4 24/25	57.4%	90%
Q1 25/26	48.5%	90%



Key Points:
64 of the 132 people who started psychological therapies between April and June 2025 did so within 18 weeks of referral.

Staff vacancies within psychology and across the multi-disciplinary teams continue to impact on waiting times.

Improvement Actions:
Community Mental Health teams are continuing to maximise use of the Psychological Therapies Groups service.

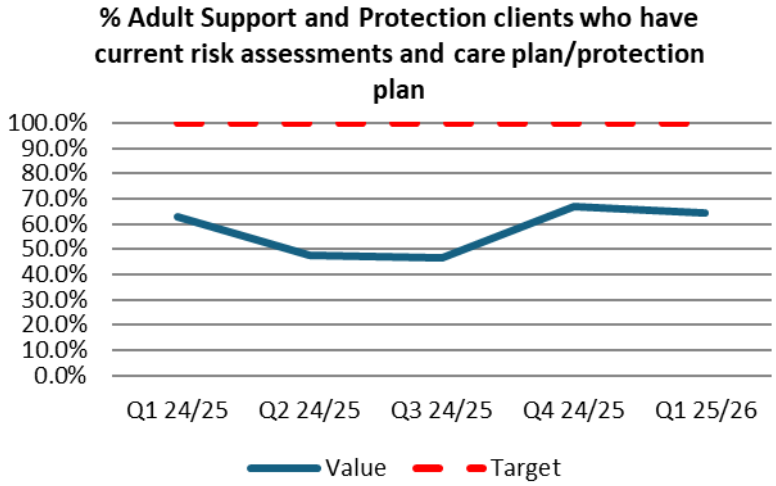
All psychology staff are picking up cases from across the teams according to the longest wait.

Staff reducing attendance at meetings as much as possible in order to prioritise clinical work.

Performance Area: Adult Support and Protection

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
20	Percentage of Adult Support and Protection clients who have current risk assessments and care plan/protection plan	64.3%	100%	N			67%	63%	

Quarter	Value	Target
Q1 24/25	63.0%	100%
Q2 24/25	47.4%	100%
Q3 24/25	46.7%	100%
Q4 24/25	67.0%	100%
Q1 25/26	64.3%	100%



Key Points:
Appropriate risk assessments and protection plans are in place for 9 of the 14 Adult Support and Protection clients brought to case conference during April to June 2025. Another 3 individuals have partial paperwork in place.

There is no Adult Support and Protection Lead Officer currently in post.

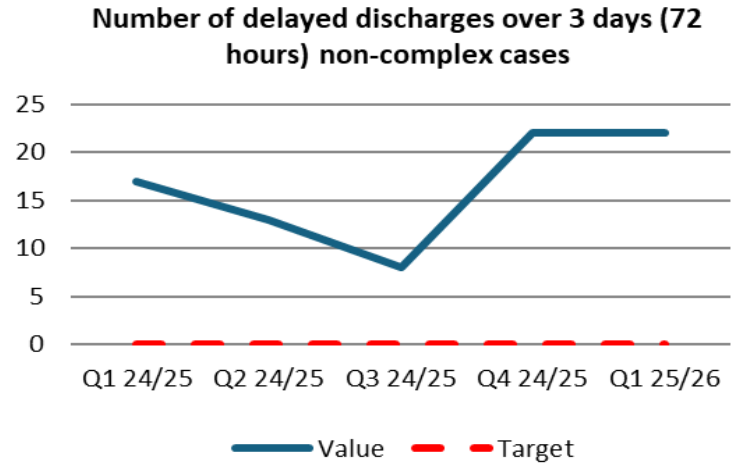
Improvement Actions:
Processes were put in place during 2024/25 to flag up gaps in recording. While there has been some improvement since then, which has been sustained across Quarter 4 2024/25 and the current quarter, it is likely that more timely and frequent checks and prompts are required.

The HSCP's Information Team will being to issue updates on a monthly rather than quarterly basis to address this and improvements in recording will continue to be monitored.

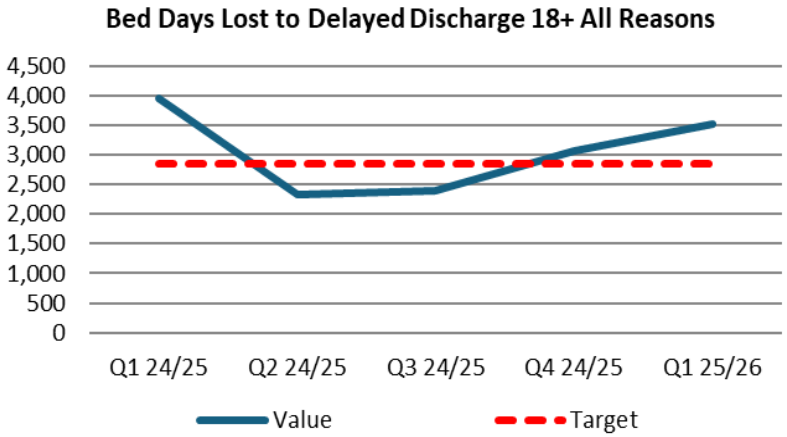
Performance Area: Delayed Discharge

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
21	Number of delayed discharges over 3 days (72 hours) non-complex cases	22	0	L			22	17	
22	Number of bed days lost to delayed discharge 18+ All reasons	3,512	2,850	L			3,064	3,953	
24	Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over	2,927	2,335	L			2,577	3,097	

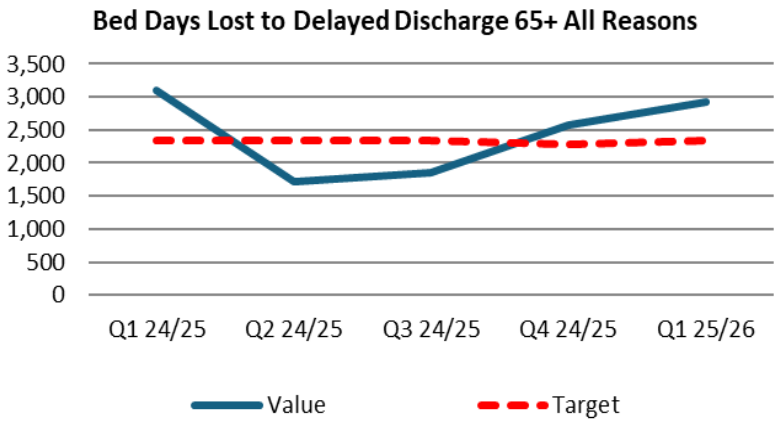
Quarter	Value	Target
Q1 24/25	17	0
Q2 24/25	13	0
Q3 24/25	8	0
Q4 24/25	22	0
Q1 25/26	22	0



Quarter	Value	Target
Q1 24/25	3953	2850
Q2 24/25	2327	2850
Q3 24/25	2399	2850
Q4 24/25	3064	2850
Q1 25/26	3512	2850



Quarter	Value	Target
Q1 24/25	3097	2335
Q2 24/25	1724	2335
Q3 24/25	1854	2335
Q4 24/25	2577	2278
Q1 25/26	2927	2335



Key Points:
The Scottish Government's aspirational target is that no one with a non-complex discharge should experience a delay of more than 3 days. This figure is a snapshot as at the monthly census point.

The average number of complex and non-complex daily delays was 39 in April to June compared with 34 in the previous quarter. There were fewer delays due to the availability of care at home services.

Bed days lost to delayed discharge for all reasons were higher than in the previous quarter but slightly lower than in the same period last year.

Bed Days Lost	Increase on previous quarter	Decrease on same quarter last year
18+	14%	5%
65+	15%	11%

Improvement Actions:
An Unscheduled Care Development Session was held on 1st April 2025 in the Vale Centre for Health and Care, attended by staff across HSCP teams, the HSCP Chief Officer, Senior Management, Clinical Director, Allied Health Professionals and representatives from a range of stakeholders including the Scottish Ambulance Service and independent sector care homes in West Dunbartonshire.

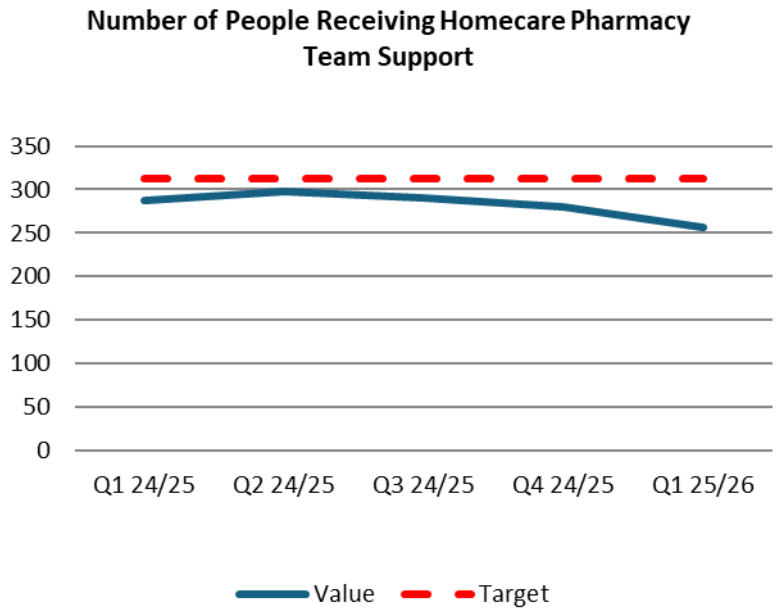
Discussions included consideration of the unscheduled care data and the culture shift required to deliver new ways of working including: digital, virtual wards; better use of care home capacity; supporting frail patients; and ensuring service users are at the heart of our services.

Feedback from breakout sessions considering challenges, what we do well and what we could do better was collated and an action plan for delivery by the Unscheduled Care Group is currently in development. This action plan will also be in line with NHS GGC's developing Transformation delivery plan for Unscheduled Care.

Performance Area: Home Care Pharmacy

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
26	Number of clients receiving Home Care Pharmacy Team support	256	312	L			280	288	

Quarter	Value	Target
Q1 24/25	288	312
Q2 24/25	298	312
Q3 24/25	291	312
Q4 24/25	280	312
Q1 25/26	256	312



Key Points:

Over the past year, the Homecare Pharmacy Team service has developed in that we now offer a more comprehensive and patient-focused approach. Senior Pharmacy Technicians have taken on expanded roles, delivering Level 2 medication reviews, while in parallel our support workers have been instrumental in maintaining high standards of care by consistently delivering core services. This collaborative model is delivering better outcomes for patients across West Dunbartonshire.

While the current figures provide a useful snapshot of activity levels, they primarily reflect the quantity of visits rather than the quality or added value they bring. These visits often involve complex, person-centred interactions that contribute significantly to patient outcomes, which take longer than the traditional core visits.

The pharmacy team's input during these visits frequently leads to:

- Enhanced medication safety and optimisation
- Improved patient understanding and adherence
- Strengthened multidisciplinary working
- Identification and resolution of systemic issues

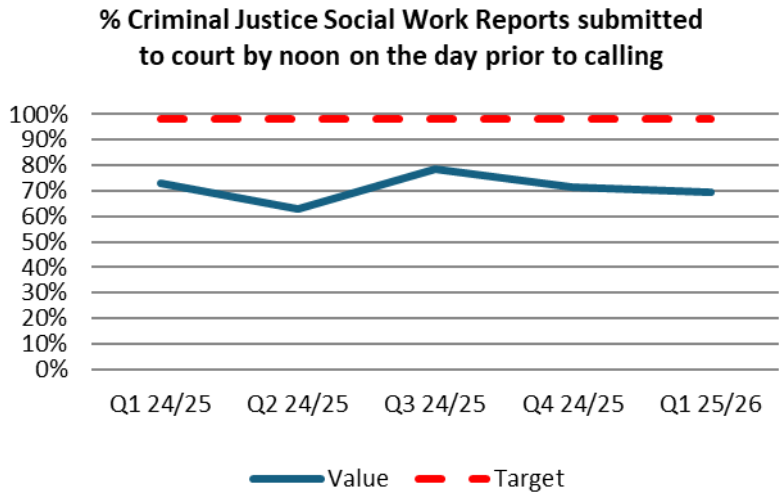
Improvement Actions:
Daily reports have been updated in line with new hospital discharge triage processes to ensure all patients who may require support from the service are being identified.

Given the significant improvements made, the target may require to be reviewed to reflect the ongoing development of the service and the more comprehensive interactions taking place with service users.

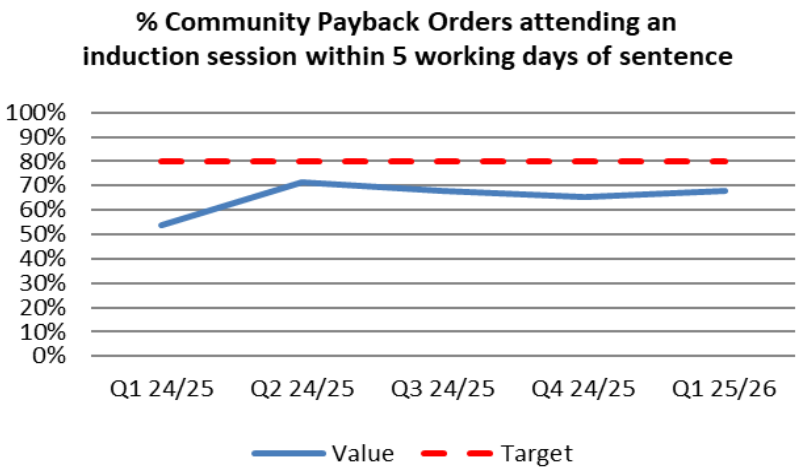
Performance Area: Criminal Justice Social Work

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
34	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	69.6%	98%	N			71.7%	72.8%	
35	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	67.7%	80%	N			65.3%	54%	
36	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	32.9%	80%	N			31.3%	28.4%	

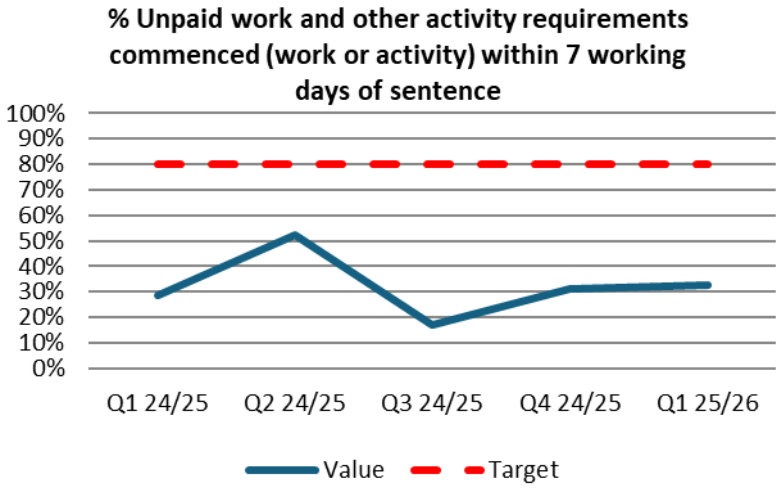
Quarter	Value	Target
Q1 24/25	72.8%	98%
Q2 24/25	62.7%	98%
Q3 24/25	78.7%	98%
Q4 24/25	71.7%	98%
Q1 25/26	69.6%	98%



Quarter	Value	Target
Q1 24/25	54.0%	80%
Q2 24/25	71.2%	80%
Q3 24/25	67.7%	80%
Q4 24/25	65.3%	80%
Q1 25/26	67.7%	80%



Quarter	Value	Target
Q1 24/25	28.4%	80.0%
Q2 24/25	52.1%	80.0%
Q3 24/25	16.9%	80.0%
Q4 24/25	31.3%	80.0%
Q1 25/26	32.9%	80.0%



Key Points:
In Quarter 1 there were requests for 227 Justice Social Work Reports to Courts between April and June 2025. A decrease of 4.2% on Quarter 4 2024/25. Figures indicate an average of 69.6% of these reports were completed on time. For every report not completed a letter is sent to Court outlining the rationale for the requested report not having been sent.

The number of Community Payback Orders imposed in Quarter 1 was 99 with 73 of these having an unpaid work requirement. Of those 99 imposed orders, 67.7% of individuals attended an induction session within 5 working days of sentence.

Service users attending work placements within 7 days has increased slightly from 31.3% in Quarter 4 2024/25 to 32.9% in Quarter 1 2025/26.

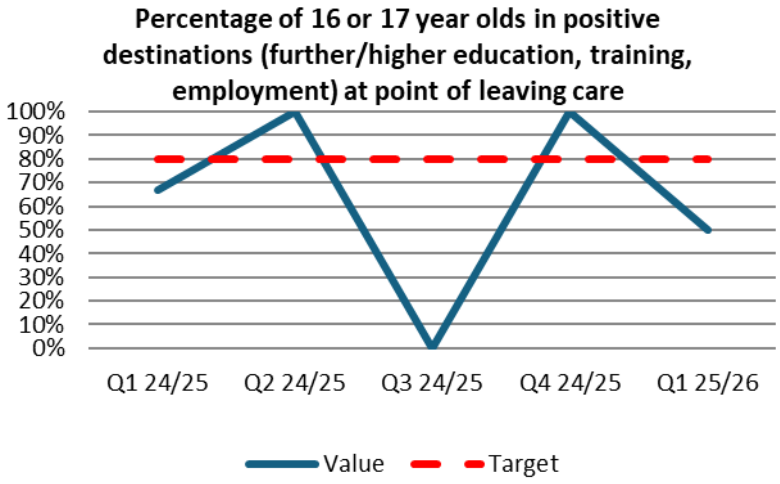
Every service user made subject to a statutory Community Payback Order at Dumbarton Sheriff Court is seen within 24 hours of the Court imposing the order.

Improvement Actions:
We require further investment in main grade qualified social worker posts to support the demands placed on the service by additional Domestic Abuse assessments for Caledonian work and to negate the impact of long-term absence on our ability to meet key performance indicators.

Performance Area: Looked After Children

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
38	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	50%	80%	L			100%	67%	

Quarter	Value	Target
Q1 24/25	67%	80%
Q2 24/25	100%	80%
Q3 24/25	N/A*	80%
Q4 24/25	100%	80%
Q1 25/26	50%	80%



*No young people aged 16 or 17 left care during this quarter.

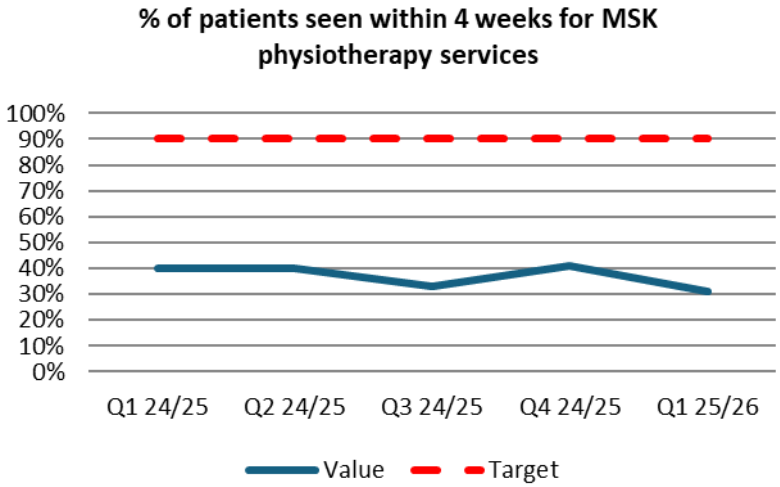
Key Points:
This relates to a very small number of young people and therefore percentages fluctuate more significantly. Numbers are also so low that they are potentially identifiable.

Improvement Actions:
The HSCP's Throughcare and Aftercare service continue to support care experienced young people to access education, employment and training alongside a range of supports in relation to housing, finances and developing confidence and life skills.

Performance Area: MSK Physiotherapy

Ref	Performance Indicator	Q1 2025/26					Q4 2024/25	Q1 2024/25	Trend over 8 Qtrs
		Value	Target	Target Type	Status	Short Trend	Value	Value	
50	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	31%	90%	N			41%	40%	

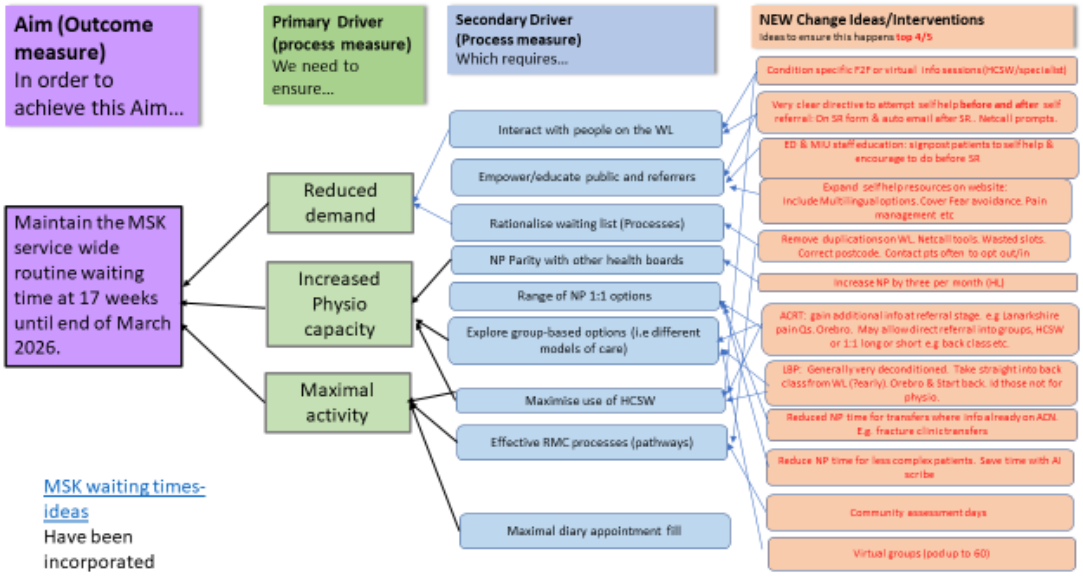
Quarter	Value	Target
Q1 24/25	40%	90%
Q2 24/25	40%	90%
Q3 24/25	33%	90%
Q4 24/25	41%	90%
Q1 25/26	31%	90%



Key Points:
Demand for the MSK service continues to rise on an ongoing basis across Greater Glasgow and Clyde. The workforce has not increased to meet rising demand due to financial constraints. The service was also required to make financial savings in 2024/25 which have impacted on capacity. MSK waiting times for a routine appointment have started to rise as rising demand exceeds capacity.

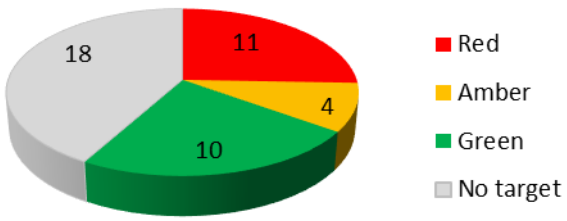
In Quarter 1 the service was challenged in ensuring that all urgent patients were seen within 4 weeks. This was due to several factors. Firstly as demand has risen so too has the need for urgent appointments to meet the proportion of demand that relates to urgent referrals. The availability of urgent appointments had been approaching the 4 weeks over several months and in Quarter 1 the service reached tipping point where urgent patients could not all be accommodated within the 4 weeks. The service took steps to remedy this. The only way to do this was by prioritisation of urgent patients by converting routine appointments to urgent appointments. This resulted in the maximum routine waiting times for MSK increasing within Quarter 1.

Improvement Actions:
Waiting times remains a priority project within the service and the 13% increase in demand within 2023/24 and further 7% rise in 2024/25 across GGC has meant that some of the impact of the waiting times work has not been realised. The updated driver diagram below illustrates the ongoing tests of change within the service. The focus is on routine waiting times, as until the routine waits come closer to the 4 week target, the % seen within the 4 week target will be relatively unchanged.



Summary of Strategic Plan Key Performance Indicators

Quarter 1: April to June 2025 (Partial Data)



West Dunbartonshire Health and Social Care Partnership
Complaints Reporting: Quarter 1 April to June 2025

Within the Model Complaints Handling Procedure developed by the Scottish Public Services Ombudsman (SPSO) is a requirement to report performance in relation to complaints internally on a quarterly basis and publicly on an annual basis in line with the SPSO's Model Complaints Handling Reporting Framework. As part of our commitment to best practice, openness and transparency we will include this framework within our Quarterly Performance Report going forward.

These indicators are set by the SPSO and should provide opportunities for benchmarking and identifying good practice and areas for improvement on a local and national basis.

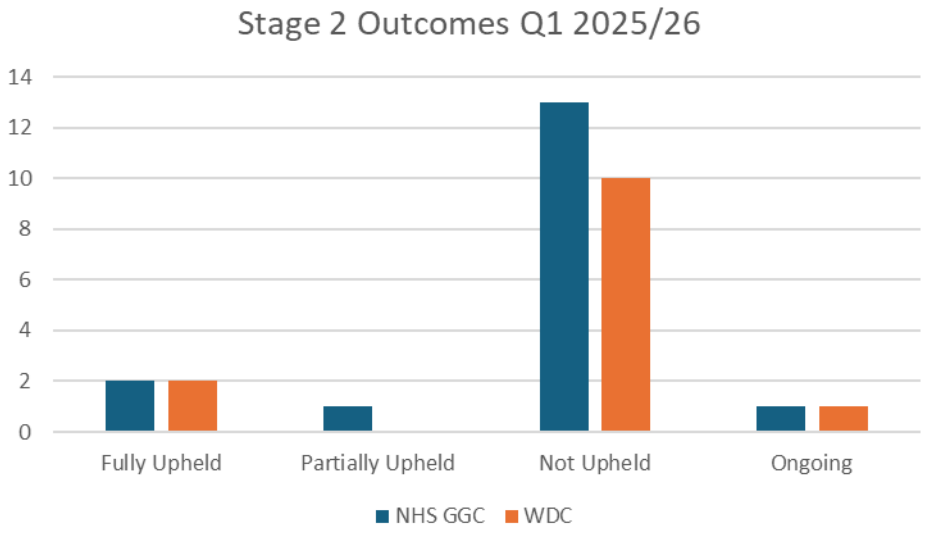
During April to June 2025 the following learning points or actions were identified through the investigation of complaints received by the HSCP.

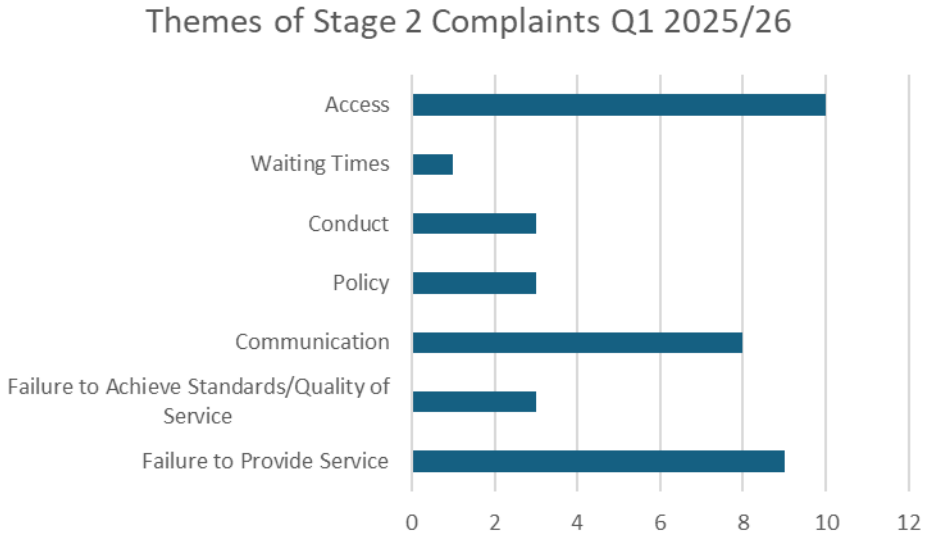
Service Area	Lessons Learned/Actions Taken
Community Health and Care Services	Reflective learning around the role of Duty to reprioritise in response to changing needs. My Life Assessment Screenings now carried out face-to-face where possible to better assess an individual's needs. Processes reviewed in relation to how we communicate respite availability with families and carers.

SPSO Indicator	Measure	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
2	Number of Stage 1 complaints (whether escalated to Stage 2 or not)	73	83	67	56	56
	Number of complaints direct to Stage 2	27	10	17	26	30
	Total number of complaints	100	93	84	82	86
3	% closed within timescale - Stage 1	Not available*				
	% closed within timescale - direct to Stage 2	55%	40%	65%	68%	80%
	% closed within timescale - escalated to Stage 2	N/A	50%	N/A	N/A	N/A
4	Average response time - Stage 1	Not available*				
	Average response time - direct to Stage 2	23	21	17	22	17
	Average response time - escalated to Stage 2	N/A	31	N/A	N/A	N/A

*The accurate recording of Stage 1 complaints, their outcomes and timescales across both West Dunbartonshire Council and NHS Greater Glasgow and Clyde systems is in early development stages.

Indicator 5: Outcomes of Complaints





Complaints may cover more than one theme.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AUDIT AND PERFORMANCE COMMITTEE

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

23 September 2025

Subject: Regulated Services Update Report

1. Purpose

1.1 To provide the West Dunbartonshire HSCP (HSCP)) Board Audit and Performance Committee with an update on Care Inspectorate inspection activity for externally commissioned regulated services located within West Dunbartonshire, internally provided services by West Dunbartonshire Council (the Council) whose service delivery is carried out by the HSCP and a summary, in table format, for Care Inspectorate inspection activity for out of area regulated commissioned services. The reporting period covered in this report is for the period 1 April to 31 August 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 Care Inspectorate inspection reports, this report includes details of the Council's internal services which are provided by WD HSCP, registered with the Care Inspectorate and inspected up to an including the 31 August 2025. This is to ensure members of the Audit and Performance Committee are kept updated and informed in relation to services provided by the HSCP on behalf of 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.

3. Background

3.1 The Care Inspectorate now uses 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 being 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 April – 31 August and reported within this period are:

<u>Externally Regulated Commissioned Services:</u>

- Strathleven Care Home – Older People Care Home
- Kingsacre Care Home – Older People Care Home
- Clyde Court Care Home - Older People Care (see Appendix 1 – Clyde Court Update Report)
- Home Instead West Dunbartonshire, Argyll & Bute and Arran Support Service – Support Service
- Acadability – Support Service

- Carraig View – Care Home - Children and Young People
- Antonine All Stars – Support Service - Children and Young People
- Harmeny School – School Care Accommodation Service - Children and Young People

Out of Authority Regulated Commissioned Services (Care Homes)

- Almond Court
- Almond View
- Argyle Care Home
- Boclair Care Home
- Buchanan Lodge
- Davidson house
- Elderslie Care Home
- Hillside View
- Northwood
- Parkhouse Manor
- Quayside Nursing Home
- Rutherglen Care Home
- Summerlee House
- Applecross Nursing Home
- Arran View
- Glasgow Esmond Street
- Hansel Village
- Millbank

Internally Provided Regulated Services:

- West Dunbartonshire HSCP Re-ablement Service – Support Service
- Crosslet House Care Home – Adults and Older People
- Craigellachie Children's Home – Children and Young People

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 One – Clyde Court Update Report

4. Main Issues

Strathleven Care Home – 30 Strathleven Place, Dumbarton G82 1BA

4.1 Strathleven Care Home is owned by Pelan Ltd. Strathleven Care Home is registered with the Care Inspectorate to provide care for a maximum of 21 older people. At the time of inspection there were 17 people living in Strathleven Care Home.

4.2 The service was inspected on 14 – 15 July 2025, and the report issued in late July 2025. The table below summarises the grades awarded to Strathleven Care Home 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
15.07.25	5	5	5	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**
10.10.24	5	5	5	4	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**
26.01.23	3	3	3	n/a	n/a

4.3 This inspection focused on 4 Key Questions –resulting in the service maintaining grades of 5 – Very Good, and 4 – Good, from the previous inspection.

4.4 Key messages highlighted by inspectors were:

- People living in Strathleven Care Home and their families were very happy with the care and support;
- People were respected and listened to because their wishes and preferences were used to shape how they were supported at home;
- People benefitted from comprehensive and up-to-date healthcare assessments, access to community healthcare and treatment from external healthcare professional;
- Management demonstrated a clear understanding about what was working well and what improvements were needed;
- People living in the care home and staff benefitted from a warm atmosphere because there were good working relationships across all departments of the care home;
- The environment was relaxed, clean, tidy and well looked-after, with no evidence of intrusive noise or smells.

<u>Kingsacre Care Home, Cochno Road, Hardgate, Clydebank G81 6RW</u>

4.5 Kingsacre Care Home is owned by Kingsacre Care Limited which is part of

the Care Concern Group. Kingsacre is registered with the Care Inspectorate for a maximum of 66 older people.

4.6 This service was inspected on 23 July 2025, this was a follow-up inspection to review one requirement made as a result of complaint investigation in May 2025, with the report being issued in late July 2025. The table below summarises the grades awarded to Kingsacre 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
24.06.25	n/a	n/a	n/a	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**
20.12.24	n/a	n/a	n/a	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**
04.10.24	4	5	4	4	3

4.7 This inspection focused on a requirement made as result of complaint investigation in May 2025. The requirement was fully met within timescales. No change was made to the grades awarded at inspection in June 2025.

4.8 Key messages highlighted by inspectors were:

- The management have focused on making improvements in falls prevention and management;
- Staff have received training to support their knowledge and share best practice;
- Improvements have been made in care planning and record keeping.

Home Instead West Dunbartonshire, Argyll & Bute and Arran – Suite 2 – 4 &11 Arcadia Business Centre, Miller Lane, Clydebank G81 1JU

4.9 Home Instead is owned by Solripe Allstars Limited. Home Instead is registered with the Care Inspectorate to provide a support service to adults and older people living in their own homes and in the wider community. At the time of inspection there 58 people being support by

the service across all areas.

4.10 This service was inspected between 15 – 18 July, and the report issued in August 2025. The table below summarises the grades awarded to Home Instead over their last two inspections. Please note that the service has only been inspected twice since registering with Care Inspectorate in February 2022;

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
18.07.25	5	n/a	5	n/a	n/a
17.05.23	5	4	5	n/a	5

4.11 This inspection focused on two Key Questions – resulting in the service maintaining grades of 5 – Very Good from the previous inspection. In this inspection report there were no requirements highlighted for remedial action.

4.12 Key messages highlighted by inspectors were:

- People were supported in a kind and thoughtful way with care professionals often going the extra mile to support people during difficult times;
- Care was tailored to each person, helping them feel respected, listened to, and involved in decisions about their support;
- Staff helped people to stay independent, encouraging confidence through practical support like learning new skills and managing routines;
- Digital tools gave people more control, allowing them to stay informed and involved in shaping their care;
- The staff team felt supported by caring managers, but there was a need to improve how often staff had one-to-one support from leaders.
- Recruitment demonstrated that staff were recruited safely but some improvements could be made to make the process clearer and more consistent.

<u>Acadability, 160 Bank Street, Alexandria G83 0UP</u>

4.13 Acadability is owned by Acadability Ltd. Acadability is registered with the Care Inspectorate to provide a support service to a maximum of 30 adults with a learning disability. At the time of inspection, the service was supporting 28 people.

4.14 This service was inspected between 1 – 3 July, and the report issued in July 2025. The table below summarises the grades awarded to Acadability 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
07.07.25	4	3	3	4	3
31.08.23	n/a	3	4	n/a	3
11.05.23	4	2	3	4	3

4.15 This inspection focused on all five Key Questions – resulting in a decrease to grade for KQ3 from 4 – Good to 3 – Adequate, all other grades remained as per previous inspection. In this inspection report there were two requirements highlighted for remedial action by the service with a timescale of 27 October 2025:

- By 27 October 2025, the provider must ensure the service is well led and managed and people receive care and support that is safe which meets their needs through robust quality assurance.
  To do this, the provider must, as a minimum:

  a) ensure managers and senior staff have the right skills and knowledge to quality assure all aspects of care and support delivery;
  b) monitor and review quality assurance systems that effectively identify issues which may impact on the health, welfare and safety of people supported;
  c) devise clear action plans with timescales where deficits and/or areas for improvement have been identified.

- By 27 October 2025, to promote the safety and wellbeing of people, the provider must ensure that staff receive essential training and development opportunities to enable them to be competent in their roles. To do this the provider must at a minimum:

  a) undertake a training needs analysis to identify what training and development is required for each role. This should include but is not limited to training that would enhance people's preferred communication needs;
  b) maintain an accurate record of all staff training, including

refresher training;

c) monitor and evaluate the effectiveness of training and development opportunities and ongoing competency of staff.

4.16 Key messages highlighted by inspectors were:

- People appeared happy and relaxed within the setting;
- Relatives were happy with the care and support their loved one received;
- Staff felt happy in their roles and worked well as a team;
- Management oversight of the service needed to improve to ensure all aspects of care delivery, such as care planning and reviews are effectively being monitored;
- Audits were not picking up areas of improvement the service needed to action;
- Supervisions and team meetings were not happening regularly and needed to improve to ensure that staff were on target with achieving their learning and development goals;
- Training statistics within the service needed improved to ensure that staff had the right skills and knowledge for their roles.

4.17 The provider put a robust action plan in place to ensure that the requirement highlighted will be met once the service is reinspected.

4.18 Management and staff continue to work to improve the service in collaboration with the HSCP and associated agencies.

Out of Authority Regulated Commissioned Services

4.19 By exception, we have provided additional inspection detail regarding out of authority regulated commission services provided by Carraig View, Antonine All Stars, and Harmeny School as there have been significant changes to their grading, experienced their first inspection or that they have not been inspected for a significant period of time.

Carraig View, Port Glasgow

4.20 Carraig View is owned by The Church of Scotland, operating as Crossreach. Carraig View is registered with the Care Inspectorate to provide a residential care service for a maximum of 4 children and young people.

4.21 This service was inspected between 25 – 26 March 2025, and the report issued in April 2025. The table below summarises the grades awarded to Carraig View over their last 2 inspections, please note that the service has only been inspected twice since registering in January 2021:

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 planned	How well do we support children and young people's rights and wellbeing
09.04.25	n/a	n/a	n/a	n/a	n/a	3
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 planned**	**How well do we support children and young people's rights and wellbeing**
26.05.22	n/a	n/a	n/a	n/a	n/a	4

4.22 This inspection focused on one Key Question – resulting in a decrease for Key Question from 4 – Good to 3 - Adequate. In this inspection report there were two requirements highlighted for remedial action by the service by 1 August and 1 September 2025:

By 1 August 2025, you must ensure that risk assessment processes support a positive and detailed approach to risk reduction. In particular you must:

a) Ensure that all risks/needs for young people are subject to regular review;

b) Ensure that the learning from all incidents updates and influences future practice to provider a reductionist approach to risk;

c) Ensure that risk assessments are appropriately detailed to ensure that staff and managers know exactly what is required from them to help support young people;

d) Ensure managers and external managers have oversight of risk assessment processes and can assess advances and barriers in these.

- By 01 September 2025, you must ensure that care planning processes fully reflect the wishes and needs of young people, and inform staff fully of their role in supporting them. In particular you must:

  a) Ensure young people are actively consulted on deciding their goals, and that these are clear and visible to them;

  b) Ensure goals are SMART (specific, measurable, achievable, realistic and timely). These should be reflective of young people's words, and should clearly describe the supports required to achieve these. Goals should be actively tracked

and subject to regular review;

c) Ensure all staff are aware of the needs and focus of work for all young people within the service and know exactly what is needed from everyone to support young people to reach their goals;

d) Ensure managers and external managers have oversight of plans, and can assess advances and barriers in progressing outcomes for young people

4.23 Key messages highlighted by inspectors were:

- Improved matching processes were not fully effective in assessing the ability to meet the needs of young people;
- Staff and managers received regular debriefs and reflective spaces, including access to consultancy;
- Risk assessments for young people required improvement to ensure a reductionist and consistent approach from staff;
- Staff training could be further developed through improved assessment processes;
- Links to health professionals were positive, and this led to some effective joint working to improve outcomes for health. This was an area of strength for the service;
- Staff helped young people to manage their family relationships well, working effectively with other professionals in doing so.

4.24 The provider put a robust action plan in place to ensure that the requirements highlighted will be met once the service is reinspected.

4.25 Management and staff continue to work to improve the service in collaboration with the host authority, West Dunbartonshire HSCP and associated agencies.

Antonine All Stars, Antonine Court Ltd, 30 Dunkenny Road, Glasgow G15 8LH

4.26 Antonine All Starts is owned by Antonine Court Ltd. Antonine All Stars is registered with the Care Inspectorate to provide support services to children and young people with physical disability, learning disability and/or complex needs. This service operates in the evenings and at weekends.

4.27 This is the services first inspection since registering in November 2023. The service was inspected between 28 – 29 May 2025, report issued in June 2025. The table below summarises the grades awarded to Antonine All Stars in their inspection:

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 planned	How well do w support children and young people's rights and wellbeing
13.06.25	4	3	3	n/a	n/a	3

4.28 This inspection focused on four Key Questions. In this inspection report there were no requirements highlighted for remedial action by the service.

4.29 Key messages highlighted by inspectors were:

- Young people benefitted from warm, respectful nurturing relationships;
- The service needed to develop a greater understanding of the individual profiles of people using the service so support could be tailored to their individual needs;
- Leaders were passionate and committed but needed to strengthen their oversight of the service;
- Young people were supported by a good number of committed and compassionate staff;
- The developing team need opportunities to come together to promote consistent support and care;
- Personal plans need to be more individualised and support people to fulfil their potential

Harmeny School, Mansefield Road, Balerno, Edinburgh EH14 7JY

4.30 Harmeny School is owned by Harmeny Education Trust which is a not-for-profit organisation with charitable status. Harmeny School is registered with the Care Inspectorate to provide school care accommodation to a maximum of 32 children and young people.

4.31 This service was inspected between 17 – 20 June 2025, with the inspection report issued in July 2025. The table below summarises the grades awarded to Harmeny School 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 planned	How well do we support children and young people's rights and wellbeing
20.06.25	n/a	n/a	n/a	n/a	n/a	5
	How well do	How good is	How good	How good is	How well is	How well do

	we support children and young people's wellbeing	our leadership	is our staff team	our setting	our care planned	we support children and young people's rights and wellbeing
11.10.24	n/a	n/a	n/a	n/a	n/a	3
	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 planned**	**How well do we support children and young people's rights and wellbeing**
18.07.23	n/a	n/a	n/a	n/a	n/a	4

4.32 This inspection focused on one Key Question – with the service receiving grades of 5 – Very Good for KQ5 which is an increase from the previous inspection. In this inspection report there were no requirements highlighted for remedial action by the service.

4.33 Key messages highlighted by inspectors were:

- Young people were kept safe both emotionally and physically by confident staff who knew and understood their needs and risks well;
- Young people experienced very warm, nurturing, and respectful interactions with staff;
- We were impressed with how well young people were supported to maintain and develop connections with family, friends and the community;
- We were impressed with the significant positive change in culture across the organisation;
- Strong leaderships supported staff wellbeing, learning and development, resulting in increased staff retention;
- The organisation's "Here 4U" project was impressive and supported transitions for young people within and out of the service;
- Quality assurance processes impacted positively on learning and development and improved practice.

4.34 The table below details the regulated services that we commission from external local authorities that were inspected during the period 1 April – 31 August. We have included this as a summary as the host authorities that we commission these placements from have responsibility for quality assurance and engaging directly with the Care Inspectorate regarding inspection activity as the HSCP does not attend the inspection feedback session with the Care Inspectorate. The Host authority will notify the HSCP

by exception in connection with quality issues and/or challenges with Care Inspectorate inspections following the feedback session.

Care Home	Date of Inspection	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
Almond Court	01.07.25	4	4	4	4	4
Almond View	18.07.25	4	4	4	4	4
Argyle Care Home	25.04.25	5	4	5	4	5
Boclair Care Home	19.05.25	5	n/a	n/a	5	n/a
Buchanan Lodge	13.05.25	5	n/a	n/a	4	n/a
Davidson House	07.04.25	4	4	4	4	4
Elderslie Care home	08.05.25	4	5	4	4	4
Hillside View	17.07.25	3	4	4	4	3
Northwood	17.07.25	5	n/a	n/a	3	n/a
Parkhouse Manor	03.07.25	4	4	4	4	4
Quayside Nursing Home	20.07.25	4	4	4	4	4
Rutherglen Care Home	02.05.25	4	n/a	n/a	n/a	n/a
Summerlee House	09.07.25	6	n/a	n/a	6	n/a
Applecross Nursing Home	02.06.25	5	5	5	4	4
Arran View	13.06.25	5	n/a	n/a	4	n/a
Glasgow Esmond St – Enable	11.07.25	5	n/a	n/a	4	n/a
Hansel Village	10.07.25	5	n/a	3	n/a	4
Millbank	08.07.25	6	n/a	6	4	n/a

Internal Regulated Services

West Dunbartonshire HSCP Re-ablement Service

4.35 West Dunbartonshire HSCP's Re-ablement Service is registered with the Care Inspectorate to provide a short-term service which supports people at home after a hospital stay, illness or injury. An integrated team, including carers, organisers, rehabilitation staff and therapists, work closely with individuals to help them regain independence and confidence with everyday tasks. At the time of inspection the service was supporting 79 people.

4.36 This service was inspected between 10 – 15 June 2025, with the Care Inspectorate's report issued in July 2025. The HSCP registered the Re-ablement Service in December 2023 and this was the first inspection. The table below summarises the grades awarded to the service:

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
19.06.25	3	3	3	n/a	3

4.37 This inspection focused on four Key Questions – with the service being awarded grades of 3 – Adequate for all 4 Key Questions. In this inspection report there were three requirements highlighted for remedial action by the service:

By 10 October 2025, the provider must ensure people receive medication support that is safe and supports their health and wellbeing. To do this, the provider must, as a minimum:

a) Ensure that people's need for medication assistance is assessed and reviewed to ensure that they receive the right level of support (prompt, assist or administer) to take their medication safely;
b) Medication records are accurate and assistance is correctly recorded;
c) Ensure that processes are in place to regularly assess staff practice and competency in medication management and in relation to medication recording;
d) Regularly audit medication records to identify any discrepancies.

By 10 October 2025, 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. To do this, the provider must, at a minimum:

a) Ensure people's choices and wishes on how to be supported are set out;
b) Ensure care plans are informed through effective risk assessments;
c) People and staff should have access to this information;
d) Review care plans when a significant change occurs, or if requested to do so.

4.38 Key messages highlighted by inspectors were:

- People appreciated the support they received and felt more confident after leaving hospital;
- Some visits didn't happen as planned, which left people feeling anxious or at risk;
- Plans about how to support people weren't always clear or kept up-to-date.
- Staff felt able to speak with managers, but managers didn't always have enough time to provide regular support;
- Ongoing staff absences and unclear roles made it harder for the team to work well together.

4.39 The service has put a robust action plan in place to ensure that the requirements highlighted will be met once the service is reinspected.

4.39 Management and staff continue to work to improve the service in collaboration with colleagues within the HSCP and associated agencies.

Crosslet House Care Home

4.40 Crosslet House Care Home is registered with the Care Inspectorate to provide a care service for a maximum of 58 older people which includes a maximum of 14 people aged between 50 to 65 years. At the time of inspection there were 51 people living at Crosslet House.

4.41 This service was inspected between 16 – 18 June 2025, and the report was issued in June 2025. The table below summarises the grades awarded to Crosslet 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
20.06.25	6	n/a	n/a	5	n/a
18.12.23	5	5	n/a	n/a	n/a

14.12.22	5	5	n/a	n/a	n/a

4.42 This inspection focused on 2 Key Questions – resulting in an increase to the previous grades for Key Question 1 of 5 – Very Good – to 6 – Excellent. In this inspection report there were no requirements highlighted for remedial action.

4.43 Key messages highlighted by inspectors were:

- People, relatives and external health and social care professionals were overwhelmingly positive about the home;
- Physical health and mental wellbeing was supported to an excellent standard with positive outcomes for people;
- The setting of the home was well maintained and was influenced by the people who lived there. Routine cleaning, checks and audits maintained the high-quality facilities that were available for people to use.

Craigellachie Children's House

4.44 Craigellachie Children's Home is registered with the Care Inspectorate to provide a care service for a maximum of 6 children and young people.

4.45 The service was inspected on 2 – 3 July 2025, and the report issued in July 2025. The table below summarises the grades awarded to Craigellachie Children's Home 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
04.07.25	n/a	n/a	n/a	n/a	4
23.09.24	n/a	n/a	n/a	n/a	3
29.12.22	n/a	n/a	n/a	n/a	4

4.46 This inspection focused one Key Question –resulting in an increase to the grade for Key Question 5 from 3 – Adequate to 4 – Good. In this inspection report there were no requirements highlighted for remedial action.

4.47 Key messages highlighted by inspectors were:

- Young people were safer as a result of living in Craigellachie;

- Leaders needed to ensure staff felt confident in following the organisation's child protection policy;
- Young people were cared for with compassion and nurture and experienced stable and therapeutic care;
- Young people were meaningfully involved in their care;
- Leaders in the service needed to improve accountable decision making by clearer documentation;
- Learning from incidents had significantly improved since the last inspection.

4.48 Management and staff continue to work to improve the service in collaboration with colleagues within the HSCP and associated agencies.

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.

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.

8.3 For internally provided regulated services that receive a grade of two or less, it is at the discretion of HSCP that new referrals should 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 – Clyde Court 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

23 September 2025

Subject: Appendix 1 – Clyde Court Update Report

1. Purpose

1.1 To provide the HSCP Board Audit and Performance Committee with an update on Care Inspectorate activity and Large Scale Investigation reporting, relating to Clyde Court Care Home, which is a residential care home service, which supports adults and older people, located in Clydebank, within West Dunbartonshire.

2. Background

2.1 Clyde Court Care Home is owned by Maven Healthcare Limited. Clyde Court is registered with the Care Inspectorate to provide residential, nursing, dementia, respite and end of life care to a maximum of 70 older people aged 65 and over.

2.2 At the time of writing this report there were 58 residents being supported in Clyde Court. 37 are placed by West Dunbartonshire HSCP and 21 residents are placed by external Local Authorities and are referred to as out of area placements.

3. Main Issues

3.1 Since May 2023, Clyde Court had fluctuating inspection scores from the Care Inspectorate and West Dunbartonshire HSCP had raised concerns regarding practice, outcomes, environment and medication.

3.2 Following an unannounced inspection by the Care Inspectorate on the 23, 24 and 25 June 2025, the home was assessed 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?	3 – Adequate
How good is our setting?	2 – Weak
How well is our care and support planned?	3 - Adequate

The table shows the inspection activity and grades relating to Clyde Court during the 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
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 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**
16.07.24	3	n/a	n/a	n/a	n/a

3.3 At the inspection on the 23, 24 and 25 June, Clyde Court were given 3 requirements; the table below details these:

Requirement No.	Requirement	Outcome
1	By 7 August 2025, the provider must ensure that people are safe and protected by being proactive in ensuring that systems and resources are in place to support good infection prevention and control. In order to do this, the provider must, at a minimum: a) ensure that staff are trained, understand and adhere to the contents of the Care Home Infection Prevention and Control Manual (CH IPCM) b) ensure the care home environment, furnishings, floor coverings and equipment are kept clean and	Requirement was assessed at an unannounced inspection on the 11 and 12 August 2025. Care Inspectorate determined that some progress had been made, however not enough to meet the terms of the requirement. Deadline for meeting this requirement was extended to 12 September 2025.

	tidy c) maintain accurate records of all regular and deep cleaning d) Infection Prevention and Control audits capture all relevant areas for improvement This is in order to comply with Regulations 3, and 4 (1) (a) and (d) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and section 8(1)(a) of the Health and Care (Staffing)(Scotland) Act 2019. This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience an environment that is well looked after with clean, tidy and well-maintained premises, furnishings and equipment' (HSCS 5.24).	
2	By 20 October 2025, the provider must ensure people live in a well led service that safe and provides care and support that meets their needs. To do this, the provider must, at a minimum: a) ensure that systems of quality assurances are in place for key areas and audits are consistently completed. b) detail actions taken to address any identified improvement and have clear responsibilities	Outcome is pending as the due date is the 20 October 2025.

	c) include an evaluation of progress made Inspection report Inspection report for Clyde Court Care Home page d) notify the Care Inspectorate of all relevant events under the correct notification heading, within the required timeframe, include detail of their handling of the event, communication with stakeholders and provide updates if applicable. This is to comply with Regulation 3 and 4(1)(a) (Welfare of users) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210). This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance systems' (HSCS 4.19).	
3	By 20 October 2025, the provider must ensure that people are safe, protected and comfortable by being proactive in ensuring that systems and resources are in place within an environment that is well maintained. In order to do this, the provider must, at a minimum: a. ensure the care home environment, furnishings, floor coverings and equipment are well-maintained and in a good	Outcome is pending as the due date is the 20 October 2025.

	state of repair b. any items that are damaged or defective must be discarded and replaced in a timeous manner c. implement robust environmental auditing, incorporating actions into a development plan and demonstrate that any issues have been resolved. This is in order to comply with Regulations 3, 10(2)(b) and (d) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment' (HSCS 5.24).	

3.6 Following the inspection in June by the Care Inspectorate, 4 Adult Support and Protection incidents were uncovered which had not been reported. These retrospective referrals were made and are being investigated in line with Adult Support and Protection policy. Further information had also come to light regarding the under reporting of incidents that could have led to Adult Support and Protection referrals.

3.7 The HSCP visited Clyde Court unannounced on 18 July, this visit included members of the HSCP Senior Management Team. Using the findings from this visit, reviewing all Adult Support and Protection referrals from 1 January, and reviewing feedback from visiting professionals including the Care Inspectorate - under the direction of the Chief Social Work Officer a Large-Scale Investigation (LSI) Consideration meeting was convened. It was agreed at this meeting that in line with our local LSI guidance and national guidance

that the threshold for LSI had been met. The scope of the LSI covers the following thematic areas:

- Governance and Oversight
- Care and Support
- Notifications
- Environment
- Staffing & Leadership

The LSI is chaired by the Chief Social Work Officer and the LSI Lead Officer Is the Head of Mental Health, Learning Disability & Addictions.

3.8 It is important to note that the LSI is a separate process to the inspection activity undertaken by the Care Inspectorate. An LSI is conducted under Adult Support and Protection and is a detailed investigation into the risks to people being supported in the service. The LSI investigates the providers practice and the HSCP's. An LSI uses a multi-agency approach where colleagues from the Care Inspectorate, Mental Welfare Commission, Police Scotland and Advocacy are invited to attend.

3.9 Clyde Court were advised on 18 July that the HSCP were reviewing the case in line with LSI guidance and they were formally notified that the HSCP was moving to LSI on the 6 August, with the first LSI meeting scheduled for the 22 August. LSI meetings will take place 8 weekly thereafter.

3.10 Given escalating concerns regarding Infection Prevention and Control, notifications and the overall quality of care and support, the HSCP issued an Immediate Assurance Letter instructing Clyde Court to:

a) Have a member of their senior management team base themselves within the home who have a background in quality assurance until all requirements from the Care Inspectorate have been fully met and to ensure the quality of care and support is improved.

b) Provide additional management to the home using registered manager(s) from your Scottish based homes to support the leadership of Clyde Court until all requirements from the Care Inspectorate have been fully met and WD HSCP is reasonably assured that the home is able to sustain quality improvement.

3.11 This was met positively by the Senior Management Team at Maven Healthcare and to date these have been actioned.

3.12 The HSCP has set up a core group of Social Workers, led by the Integrated Operational Manager for Community Care and Social Work. This group focus on Clyde Court and they operate under the remit of the LSI, they observe practice in the home, undertake social work reviews, undertake adult support and protection investigations, deal with concerns and incidents, highlighting

areas of concerns to the LSI Lead Officer. This core group will meet formally every 4 weeks.

3.13 The HSCP met with families of those resident in Clyde Court on 25 August, 40 family members attended. The HSCP explained what an LSI was and what this meant and the actions we had taken. This session was also used to listen to families' experiences. At the end of the session HSCP staff were available to hear directly from families about any significant/immediate concerns they had. Feedback from this session will be fed back to the LSI and where appropriate the Care Inspectorate.

3.14 The HSCP remains significantly concerned regarding the quality of care and support, a moratorium was put in place on all admissions, including respite on the 2 July and this will remain in place until the LSI has concluded, Care Inspectorate grades have improved and the HSCP is assured that Clyde Court has sustained and embedded quality improvement within its service.

3.15 A meeting with the Local Authorities who make external placements (out of authority placements) in Clyde Court was held on the 27 August, all out of authority placements will be reviewed by the placing authorities.

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 The HSCP will review the number of available beds and impact the moratorium is having on Clyde Court in relation to its continuing financial sustainability.

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: Val Tierney Chief Nurse

23 September 2025

Subject: Health and Care (Staffing) (Scotland) Act 2019 (HCSSA) Implementation Status and Assurance Report

1. Purpose

1.1 The Health and Care (Staffing) (Scotland) Act 2019 (The Act) took effect on April 1, 2024. The Act provides a statutory basis for the provision of appropriate staffing in health and care services, to enable delivery of safe, high-quality care and improved outcomes for service users. The Act assigns responsibilities to integration authorities and health boards.

1.2 This report provides assurance on implementation of the Act within West Dunbartonshire HSCP and describes the reporting requirements for health and social care.

2. Recommendations

2.1 Note that the Act affects Health and Care services differently, with separate reporting requirements and timescales.

2.2 Note health services delegated to West Dunbartonshire HSCP report to NHS Greater Glasgow and Clyde (NHSGGC) via Quarterly Internal Assurance Reports which inform NHSGC's Annual Report to Scottish Government.

2.3 Note the overall level of compliance for delegated health services in West Dunbartonshire HSCP Quarter 1 (2025) Internal Assurance Report is assessed as reasonable (Appendix 1).

2.4 Note that Integration Authorities have a duty to publish and report annually to Scottish Government for all care services registered with The Care Inspectorate, in the financial year they are first planned or secured by the Integration Authority, on the steps taken by the organisation to comply or mitigate risks regards Section 3(2) of the Act.

2.5 Note the reasonable level of assurance provided by West Dunbartonshire HSCP in their annual report submitted to Scottish Government 30th June 2025 (Appendix 2).

2.6 Agree to publish the annual report submitted to Scottish Government by West Dunbartonshire HSCP on 30th June 2025 (Appendix 2).

3. Background

3.1 The Act was passed by the Scottish parliament in May 2019 coming into force on the 1st of April 2024.

3.2 Implementation of the Act is about ensuring quality of care provision and ensuring availability of a competent and effective workforce. It aims to embed a culture of openness and transparency, ensuring staff are informed about decisions relating to staffing and able to raise concerns. It builds on existing policies and procedures within both health and care services.

3.3 Throughout 2024 NHSGGC undertook a programme of testing for all duties within the Act. This identified the actions and activities to be taken to close any gaps and allowed for evidence banking and benchmarking regards levels of compliance. As the NHSGGC program concludes a transition plan has been developed to facilitate business as usual working that embeds the principles and requirements of the Act.

3.4 The Safe Staffing programme (SSP) was commissioned by the Scottish Government to prepare the social care sector and the Care Inspectorate for commencement of the act. The programme's vision is to ensure registered social care services in Scotland have the right people, in the right place, with the right skills at the right time working to ensure people experience excellent health and care outcomes.

3.5 The Act affects Health Services and Care Services in different ways.

3.6 For care settings, the Act places a duty on those who provide care services to ensure both appropriate staffing and appropriate training of staff.

3.7 The statutory duty at Section 3(2) of the Act states that: In planning or securing the provision of a care service from another person under a contract, agreement or other arrangements, every local authority and every integration authority must have regard to:

I. the guiding principles in the Act (section 1 of the Act).
II. the requirement on care service providers to have regard to the guiding principles (section 3(1) of the Act).
III. the duty on care service providers to ensure appropriate staffing (section 7 of the Act).
IV. the requirement on care service providers with regard to training of staff (section 8 of the Act).
V. the requirement on care service providers to have regard to guidance issued by the Scottish Ministers (section 10 of the Act).
VI. the duties on care service providers under Chapter 3 of Part 5 of the Public Services Reform (Scotland) Act 2010, for example with regard to registration of care services; and
VII. the duties on care service providers under Chapter 3A of Part 5 of the Public Services Reform (Scotland) Act 2010, for example with regard to the use of any prescribed staffing methods or staffing tools. Note that the Health and Care (Staffing) (Scotland) Act 2019 inserted chapter 3A

into the Public Services Reform (Scotland) Act. Each year, you must report on the steps you have taken, and any ongoing risk that may affect your ability, to comply with the duty above (section 3(6) of the Act).

The following care services are in scope of the Act:

- a support service.
- a care home service.
- a school care accommodation service.
- a nurse agency.
- a childcare agency.
- a secure accommodation service.
- an offender accommodation service.
- an adoption service.
- a fostering service.
- an adult placement service.
- child minding.
- day care of children; and
- a housing support service.

3.8 The Integration Authority (IA) has a duty to report for all care services listed under section 47 (1) of the Public Services Reform (Scotland) Act 2010. This is all services registered with the Care Inspectorate, and these must be reported in the financial year they are first planned or secured by the Integration Authority. West Dunbartonshire HSCP Annual Report 2024-2025 is contained in Appendix 2.

3.9 For health settings, the Act places a duty on Health Boards to ensure both appropriate numbers of staff and appropriate types of professions.

3.10 Where health care is delegated to an integration authority, the duties and requirements under the Act still apply. To support this the Act lists a number of requirements that must be followed. These are summarised below:

I. Reporting to Scottish Ministers on the use of high-cost agency staff
II. Identifying risks relating to staffing in real-time and having a procedure to escalate risk to address these and identify those that are severe and recurring.
III. Seeking and having regard to advice given by clinicians on staffing
IV. Ensuring adequate time is given to clinicians who lead a team of staff to fulfil their leadership responsibilities
V. Ensuring staff receive appropriate training for their role
VI. Using the common staffing method (only in certain circumstances)

3.11 Where a Health Board has delegated healthcare functions to an Integration Authority, they must be included in all reporting. The report is commissioned via the HSCP Chief Officers. West Dunbartonshire HSCP is required to submit quarterly assurance reports to the Health Board using the agreed

template on an ongoing basis. West Dunbartonshire HSCP (Health) Quarter 1 92025) report is contained in Appendix 1.

4. Main Issues

4.1 We can provide reasonable assurance regarding compliance with the principles and duties enshrined in the Act. Generally sound systems of governance, risk management and control are in place.

4.2 There is a need to continue to promote awareness across all relevant service areas in West Dunbartonshire HSCP to support a consistent approach to implementation and to embed this work in business-as-usual processes until substantial assurance can be provided and this becomes blended with our ongoing reporting and focus on care quality, workforce, financial and risk assessment management.

4.3 The HSCP have a baseline understanding of current compliance and assurance levels. Gap analysis has informed the action plan for 2025/2026 which will support us to work towards substantial assurance by developing our business-as-usual processes where feasible with available resources.

5. Options Appraisal

5.1 Not required

6. People Implications

6.1 For Health services the introduction of the Common Staffing Framework and associated mandated staffing level tools (where they exist) represents a changed approach to staffing.

6.2 It may be challenging to manage staff expectations following completion of the annual Staffing Level Tool runs (SLT) in those health services where use is mandated by the act.

7. Financial and Procurement Implications

7.1 Challenging limitations to public funding and recruitment in health and social care render this a difficult environment for the implementation of the Act.

7.2 There are potential cost implications for the HSCP because of the changed approach to staffing where completion of staffing level tools and the common staffing method outputs reveal a requirement for investment.

8. Risk Analysis

8.1 Strategic and Service Risk registers have been reviewed and updated related to the implementation of the Act

8.2 There is a risk of increased staffing costs with the introduction of mandatory use of staffing level tools and the application of the common staffing method.

8.3 There are currently no mandated staffing level tools developed for use in regulated care services.

9. Equalities Impact Assessment (EIA)

9.1 Not required

10. Environmental Sustainability

10.1 No impact

11. Consultation

11.1 Regular progress reports have been shared with West Dunbartonshire HSCP SMT throughout 2024/25.

11.2 Quarterly Assurance report submitted to NHSGGC Health Care Staffing Oversight Board.

11.3 Annual Report Submitted to Care Inspectorate June 2025 and The Care Inspectorate.

11.4 HSCP staff have been involved in the planning and implementation groups both at HSCP and NHSGGC level.

12. Strategic Assessment

12.1 The requirements of the Act are fully aligned with the ambitions of our Strategic delivery plan Improving Lives Together.

13. Directions

13.1 No directions issued with this report

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Designation Chief Nurse West Dunbartonshire HSCP
Date 08.09.2025

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Appendices:

Appendix 1: West Dunbartonshire HSCP Quarter 1 2025 HCSA Assurance Report to NHSGGC

Appendix 2: West Dunbartonshire HCSA Annual Report [Care] 2025

Background Papers - N/A

Guidance

> This template is to be used to identify the key areas of assurance, gather evidence against each of the duties, in conjunction with the HCSSA resources developed such as NHSGGC SOP's and HIS or SG Guidance documents.
> We encourage an improvement approach to the action section to map out timelines, risk (and mitigations)and responsibilities.
> Complete the levels of assurance in the drop down box and encourage regular review to update where the levels are less than substantial.
> A number of duties cross map against one another and encourage this to be reflected in the response.
> Also identify significant risks or challenges that you may need some support to mitigate or are already in the process of review.
> Identify areas of success that may benefit from learning or approach being shared.
> Enactment began on 01 April 2024. Q4 (24-25) Assurance should be built upon and show incremental progression towards the position to be issued in the formal annual report to Scottish Government due April 2026
> This template does not replace the need to complete tools such as Real Time Staffing assessments or Staffing level Tools etc. It is used to complement the application of those tools and any related data and outcomes.
>

Level of assurance	System adequacy	Controls
Substantial assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non- compliance.
Limited assurance	Significant gaps, weaknesses or non- compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

Glossary & Resources

This reference tab will be updated as more resources are available and can be linked to published resources where possible

The Health and Care (Staffing) (Scotland) Act 2019	https://www.gov.scot/publications/health-care-staffing-scotland-act-2019-statutory-guidance/
Roles that the ACT applies to	https://www.gov.scot/publications/health-and-care-staffing-scotland-act-2019-overview/pages/roles-in-scope-of-the-act/
Health Improvement Scotland (HIS) HCSSA Quick Guides	https://learn.nes.nhs.scot/74342
NHSGGC Health and Care (Staffing) (Scotland) Act 2019 - HCSSA Website	https://www.nhsggc.scot/health-care-staffing-scotland-act-2019/
NHSGGC Real Time Staffing and Risk Escalation Organisational Standard Operating Procedure (RTS & RE SOP)	https://live.nhsggc.scot/downloads/nhsggc-real-time-staffing-and-risk-escalation-sop/
NHSGGC Time to Lead Standard Operation Procedure (TtL SOP)	https://live.nhsggc.scot/downloads/nhsggc-time-to-lead-sop/
NHSGGC TtL Case Study and Team Level SOP Case Study - Anaesthesia & Critical Care Acute Wide	https://live.nhsggc.scot/downloads/nhsggc-time-to-lead-sop-case-study-poster-anaesthesia-critical-care/
	https://www.youtube.com/watch?v=9GdJ2tKiMdU
NHSGGC Common Staffing Method SOP	NHSGGC Common Staffing Method SOP - NHSGGC
NHSGGC Common Staffing Method (CSM) Case Study Maternity Services	https://live.nhsggc.scot/downloads/csm-case-study-poster-maternity-services/
	https://www.youtube.com/watch?v=F6e1D5Sg1LA
NHSGGC Real Time Staffing and Risk Escalation SOP - Anaesthesia Department GRI	https://live.nhsggc.scot/downloads/rts-re-sop-anaesthesia-dept-gri/
	https://live.nhsggc.scot/downloads/rts-re-sop-case-study-poster-anaesthesia-dept-gri/
	https://www.youtube.com/watch?v=6xVCDoZGCN0
NHSGGC Draft Workforce Plan Template - ONLY AVAILABLE THROUGH SHAREPOINT. For further assistance contact ggc.healthcare.staffing@nhs.scot.	DRAFT Workforce Plan Template.pptx
NHSGGC Nursing and Midwifery Safe to Start In-Patient Hospital Services Process and VLog for reference	NHSGGC Nursing and Midwifery Safe to Start In-Patient Hospital Services Process - NHSGGC
	https://www.youtube.com/watch?v=IFm05ynHwxc
NHSGGC RTS & RE SOP - Orthotics	NHSGGC RTS & RE SOP - Orthotics - NHSGGC
NHSGGC RTS & RE Case Study - Orthotics	NHSGGC RTS & RE Case Study - Orthotics - NHSGGC
NHSGGC RTS & RE SOP - Microbiology	https://www.nhsggc.scot/downloads/real-time-staffing-risk-escalation-sop-microbiology/
NHSGGC Psychology Real Time Staffing & Risk Escalation SOP	https://www.nhsggc.scot/downloads/real-time-staffing-risk-escalation-sop-psychology/
NHSGGC Psychology Time to Lead SOP	https://www.nhsggc.scot/downloads/time-to-lead-sop-psychology/
In Development	
NHSGGC Psychiatry Real Time Staffing & Risk Escalation SOP	*To be published on HCSSA Website June 2025*
NHSGGC Psychiatry Time to Lead SOP	*Expected June 2025*

Assurance Statement Summary

Requires Director or Chief Officer to complete (or authorised depute)

I am aware that I am required to provide an assurance to the Boards Clinical Leaders in regards to the compliance and assurance levels in relation to the Health and Care (Staffing) (Scotland) Act 2019 to enable them to conclude an internal assurance report for the previous quarter, as part of the legislated reporting for the organisation.

To assist you in that process, I can confirm that I have received and reviewed the required assurances (including associated checklists) from Deputy Directors (or equivalents) within my command

Based on that review, and my own knowledge of matters in my area of responsibility

There are, in my opinion, no significant matters arising in my area of responsibility which would require to be raised specifically to contribute to the internal assurance report, be this an area of challenge or risk, or an area of success which would benefit from shared learning.

1. Head of HR post currently vacant - challenge re progressing completion of workforce plan - SMT session planned for August 2025 to focus on developing interim plan for 2025 - full review to be aligned with life cycle of HSCP strategic plan 26- 28 .

2. Common Staffing Method outputs present a financial challenge for HSCP - across District Nursing and School Nursing

3. Impact of the reduced working week is being assessed and continues to be expressed across a range of affected services - detailed evaluation udetaken and submitted to NHSGGC August 2025

Apart from anything identified above, there are, in my opinion, no other significant matters arising which would require to be raised specifically .

Name Beth Culshaw

Job Title Chief Officer

Date 07.07.2025

Duties	Assurance Levels (Select from Drop Down)
12IA Duty to ensure Appropriate Staffing	Reasonable Assurance

Please outline actions to meet 'Substantial Assurance' levels i.e. Key performance Indicators, Improvement methodology, introduction of new tools, recording templates, development of SOPs. This may be a phased plan and if so, how this progresses to Substantial or to Reasonable Assurance, from Limited or No Assurance is encouraged

Checklist for professional or service leads to discuss with their teams to facilitate discussion, find any gaps or identify evidence. - Please Answer Each

This section is used for Consistency Checking PLEASE DO NOT OVERWRITE, Additional Actions should be listed in the separate section below

Evidence Source	Summary	Location	Action(s) Required	Yes*	No or Partial**
Governance and Ove	HCSA principles understood . Q 4 report shared with SMT, JSF . Combined Health and Care HCSA assurance will be presented at August 2025 IJB Audit and Perfromance Committee . Relfected and discussed at SMT, HSCP CCG, and HSCP workforce Planning Group . requirements of the act Reflected in updated IJB Strategic risk register. Monitor service supply and emand via weekly SMT oversight reports . Review of quality metrics via CCG structures . Review of datix incidents and significant adverse events learning and action plans. RTS and risk escalation SOPs developed and	HSCP SMT folder Shared drive	Defined systems &processes are in place, and utilised, in function and professional groups to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as identified in scope of the Act are working in such numbers as are appropriate for the health, wellbeing and safety of patients; the provision of safe and high-quality health care; and in so far as it affects either, the wellbeing of staff. > Local Workforce Plans are in place and give reference to the Acts guiding principles and its duties as appropriate and the systems and processes in relation are being considered and used > Local Workforce Plans include ensuring Staff in Roles identified in the Act are suitably qualified and receive required Training to carry out their roles appropriately. >Local Workforce Plans include workforce action plans that are regularly reviewed for progress by SMT or equivalent.		Partial - workforce plan due to be updated by end 2025
Communication with	Im matters - team wellbeing and functioning , SWAY newsletter, lcoal communicaio		The systems and processes have regard to the nature of the particular kind of health care provision and the local context in which being provided incl number of patients / service users its provided to and their needs. (eg RTS & RE SOP Local Team, Business Continuity Plans, where app CSM with Dynamic Service review, also any other workforce planning for service in place) **>RTS & RE SOP for Service / Team** **>Business Continuity Plan is in place**	Yes	
Staff Wellbeing Reso	Range of well publicised resources that staff can access . Civility saves lives , peer support , clinical supervision, caseload management supervision	Staff net nhsggc. Wdhscp shared folder	These systems and processes include having regard to appropriate clinical advice	Yes	
PDP /Annual review	Staff fhave annual review - personal development plans in place - perfromance data reviewed regulary via team Leads throught to SMT	TURAS	Any new or revised agreements with other Boards, Independent Contractors, Third Parties from Apr24 give regard to the guiding principles and duties of the act as part of the specification or contractual agreement.	Yes	
Elctronic Care Manag	Inclusive care Planning Processes are implementd across the HSCP	EMIS CMIS Care First	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)		Partial
Business Continuity I	Business continuity Plans are in Place for all services and are reviewed and tested regularly	HSCP SMT shared Drive			
SMT Standing report	Perfromance reports - trend analysis - workload quality metrics and staffing provide traingulated oversiight	SMT / Perfromance and audit an			
Complaints Feedbac	Complaints review - trend analysis and learning	SMT/Servic area specific activity			
Strategic Planning	Set priorites within local context needs and numbe	HSCP website			

Required * Complete the table to the Left Required ** Complete the table below

Areas of Shared Learning or Success to Spotlight
Care Opinion will go live for 'health' in WDHSCP from Spetember 2025
West Dunbartosnhire Adverse Event Oversight Group established from June 2025 supports more rigourous local approach to decision making and governance of decsions and improvement in KPI around SAER management

Areas of Challenge or Concern & Mitigations Required
West Dunbartosnhire HSCP Workforce Plan - under development - vacancy Head of HR post
Implementation of Safe Care

Actions	Time scale #	Lead	Governance	Risks
	End of August 2025	Head of HR	HSCP	Hof HR Vacancy - succesful recrutiment required
1. Update WDHSCP Workforce Plan (Action tracker Sept 2025/ Audit octeober 2025) cyclcle to be aligned with HSCp Strategic planning) Content of wokforce plan to be updated to reflect Action Tracker from Workforce Plans are due in September and there is an audit in October so to consider when setting dates. Future Due Diligence. Use of 6 step methodology and reference to the Act, with action plan. How is the Reduced Working Week impacting appropriate staffing levels? Have the outputs of the CSM Staffing level Tools identified any area of workforce that require action in the plan? Do Workforce plans include the elements of the act around protected learning time and leadership?	tbc			
5 Strenghen evidence of learning from complaints - evidence base at HSCP level	2025- 2026	Head of Strategy a	WD CCG	Capacity for oversight and systematically gathering learning
6 Establish monthly datix oversight for unmitigated issues or severe and recurrent risk	tbc.	Chief Nurse	SMT /CCG	Require support from NHSGGC GCSU
7. Strenghen overisght and management of risk wihtin school nursing service / develop data to enahnce CSM traingulation prcess to evidence staffing requiremnts				
6 Assessment of Impact of the Reduced Working week	End August 2025	Head of HR		
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Please provide estimated date for action to be completed with Evidence available

Duties	Assurance Levels
12IC Duty to have Realtime Staffing in Place	Reasonable Assurance
12ID Duty to have Risk Escalation in place	Reasonable Assurance
12IE Duty to have arrangements to address severe and recurrent risks	Reasonable Assurance

Please outline actions to meet 'Substantial Assurance' levels i.e. Key performance Indicators, Improvement methodology, introduction of new tools, recording templates, development of SOPs. This may be a phased plan and if so, how this progresses to Substantial or to Reasonable Assurance, from Limited or No Assurance is encouraged

Checklist for professional or service leads to discuss with their teams to facilitate discussion, find any gaps or identify evidence. - Please Answer Each
This section is used for Consistency Checking PLEASE DO NOT OVERWRITE, Additional Actions should be listed in the separate section below

Evidence Source	Summary	Location	Action(s) Required	Yes*	No or Partial**
NHSGGC Common s	CommoncStaffing Method Reports Submitted to SMT and NHS	HSCP SMT Shared drive	Defined systems and processes are in place, and utilised, for the real-time assessment of compliance with the duty to ensure appropriate staffing, in all functions and professional groups. Including a means for raising awareness among all staff of the methods for identifying risk, reporting to the individual with lead professional responsibility , mitigation, and seeking and having regard to clinical advice. Including the means to provide training to relevant individuals with lead professional responsibility and other senior decision-makers on how to implement the arrangements in place to comply with this duty. > **Local level RTS & RE SOP (completing all aspects of Org level SOP Checklist)** **>Staff are appropriately informed and understand the SOP** **>Are aware of the Time To Lead local SOP and its interrelatedness to Clinical Advice and Risk Escalation?**	Yes	
HSCP Workforce Gr	Develops workfprce plans reviews and supports HCS implemer	West Dumbartonshire HSCP SMT shared folder / Hscp Workforce teams chanel	The systems and processes include the means for any member of staff to identify any risk caused by staffing levels to the health, well-being and safety of patients; the provision of safe and high-quality health care; or, in so far it affects either of those matters, the wellbeing of staff. **>Are your team huddle / meeting in place and recorded?** **>Are the factors for assessing actual and potential staffing concerns in your SOP?** **> Is Datix incident reporting process within your SOP?** **> Are Staff Wellbeing considerations included in your SOP?** **> Are staffing concerns and voiced care concerns escalation processes in your SOP for in and out of hours?**	Yes	
SMT /IJB	Regular oversight of performance, incidents, trend analysis	SMT minutes - papers submitted to IJB and Performance and Audit Committee	The systems and processes include the means for the initial notification / reporting of that risk to the relevant individual with lead professional responsibility, and for that individual to seek, and have regard to, appropriate clinical advice as necessary. **> Are LPs and senior decision makers clearly defined and identifiable in your SOP?** **> Are appropriate clinical advice processes included within your local SOP to ensure clarity regarding roles and responsibilities?** **>Are the appropriate mitigations included within the SOP or a Business Continuity Plan?**	Yes	
Quality of care Mea	Implementation of excellence in Care - CCAT audits - nursing .	HSCP SMT &CCG minutes - paper:	The systems and processes include means for this onward reporting in to escalate further, as necessary, in order to reach a final decision on a risk, including as appropriate, reporting to members of the relevant organization. **>Do you have a flow process map in place so this is clearly identified and understood within your SOP?**	yes	
Annual Clinical and	Annual review of good practice acros HSCP - slected examples	HSCP SMT Shared drive	The systems and processes include means for notification of every decision made following the initial report, and the reasons for that decision, to anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice. **> Are local records held and include minimum requirements as outlined in the Organizational level RTS & RE SOP**?	Yes	safe levels as opposed to minimum requirements
WDHSCP Risk regist	Operational and Strtegic risk registers regularly reviewed	Operational risk register - HOS . S	The systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to record any disagreement with any decision made following the initial identification of a risk and to request a review of the final decision made on an identified risk. **> Does your SOP include LPs/senior decision makers notification to the individual who originally escalated the staffing concern?** **>Does your SOP set out how staff can record disagreements and formally request a review**		Partial
NHSGGC rts and ris	Implementation means that staff understand the procedures required andrecognise professionl responsibility to identify and escalat concerns and risks . Thre is a clear process to enable mitigation and raise escalations. Staff have nee necouraged to undertake e rostering masterclassess across all	Chief Nurse Prfesiional Meeting Minutes	The systems and processes include means for ensuring that individuals with lead professional responsibility and other senior decision-makers receive adequate time and resources to implement the arrangements. **>Do you have the interrelated Time To Lead SOP in place for your team?**		Partial
SMT /IJB	Governance and risk managemnt processes clearly defined and wll established - subject to regular review	hred drive	Defined systems and processes are in place, and utilised, in all functions and professional groups, for the collation of information relating to every risk escalated to such a level as the relevant organisation considers appropriate. To identify and address risks that are considered severe and / or liable to materialise frequently and so far as possible, along with a requirement to seek and have regard to appropriate clinical advice in carrying out such mitigation. Also to report or escalate to a more senior decision-maker, including to members of the relevant organisation as appropriate **>Are you using Datix reports, SSTS reports and local records to systematically identify, analyse, evaluate, mitigate and manage RTS severe and recurrent risks consistently and at an appropriate level?**		Partial
Clincial incident Datix reports	via smt and clinical governance datix reports are be used to identify severe and recurrent risks - and inform decision making regards inclusion on the appropriate level of risk register and consideration of mitigation and escalation . This	smt minutes - papers submitted t oIJB and Performance and Audit Committee	Processes include means for identification of actions to prevent further materialisation of such risks and the process to escalate recurring incidents to a Risk and escalate according to the Boards Risk Policy on Severe and recurring risk? **> Is this captured in your RTS & RE process or within other processes?**		Partial
WDHSCP	Safeto start and rts and risk escalation fully implemented across nursing and msk physiotherapty services	HSCP Shared Drive	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)		Partial
Quarterly Clinicla and Care Governance	Intorduced to IJB Audit and Performance from August 2025 /	HSCP Shared drive A&P minutes a	Do You Have Safecare in use for Real Time Staffing and has your local SOP been updated to Reflect this, including escalation, mitigation, disagreement in decision making and resolution?		No

Required * Complete the table to the Left Required ** Complete the table below

Areas of Shared Learning or Success to Spotlight
Strenghened Quarterly Clinical and Care Governance report intorduced from August 2025 to IJB Audit and Perfromance from August icnlude HCSA and highlight severe and recurring risks implications for care quality
Act

Areas of Challenge or Concern & Mitigations Required
Deployment of Safe Care
Commitment to develop agreed and funded recruitment pipeline for SCPHN student Health visitors and
Next steps - so what following completion of CSM -undertanding expectations at HSCP level following sign off

	Time scale #	Lead	Governance	Risks
1 Continue to develop understanding of RTs and RE across HSCP and embed practice as BAU across all eligible groups (nb laon practioners in small integrated teams)	Ongoing	VT CN	CN group / SMT	Failure to embed in BAU
2 Support and fund post graduate opportunities to maintian pipeline and prevent future materialisation of risk	annual review of local requiremnts	VT CN	Via SMT /Workforce Planning	Financial capacity to support and fund adequate numbers of post graduate stduents
3. Strenghen how SMT reviewing recurrent incidents and Escalations and converting to HSCP Risk register for review and mitigate / manage / report?				
4. Map all localised service SOPs to confirm completion				
5. Strengthened Quarterly Clinical and Care Governance report introduced from August 2025 to IJB Audit and Performance from August include HCSA and highlight severe and recurring risks implications for care quality				
6				
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10				

Please provide estimated date for action to be completed with Evidence available

Duties	Assurance Levels
12IF Duty to seek clinical advice on staffing	Reasonable Assurance

Please outline actions to meet 'Substantial Assurance' levels i.e. Key performance Indicators, Improvement methodology, introduction of new tools, recording templates, development of SOPs. This may be a phased plan and if so, how this progresses to Substantial or to Reasonable Assurance, from Limited or No Assurance is encouraged

Checklist for professional or service leads to discuss with their teams to facilitate discussion, find any gaps or identify evidence. - Please Answer Each

This section is used for Consistency Checking PLEASE DO NOT OVERWRITE, Additional Actions should be listed in the separate section below

Evidence Source	Summary	Location
WDHSCP Teams	RTS and risk escalation process in place and followed across all nursing families and msk physio therapy	WDHSCP Workforc Planning and HCSA Site
WDHSCP SMT reports CSM	Follow NHSGGC Common Staffing Method SOP . Follow NHSGGC Safe to start Realtime staffing SOP . Common staffing report clearly articulate professiona perspective - operational HOS and managers included in triangularion meetings the outcome of which is recorded	WDHSCP Workforc Planning and HCSA Site
WDHSCP CCG Datix reeprots	Clinical incident reporting review & oversight . Adverse event oversihgt group has professional representation	WDHSCP Shared Drive
Vacancy Panel reports	profesional advice rpovided on vacany management	Minute wdhscp shared drive

Action(s) Required	Yes*	No or Partial**
Clear Definition of Clinical Leader locally (Part of Time to Lead SOP)	Yes	
System and processes are in place, and utilised, in all functions / professional groups, to seek and have regard to appropriate clinical advice in making decisions and putting in place arrangements relating to staffing under sections 12IA to 12IE and 12IH to 12IL and to record and explain decisions which conflict with that advice.		Partial
The systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any risks caused by that decision are identified and mitigated so far as possible.	yes	
These systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any person who provided clinical advice on the matter is notified of the decision and the reasons for it and this person is able to record any disagreement with the decision made.	Yes	
These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to enable and encourage other employees to give views on the operation of section 12IF and to record those views. For these to be considered as part of the reporting process agreed professionally and operationally, to be considered for the reporting and for to the members of the board on at least a quarterly basis about the extent to which they consider the relevant organisation is complying with the duties in 12IA to 12IF and 12IH to 12IL.	Yes	
These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the relevant organisation on at least a quarterly basis about the extent to which they consider the relevant organisation is complying with the duties in 12IA to 12IF and 12IH to 12IL.	Yes	
These systems and processes include the means to raise awareness among individuals with lead clinical professional responsibility for a particular type of health care in how to implement the arrangements in this duty and adequate time is provided for this to be carried out.	Yes	

Required * Complete the table to the Left

Required ** Complete the table below

Areas of Shared Learning or Success to Spotlight

Areas of Challenge or Concern & Mitigations Required

Action	Time scale #	Lead	Governance	Risks
1Review vacancy panel sop and paperwork to ensure compliant with HCSA dduty to se	Jun-25	GG	SMT	Vacancy Head of HR
2 Seek to strenghen operational/ professional assurance re AHP - e.g. SLT, OT arrangm	Jun-25	prefessional leads AHP	SMT	
3Ensure there is a clear definition of a clinical leader in place, is that for all job families?				
4Action to ensure systems and processes in place have appropriate clinical advice / are involved in decision making – is that linked to the clinical input to recruitment				
5What intelligence is coming from Supervision meetings / PDP-Rs in respect to decision making and disagreements in the interim				
6Are local TtL SOPs in place - map loclaised service sops				
7evidence is there of Reasonable assurance from iMatters reports / PDPR's / Clinical Supervision?				
8				
9				
10				

Please provide estimated date for action to be completed with Evidence available

Duties	Assurance Levels
12IH Duty to ensure adequate time given to clinical leaders	Reasonable Assurance

Evidence Source	Summary	Location
NHSGGC	Time to Lead SOP - discussed at ESMT - disucssion re defining who wihtin teams are 'clinical leaders' and what their responsibilites are .	
Datix WDHSCP	Local sop dsrequires Clinical leaders to datix when they 'step down ' to mitigate risk in front line service delivery - and record activites e.g Prctice develpoment , quality assurance, supervisioon that were impacted by this .	WDHSCP HCSA Teams chanel Datix reports
SSTS	Record Time to Lead on SSTS - keep records where this had been compromised - record kept - datix completed	
1-1 Supervision Reco	Evidence of discussion at supervision recorded - also any mitigations	Team Level supervision records
NHSGGC	Time to Lead SOP - discussed at ESMT - disucssion re defining who wihtin teams are 'clinical leaders' and what their responsibilites are .	NHSGGC Staff Net

Areas of Shared Learning or Success to Spotlight

Areas of Challenge or Concern & Mitigations Required
Introduction of safe care and e rostering

Please outline actions to meet 'Substantial Assurance' levels i.e. Key performance Indicators, Improvement methodology, introduction of new tools, recording templates, development of SOPs. This may be a phased plan and if so, how this progresses to Substantial or to Reasonable Assurance, from Limited or No Assurance is encouraged

Checklist for professional or service leads to discuss with their teams to facilitate discussion, find any gaps or identify evidence. - Please Answer Each

This section is used for Consistency Checking PLEASE DO NOT OVERWRITE, Additional Actions should be listed in the separate section below

Action(s) Required	Yes*	No or Partial**
Defined systems and processes are in place, and utilised, in all functions and professional groups, to ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties. > There is a local Time To Lead SOP in Place which states local process / people - See Organisational Time to Lead SOP		Partial
The systems and processes include the means to identify all roles, and therefore individuals, with lead clinical professional responsibility for a team of staff and include time and resources for these individuals to supervise the meeting of the clinical needs of patients in their care; to manage, and support the development of, the staff for whom they are responsible; and to lead the delivery of safe, high-quality and person-centred health care. This includes: - **> Oversight of care delivery including enhancing patient experience** **> Clinical supervision and observation of clinical practice** **> Lead on quality improvement and change in a clinical service** **> Act as a role model for colleagues, and setting standards for care delivery** **> Direct management of staff (including rostering, appraisals, PDP, recruitment etc**	Yes	
These systems and processes include the means to determine what constitutes sufficient time and resources for any particular individual. **> Emulate the requirements utilising the Organisational Time to Lead SOP as an example for a locally adapted SOP**		Partial
These systems and processes include the means for ensuring this duty has been reviewed and considered within the context of job descriptions, job planning and work plans, as appropriate.		Partial
These systems and processes include the means to consider outputs from activities carried out to meet this duty in order to inform future workforce planning and protect the leadership time required for clinical leaders. **> Running the common staffing method (where applicable)** **> Implementing real-time staffing assessment and risk escalation procedures** **> Resource management (rostering, procurement, effective use of resources etc)**		Partial
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	yes	
Do You Have SafeCare in use for Real Time Staffing (In process of being rolled out organisationally)? If so are you utilising this for Time to Lead and producing reports? If so, has your local SOP been updated to reflect this?		No

Required * Complete the table to the Left Required ** Complete the table below

Action	Time scale #	Lead	Governance	Risks
1. Ensure all staff who require adequate time for clinicla leadership roles are indentified and that provision of this is adequate and oversight and monitoring is strenghened (review all band 7 posts intilly for assurance)	Aug-25	VT - nursing AHP Professional Leads / HOS	SMT	
2what evidence is there of Reasonable assurance from iMatters reports / PDPR's / Clinical Supervision?				
3Are local TtL SOPs in place as partial but evidence looks like incomplete? Do you have a mapping of all Localised Service TtL SOPs required and completed				
4				
5				
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7				
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Please provide estimated date for action to be completed with Evidence available

Duties	Assurance Levels
12II Duty to ensure appropriate staffing: training of staff	Reasonable Assurance

Please outline actions to meet 'Substantial Assurance' levels i.e. Key performance Indicators, Improvement methodology, introduction of new tools, recording templates, development of SOPs. This may be a phased plan and if so, how this progresses to Substantial or to Reasonable Assurance, from Limited or No Assurance is encouraged

Checklist for professional or service leads to discuss with their teams to facilitate discussion, find any gaps or identify evidence. - Please Answer Each
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Evidence Source	Summary	Location
NHSGGC /HSCP repo	Induction records - NHSGGC. Statutory Mandatory Compliance .	WDHSCP Shared Drive
PDP and review	Undertaken annually for all staff with 6 month review. Staff access role specific essential learning - monitor 2% PAA for study level. Succession planning is in place to identify need for specialist education e.g. spQ, SCPHN	TURAs
Revalidation Nursing	Nursing - 35 hours over three years L&E evidence required	ees, local records for supervision

Action(s) Required	Yes*	No or Partial**
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all relevant employees receive such training as considered appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b) **> Is education and training in place at informed level for all roles in the Act?** **>Is education and training in place at skilled level on the Act for leadership roles?** **>Is local education and training in place?**		Partial
These systems and processes include means to determine the level of training required, and time and resource to support this, for all relevant employees. **> Promotion of Turas Modules based on staff roles and responsibilities** for HCSSA **> All other professional and process related training to ensure staff can adequately carry out their role is made available on joining and refreshed on a recurring basis as appropriate**		Partial
These systems and processes include the means to ensure all relevant employees receive both time and resources to undertake the training. **> Identify how this is monitored and reviewed**		Partial

Required * Complete the table to the Left — Required ** Complete the table below

Areas of Shared Learning or Success to Spotlight

Areas of Challenge or Concern & Mitigations Required
1. unable to monitor number of staff who have completed turas modules and secure
2. Not all training is recorded on systems eg Basic life support burdensome from an

Action	Time scale #	Lead	Governance	Risks
1Require to strenghen and articulate clear role / profession specific mandatory training with timescales for completion and review across professional groups		?		
2actions need expanded for evidence and tracking and with target timelines?				
3Turas Module completion - challenging due to lack of reporting. Are there others reporting aspects of training etc difficult, as I know Protected Learning Time is looking on how they can all be reported? Assume admin perspective is due to no reporting / manual checks and bringing together reports?				
4Is there any evidence that staff are not getting appropriate time to undertake training required for their roles as part of the PDP-Rs, Team and Performance Management meetings, Supervisions?				
Due Diligence, What is the current % of Stat Man Training for the HSCP and action plan for improving if needed?				
6				
7				
8				
9				
10				

Please provide estimated date for action to be completed with Evidence available

Duties	Assurance Levels
12IJ Duty to follow common staffing method	Substantial Assurance
12IK Common staffing method: types of health care	Substantial Assurance
12IL Training and consultation of staff	Substantial Assurance

Evidence Source	Summary	Location
Common Staffing Methd reports HV, School Nurse , District Nursing , Clinical Nurse Specialist	Fully Implemented all eligible teams to date	HSCP SMT Shared drive
Staffing Level Tool Runs	implemented where mandated	HSCP SMT Shared drive
CSM reports WD HSCCP	Staff have accessed learning on completion of workload tools and application of csm . Triangulation	HSCP SMT Shared drive

Areas of Shared Learning or Success to Spotlight

Areas of Challenge or Concern & Mitigations Required

Please outline actions to meet 'Substantial Assurance' levels i.e. Key performance Indicators, Improvement methodology, introduction of new tools, recording templates, development of SOPs. This may be a phased plan and if so, how this progresses to Substantial or to Reasonable Assurance, from Limited or No Assurance is encouraged

Checklist for professional or service leads to discuss with their teams to facilitate discussion, find any gaps or identify evidence. - Please Answer Each
This section is used for Consistency Checking PLEASE DO NOT OVERWRITE, Additional Actions should be listed in the separate section below

Action(s) Required	Yes*	No or Partial**
Clearly defined systems and processes are in place to ensure that all employees receive such training as considered appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b) and such time and resources as considered adequate to undertake this training. **>CSM Reporting Template**	Yes	
These systems and processes include means to determine the level of training required, and time and resource to support this, for all relevant employees	Yes	
These systems and processes include the means to deliver the agreed level of training to all relevant employees.	Yes	
These systems and processes include the means to ensure all relevant employees receive both time and resources to undertake the training. **>Predicted absence allowance**	Yes	
The Common Staffing Method has been applied on an annual basis over a two week period in the legislated areas of practice. **>CSM SOP** **>Toolkits** **> CSM Reporting Template** **>CSM Local Report**	Yes	
All elements of the Common Staffing Method have been included **>CSM SOP** **>Toolkits** **> CSM Reporting Template** **>CSM Local Report**	Yes	
"These systems and processes include taking into account the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care (particularly those to which the common staffing method does not apply). **>CSM Local Report**	Yes	
These systems and processes include taking into account comments by patients and individuals who have a personal interest in their health care, which relate to the duty imposed by section 12IA. **>CSM Reporting Template**	yes	
These systems and processes include taking into account comments by employees relating to the duty imposed by section 12IA. **>CSM Reporting Template**	Yes	
These systems and processes include means to identify and take all reasonable steps to mitigate any risks. **>Datix Risk Module**	yes	
"These systems and processes include means to decide what changes (if any) are needed to the staffing establishment and the way in which health care is provided as a result of following the common staffing method. **>CSM SOP** **> CSM Reporting Template** **>CSM Local Report**	yes	
"Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of employees. **>CSM SOP**	yes	
These systems and processes include means to encourage and support employees to give views on staffing arrangements for the types of health care described in section 12IK. **>CSM Reporting Template**	yes	
These systems and processes include means for taking into account and using views received to identify best practice and areas for improvement in relation to staffing arrangements.9 **>CSM SOP** **>CSM Reporting Template**	cyes	
These systems and processes include training employees (in particular those employees of a type mentioned in section 12IK) who use the common staffing method on how to use it. **>CSM SOP** **>CSM Reporting Template Guidance** **> Toolkits** **>HCSSA Informed / Skilled level Learning**	yes	
These systems and processes include ensuring that employees who use the common staffing method receive adequate time to use it. >CSM SOP >Link to Time to Lead Assurance	yes	
These systems and processes include providing information to employees engaged in the types of health care mentioned in section 12IK about its use of the common staffing method, including the results from the staffing level tool and professional judgement tool; the steps taken under 12IJ(2)(b), (c) and (d) and the results of the decisions taken under 12IJ(2)(e). **>CSM SOP** **>CSM Reporting template**	yes	
Required * Complete the table to the Left	Required ** Complete the table below	

Action	Time scale #	Lead	Governance	Risks
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
Please provide estimated date for action to be completed with Evidence available				

West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire

Health & Social Care Partnership

Chief Officer: Beth Culshaw

Declaration

Name of local authority / integration authority: West Dunbartonshire Health and Social Care Partnership Board

Report authorised by:

Name: *Lesley James*

Designation: Chief Social Work Officer

Date: *30th June 2025*

Details of where the report will be published: via CMIS

1 Information Required

1.1 This section will detail the steps taken by West Dunbartonshire Health and Social Care Partnership Board ("WD HSCP Board") in 2024/2025 to comply with section 3(2) of the Health and Care (Staffing) (Scotland) Act 2019:

3(2) In planning or securing the provision of a care service from another person under a contract, agreement or other arrangements, every local authority and every integration authority (within the meaning of section 59 of the Public Bodies (Joint Working) (Scotland) Act 2014) must have regard to—

(a) the guiding principles for health and care staffing, and
(b) the duties relating to staffing imposed on persons who provide care services—

(i) by virtue of subsection (1) and sections 7 to 10, and
(ii) by virtue of Chapters 3 and 3A of Part 5 of the Public Services Reform (Scotland) Act 2010.

1.2 WD HSCP Board is committed approach to delivering services that are person centred, outcome focused and that meet the aims of West Dunbartonshire's strategic plan – Improving Lives Together: http://www.wdhscp.org.uk/media/2666/wd-strategic-plan.pdf

1.3 WD HSCP Board approach to commissioning services also follows key strategic documents including:

- West Dunbartonshire Council's Sustainable Procurement Strategy: Sustainable Procurement - West Dunbartonshire Council Procurement Strategy

- NHS Greater Glasgow and Clyde Procurement Strategy: https://www.nhsggc.scot/downloads/procurement-strategy-2022-2025/

1.4 It is noted that the NHS Greater Glasgow and Clyde Procurement Strategy have been updated, however these strategies did not come into effect until after the reporting period for this report.

1.5 All procurement processes carried out on behalf of the WD HSCP Board by West Dunbartonshire Council are in line with Standing Orders in relation to contracts, links to these documents are included below:

- West Dunbartonshire Council Standing Orders: Document.ashx
- West Dunbartonshire Council Financial Regulations: Document.ashx

1.6 The following is a list of contracts which have been awarded in 2024/25 on behalf of WD HSCP Board by its parent body, (West Dunbartonshire Council).

Procurement Process	Contract Title	Start Date	End Date
Direct Award	Provision of a Near Fatal Overdose Response Service	1st April 2025	31st July 2028
Direct Award	Provision of Services for Multiple and Complex Needs	1st April 2025	31st July 2028

1.7 As part of any procurement exercise, a number of steps were taken which demonstrate that there was regard given to the guiding principles of the Act. These have been detailed below:

- Provider must be registered with the Care Inspectorate to deliver the services they are being contracted to.
- Providers must provide an examples of previous experience in delivering similar services.
- Providers are required to have a minimum grade of 3 in all KQ themes.
- Providers must have appropriately skilled and qualified staff providing support to the defined user group.
- The Provider must have in place formal written policies and procedures to ensure that a risk assessment, as required under Health and Safety legislation is conducted on all aspects of tasks to be carried out by staff.

This must lead to the production of clear safe systems of work for all staff being developed and must form part of their staff induction process

1.8 Within our Invitation To Tender documentation we have sections on staffing within the technical envelope and service specification. A summary of these points can be seen below:

- Providers will have in place a comprehensive staff learning and development plan that will meet the needs of the Service, including comprehensive induction and continuous learning pathways.
- The Provider will ensure that Staff have the necessary skills, experience, knowledge, qualifications, registration with professional bodies and aptitude to respond to the needs of people who use the Service. Staff providing the Service must hold or be working towards a minimum qualification of SVQ II in the relevant field.
- The Provider shall recruit staff in line with their Safer Recruitment policy and process (including PVG scheme membership).
- Supporting workforce development is a critical part of ensuring a high quality, outcomes focussed service is provided to those receiving services. Can you outline what your learning and development training pathway will be for this service?
- Given the complexity of this service and the impact that this can have on staff, please describe what your approach is to promoting and supporting health and wellbeing within your workforce

1.9 Our Terms and Conditions have various clauses that relate to safe staffing, recruitment, and Disclosure Scotland requirements, specifically relating the Protection of Vulnerable Groups Scheme membership.

1.10 Our Quality Assurance and monitoring systems are being revised to align to outcomes and also incorporate the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

1.11 Any significant event, including those relating to staffing is required to be reported to WD HSCP. Our Quality Assurance collate and action this information. We also have positive links with the Care Inspectorate and work with them in relation to specific incidents and those that are serious in nature which may result in a Large Scale Investigation.

2. Please detail any ongoing risks that may affect your ability to comply with the duty set out in section 3(2).

2.1 The current financial context for WD HSCP Board and the cost pressures facing local commissioned providers (particularly in relation to Employers National Insurance Contributions) but additional strain on services and may hinder the ability to continuously improve.

2.2 The current financial context for WD HSCP Board has meant that the Quality Assurance team is staffed by 0.8FTE meaning that we have limited ability to undertake contract monitoring activity and rely on Provider returns as our resource is focused in supporting organisations in our areas that are experiencing challenges in relation to their quality.

2.3 Given recruitment and retention challenges within the sector and particularly within West Dunbartonshire, we have seen an increase in Recruitment Agency use and there is a risk that lack of continuity of staffing across both internal and externally provided services will lead to challenges regarding quality and consequently impact on outcomes for people requiring support.